PUBLIC LAWS AND INVESTMENTS INTENDED TO PROMOTE THE USE OF

# Medical Expertise in the Diagnosis & Treatment of Child Abuse & Neglect

## RESEARCH BRIEF


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# Acknowledgments

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# Introduction

**Health care professionals, most notably board-certified child abuse pediatricians (CAPs), are essential partners in protecting children. These professionals, when timely and meaningfully engaged by child welfare professionals and law enforcement, provide critical expertise to respond to childhood trauma, and to guard against both under and over-diagnosis of child maltreatment.[1]**

11%
increase in
deaths in 4 years
Nationally, 1,720 children[2]
died from child abuse and
neglect in 2017; representing
an 11% increase from 2013.[3]

# Background

Congress has enacted laws, including the Child Abuse Prevention and Treatment Act (CAPTA),[4] which recognize the important and unique role of health care professionals in the accurate identification, diagnosis and treatment of child maltreatment. Some states have enacted laws that set forth, some in great detail, when and how specially-trained health care professionals are to be enlisted by child welfare professionals or law enforcement during a child abuse investigation, and throughout civil and criminal court proceedings.

Despite federal and state laws recognizing the value of health care providers with expertise in child maltreatment, there remains insufficient standardized practice or investment to ensure that children receive timely and appropriate medical evaluations and care. In addition, child welfare professionals and law enforcement often lack access to the expertise of CAPs or another health care provider with specialized training in child maltreatment, and are left to make decisions about child abuse and child safety without knowledge regarding injury epidemiology, injury mechanisms, infant and child development and medical diseases that impact children. Identifying abused children before their injuries are permanent or, in some cases, fatal, requires systems of care and evaluation that are based in best practices and informed by science.

***Since the enactment of the Child Abuse Prevention and Treatment Act (CAPTA)[4] 40 years ago, Congress has recognized, but not prioritized or adequately invested in, or monitored strategies intended to promote collaboration between child protective services, law enforcement and specially trained medical expertise.***

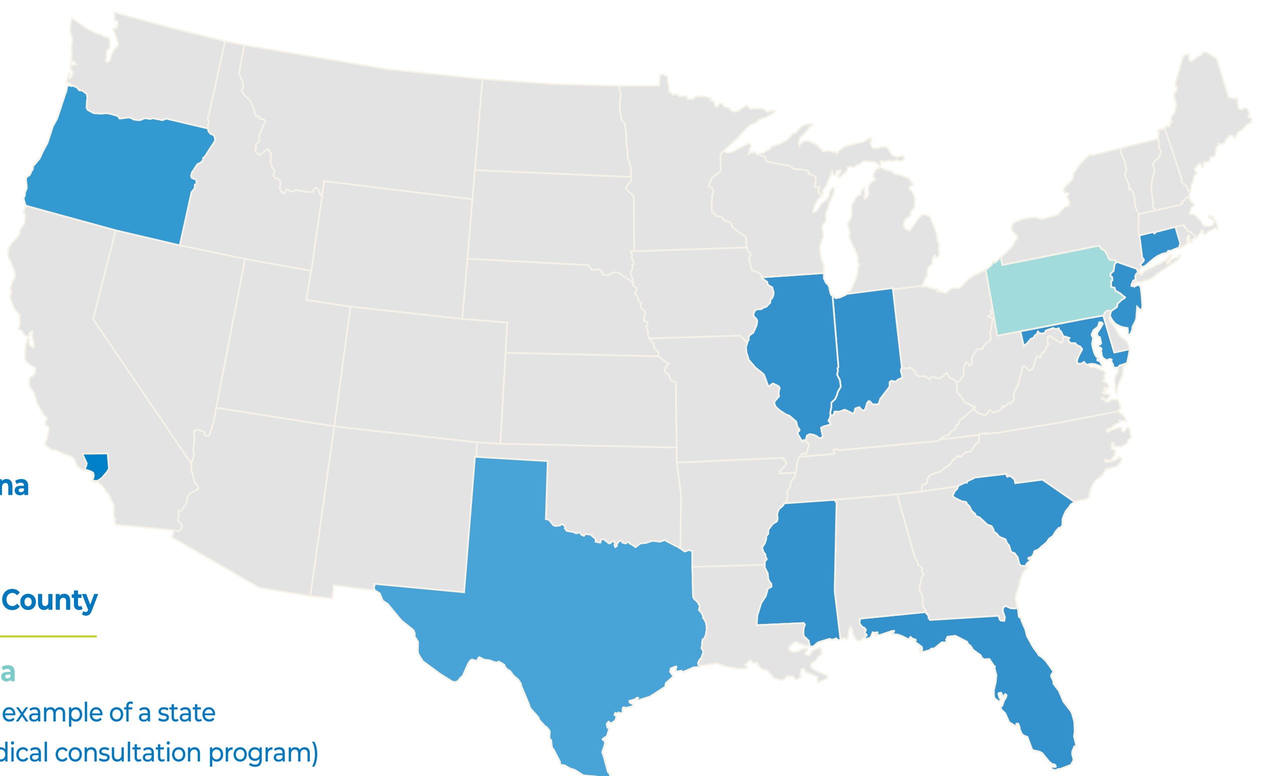
# The Research

In writing this research brief, the authors examined the statutes and/or administrative policies of eleven states (Connecticut, Florida, Illinois, Indiana, Maryland, Missouri, New Jersey, Oregon, Pennsylvania, South Carolina and Texas) and the City of Los Angeles to understand whether and how child protection statutes or administrative policies:

1. **ESTABLISH** an expectation that a child, who was reported as a suspected victim of child maltreatment, is referred for a medical evaluation; and whether there are any added requirements related to children with specific types of injuries or demographics (e.g., infants and toddlers);
2. **ARTICULATE** the specific design of a child abuse medical evaluation and consultation program that utilizes health care providers with specialized training in child maltreatment (e.g., CAPs);
3. **IDENTIFY** a designated funding source for medical evaluation and consultation; and
4. **CREATE** a (state or local) child protection medical director; and if so, what this position is specifically responsible for.

## RESEARCH CONDUCTED IN:

Connecticut
Florida
Illinois
Indiana
Maryland
Missouri
New Jersey
Oregon
South Carolina
Texas
Los Angeles County



Pennsylvania
(chosen as an example of a state without a medical consultation program)

## This analysis had these limitations:

1. Only 12 jurisdictions were included in the primary analysis. These jurisdictions - except for Pennsylvania - were chosen because the authors were aware that a medical consultation program existed. Pennsylvania was chosen as an example of a state without a medical consultation program. Ohio was not included in the overall examination of state statute or administrative policies but is discussed in this publication as it relates to Ohio's Timely Recognition of Abusive Injuries (TRAIN) Collaborative.[5]
2. Assessing to what degree state or local statute or written policy aligned or conflicted with on-the-ground practice was pursued by an interview with a child abuse pediatrician in each of the 13 jurisdictions. This area deserves further review and analysis.

## Rates of Child Maltreatment by Types of Child Victims[6]

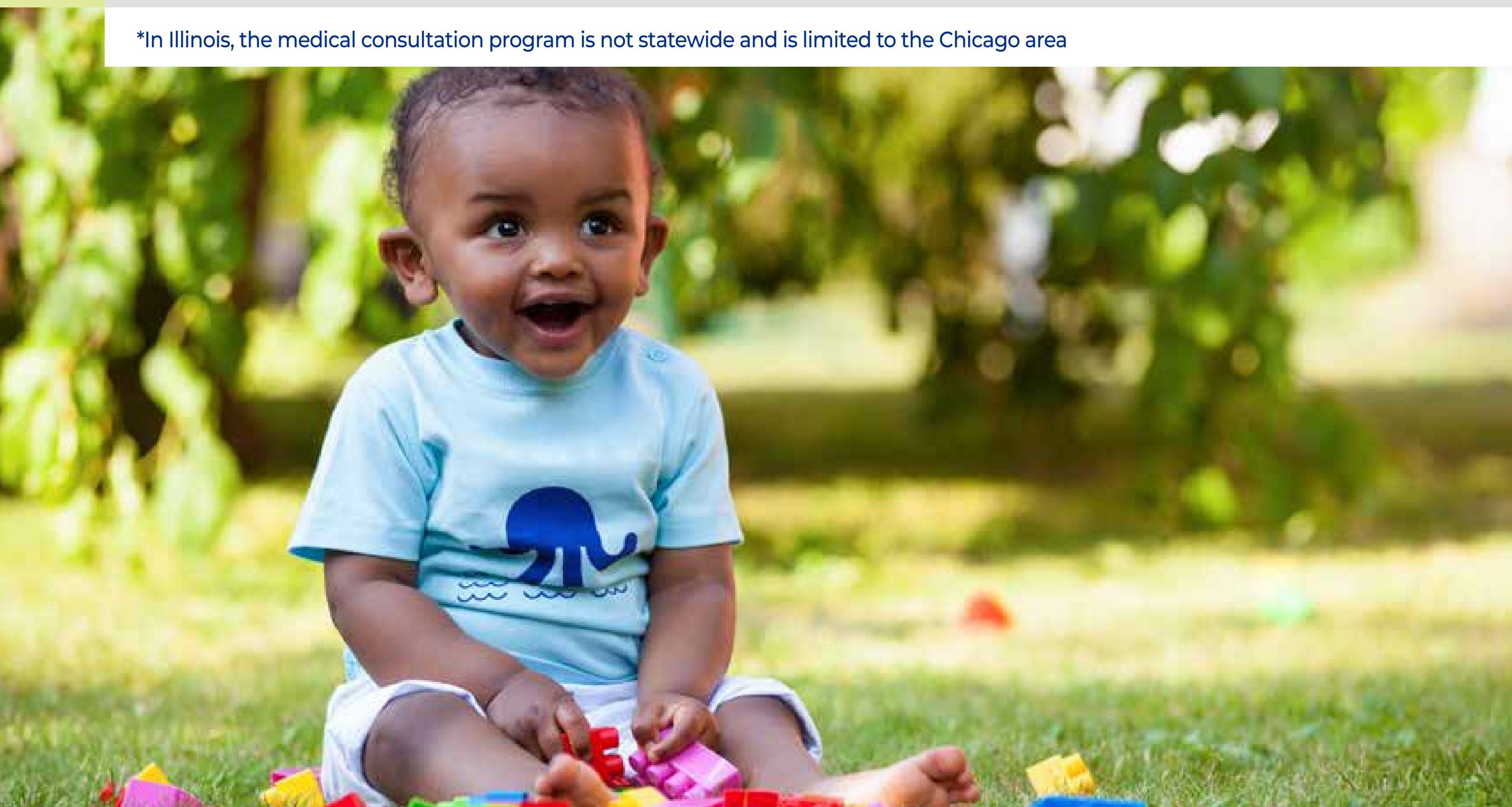
| in the year 2017[7] | number of children under 18 years of age[8] | rate of children per 1000 in the population, receiving an investigation or alternative response[9] | Rate of Child Victims per 1000 Children | | | |
|---|---|---|---|---|---|---|
| | | | all ages | less than 1 year of age | 1 year of age | 2 years of age |
| National | 74,312,174 | 47.1 | 9.1 | 25.3 | 11.7 | 11.0 |
| Connecticut | 743,826 | 32.8 | 11.3 | 30.4 | 16.0 | 14.9 |
| Florida | 4,201,983 | 70.5 | 9.5 | 28.0 | 14.4 | 13.5 |
| Illinois | 2,897,185 | 46.3 | 9.9 | 25.4 | 14.7 | 13.2 |
| Indiana | 1,573,409 | 103.7 | 18.6 | 61.7 | 24.8 | 23.1 |
| Maryland | 1,347,506 | 24.1 | 5.6 | 8.1 | 6.2 | 6.0 |
| Missouri | 1,382,971 | 50.9 | 3.3 | 4.7 | 4.1 | 3.8 |
| New Jersey | 1,979,018 | 37.6 | 3.4 | 8.2 | 3.9 | 3.9 |
| North Carolina | 2,302,346 | 52.4 | 3.2 | 6.8 | 3.8 | 3.8 |
| Ohio[10] | 2,605,235 | 41.5 | 9.6 | 25.7 | 11.0 | 10.6 |
| Oregon | 873,619 | 51.9 | 12.7 | 29.9 | 16.7 | 15.9 |
| South Carolina | 1,104,674 | 62.2 | 15.5 | 38.1 | 21.4 | 19.8 |
| Texas | 7,366,039 | 38.5 | 8.3 | 27.0 | 13.0 | 11.8 |
| Pennsylvania[11] | 2,664,515 | 16.1 | 1.7 | 2.6 | 1.6 | 1.7 |

Pennsylvania was chosen as an example of a state without a medical consultation program

## Key Aspects of Responses to Child Maltreatment

| state or county | medical evaluation and consultation program | designated funding for program | specific injuries or age of child triggers medical evaluation | designated medical director |
|---|---|---|---|---|
| Connecticut | yes | yes | no | yes |
| Florida | yes | yes | yes | yes |
| Illinois* | yes | yes | yes | no |
| Indiana | yes | yes | yes | no |
| Los Angeles | yes | yes | yes | yes |
| Maryland | yes | yes | yes | yes |
| Missouri | yes | yes | yes | no |
| New Jersey | yes | yes | yes | no |
| North Carolina | yes | yes | yes | yes |
| Ohio | yes | yes | yes | yes |
| Oregon | yes | yes | no | no |
| South Carolina | yes | yes | yes | no |
| Texas | yes | yes | yes | no |
| Pennsylvania | no | no | no | no |

*In Illinois, the medical consultation program is not statewide and is limited to the Chicago area



# Key Findings

- **Among the 12 medical consultation programs we reviewed, the types of child abuse reports included in the programs is highly variable.**

- **The interaction between the medical consultation programs and the locally operated children's advocacy center (CAC) is highly variable and often difficult to assess, particularly as it relates to physical child abuse.**

- **In nine of the 12 jurisdictions with medical consultation programs, specific injuries and/or age of a child triggers a medical evaluation. In each jurisdiction, it appears that the need for the consultation can be over-ridden by the CPS supervisor under certain conditions.**

- **There are very limited data about the effect of the medical consultation on outcomes (e.g., decrease in re-referrals or re-abuse, reduced trauma for the child, change in diagnosis based on expert opinion from a CAP, a decrease in unnecessary removals).**

  **This is particularly important in the current environment in which there have been several publicized articles in the lay press about alleged errors made by CAPs without discussion or comparison to errors made when CAPs are not involved and/or no medical expertise is available.[12]**

- **There are limited data about the costs associated with the medical consultation programs. In particular, the per child cost of obtaining this expertise and how it compares to other costs in the child welfare system. In addition, the source of this funding and whether the CAPs are employed by the state or contracted with the state is variable and not always clear. This is particularly important in the current environment in which multiple concerns have been raised about the relationships between CPS and CAPs.[13]**

# Recommendations for Next Steps

**Based on the information collected as part of this review, listed below are the recommendations for Child Protective Services agencies, child abuse pediatricians, policy makers and others who are responsible for the safety and well-being of children:**

1. **Work with government agencies to fund research to identify and develop standardized quantifiable outcomes of medical consultation programs. This includes measuring these outcomes and identifying which attributes of the programs are most associated with beneficial outcomes to children and families. When evaluating medical consultation programs, encourage comparison to the current practice standard rather than a perfect system without errors.**
2. **Measure the cost of different approaches to medical consultation and evaluate state-level funding mechanisms for sustainable administration of these programs.**
3. **Develop a tool kit for jurisdictions and/or states to assist in development of medical consultation programs, which includes evaluation metrics.**
4. **Monitor and strengthen federal statutes, including the Child Abuse Prevention and Treatment Act and the Victims of Child Abuse Act, to promote the use of health care providers with maltreatment assessment training, and increase access to specialized medical evaluations during a child abuse investigations.**
5. **Evaluate models of medical directorship for child welfare agencies for states who are interested in establishing robust systems of inter-professional care.**

# Reference Notes

[1] See for example:

- Anderst, J., et al. (2009). "Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion?" Child Abuse Negl 33(8): 481-489.
- McGuire, L., et al. (2011). "Child abuse consultations initiated by child protective services: the role of expert opinions." Acad Pediatr 11(6): 467-473.
- Girardet, R., et al. (2018). "Child protective services utilization of child abuse pediatricians: A mixed methods study." Child Abuse and Neglect, 76: 381-387

[2] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/ child-maltreatment. [2] Public law 93-247.

[3] Ibid.

[4] Public Law No: 112-275.

[5] http://ohioaap.org/trainnetwork

[6] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/ child-maltreatment.

[7] Child Maltreatment 2017, Table 3–6 Victims by Age, 2017.

[8] Child Maltreatment 2017, Table C–2 Child Population, 2013–2017.

[9] Child Maltreatment 2017, Table 3-1 Children Who Received an Investigation or Alternative Response, 2013-2017.

[10] Ohio was not included in the overall examination of state statute or administrative policies, but this publication references Ohio's Timely Recognition of Abusive Injuries (TRAIN) Collaborative in the discussion of sentinel injuries.

[11] Pennsylvania operates what the Pennsylvania Department of Human Services (PA DHS) describes as an "alternative response" where certain reports are classified as General Protective Services (GPS). GPS reports often trigger a legally required assessment of the child or family. To date, Pennsylvania has not reported data about the number of GPS assessments or related outcomes (e.g., validated or invalid) within the data submitted to The National Child Abuse and Neglect Data System (NCANDS). As a result, the data within the annual Child Maltreatment, which was the source of the above chart, does not provide a reliable measure of the number or rate of children in Pennsylvania receiving an investigation or alternative response. Additionally, variation in state definitions of child abuse and neglect assures that what some states might capture as neglect is instead categorized as a GPS case in Pennsylvania. These factors then should be understood when comparing Pennsylvania's data to national or another state's data reported within Child Maltreatment.

[12] See for example:

- Hixenbaugh M. Hundreds of parents accused of child abuse by doctors come forward. Houston Chronicle. December 5, 2019 https://www.houstonchronicle.com/news/houston-texas/houston/article/Hundreds-of-families-accused-of-child-abuse-by-14882290.php
  - An ER doctor was charged with abusing his baby. But 15 medical experts say there's no proof https://www.nbcnews.com/news/us-news/er-doctor-was-charged-abusing-his-baby-15-medical-experts-n1123756

[13] See https://www.americanbar.org/groups/litigation/committees/jiop/articles/2017/summer2017-combating-medical-experts-abuse-neglect-cases-juvenile-court-act/ and = Narang S. Understanding limits to legal immunity in child abuse cases. AAP News 2016: https://www.aappublications.org/news/2016/09/12/Law091216

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