MULTIDISCIPLINARY DECISION-MAKING MODEL FOR CHILD ABUSE IN MAINE- 2nd Edition 1999

Jim Jacobs, Ph.D.

The Multidisciplinary Decision-Making Model for Child Abuse in Maine, 2nd Edition is a valuable resource for professionals whose work involves or even touches upon child abuse and neglect cases here in Maine. If a physician, attorney, therapist, educator, judge, foster parent or others, involved in child maltreatment issues, needs to know about an area of expertise or information outside their own profession, or information regarding their profession's laws and responsibilities regarding child maltreatment, much of that information will be found here.

The second edition of the manual was published by the Child Abuse Action Network in 1999. Since the first edition was published, there have been increases in our understanding of causes, treatment and consequences of abuse and neglect, along The manual first examines the overarching context of the different timelines which are operating in child maltreatment issues. These can be divided into three major timelines, all different but interconnected: those of the child, the parent and the law. They are each different and together they will drive and shape the field of child maltreatment for the near future in Maine.

As an aggregate, children pass through different developmental stages, with differing needs at each point. We can call these stages "windows," because they open for a time of interaction around a particular issue or set of issues, and then they close. These windows, especially the earliest ones, from pre-natal needs through about three years old are often called a "critical" period by developmental researchers and experts. Luckily, in the vast majority of parent-child relationships, in the earliest years there is exquisite sensitivity to the thousands of moment-to-moment interactions between parent and child, along with enough flexibility on both sides to allow for the development of individual differences. It seems one of the worst of tragedies when those parents whose destiny were to be the caretakers cannot assume this role. Current research on children who have been severely abused or neglected in their early years is demonstrating there are changes in brain structure and neurological processing as a young child attempts to adapt to an abusive environment. These can be reflected in increased impulsivity, aggression and autonomic reactivity, which becomes embedded and difficult, if not impossible, to change later on. The groundwork for the "cycle of abuse" is laid when intervention is too late and too little.

Interventions with adult parents move at a different rate. We all wish that parents with problems reflected in child maltreatment could be rapidly rehabilitated. After all, in an ideal world, a child's parents and family are the best environment for a child, where a child can be loved and cherished. In some cases, a nudge in the right direction can act as a "wakeup call" for parents moving in the "wrong direction." Unfortunately, the parents who become more involved with systemic interventions have more serious issues, perhaps related to their own history, constitution and ongoing problems, such as substance abuse, domestic violence and mental health issues. Although we would like them to change quickly, and their children need them to change quickly, research strongly suggests that adults move through change at their own timelines. An understanding of this component is critical to understanding

problems that will arise in many, if not most, child maltreatment cases.

The research on how adults move through rehabilitation have demonstrated that treatment effectiveness of a variety of problems varies considerably from individual to individual. In the past, this variation has been "blamed" on the client, "Inadequate motivation, resistance to therapy, defensiveness, etc. " More recent studies have change led to the development of a model which appears to proceed more or less linearly. A short review of this research is summarized in the manual. This piece in itself is vital to the understanding of the evolution of child protection issues, as the language from the this research has become familiar to Child Protective personnel and Judges, both of whom have been acquainted with this research through training over the past few years.

The law also has timelines, which are reviewed in the manual. The complete Child Protective law is reproduced in the manual for reference. Federal guidelines and funding patterns have shaped Maine’s laws. Essentially, once a child comes into state custody, a plan for permanency generally needs to be in place by the end of a year. The time allowed for parental change may be even less than this as even after a preliminary hearing, another is scheduled in a month, and parents who want to believe they have no serious personal problems may continue in denial without using available interventions. Even after a full hearing, it takes time to set up appointments and begin treatment.

The original Multidisciplinary Decision-making Model for Child Abuse in Maine was the product of a forty member task force which met monthly throughout 1994. It identified important decision-making stages and guidelines to be used in making those decisions. These guidelines strive to identify the "best practice" and are not necessarily reflective of current practice in all areas. Due to limitations of resources, many areas of this state are unable to implement ideal practices in all circumstances. Current revisions were provided by former task-force members and new task force members through 1999, who were asked to review relevant sections and make changes to bring the Manual up to date.

The model provides a paradigm for professions directly involved in making decisions on behalf of children who have been abused or neglected. It defines the role and responsibilities of each professional and is intended to facilitate both understanding and collaboration among them.

The first page or "grid" of the appendixes identifies eight decision-making disciplines:
DHS - This category includes all of the functions of the Department of Human Services including child protective services, children's services, adoption and all of the administrative services supporting the child abuse and neglect system.

AAG (COURT/JUDICIAL) - The Attorney General's Office represents the Department of Human Services in civil (CV) child protection cases. (This section also includes the roles of the judiciary as defined by statute.)

LE - This category includes all law enforcement officials (except the District Attorney's office) involved in investigation and prosecution of criminal (CR) child abuse and neglect cases.

DA - The District Attorney's Office represents the State in criminal child abuse and neglect cases.

E - This category includes all educators who work with children who have been abused or neglected and families who have been affected by child abuse and neglect.

M - This category includes all medical professionals who work with children who have been abused or neglected and families who have been affected by child abuse and neglect.

PS – (Psychosocial) This category includes all mental health, substance abuse, and domestic violence professionals who work with children who have been abused or neglected and families who have been affected by child abuse and neglect.

R- Reference documents section. This includes the law itself and several specialty protocols.

Throughout this manual, documents are identified by letters referring to these disciplines. In addition, documents that apply to all disciplines are identified as MD or Multi-Disciplinary.

The Model further identifies five decision-making stages within the child abuse and neglect system.

Reporting - This category refers to the stage when abuse or neglect is suspected and the professional response to that suspicion.

Investigation - In both civil and criminal cases, the Department of Human Services and law enforcement officials are responsible for gathering evidence and information to determine whether abuse or neglect has occurred.

Assessment and Treatment - Once abuse and neglect has been substantiated, professionals assess the nature of the problem and determine what needs to be done to protect children from further abuse and to provide treatment to alleviate the effects of past abuse.

Court - In both civil and criminal cases, the court, using the legal standards established by the legislature, determines whether abuse or neglect has occurred and the appropriate disposition to be applied. This stage includes the preparation for court, the court proceedings themselves, and the quasi-judicial administrative proceedings held by the Department of Human Services.

Prevention/Collateral - This category includes efforts to prevent abuse and neglect from occurring and also describes resources and efforts for multi-disciplinary collaboration.

The grid identifies the essential decisions to be made at each stage of the proceeding and the role of each

of the participants during each stage. The manual gives an overview of the system with guidelines and protocols attached to provide information and direction to those making decisions about cases of child abuse or neglect.

A goal of this manual is to improve collaboration and cooperation among professionals working in this field by increasing knowledge and encouraging uniform practice throughout the state. All of this, we hope, will improve the lives of children who have been abused and neglected and to improve communication and cooperation among professionals in all areas, including prevention, to create communities working towards an end of child abuse and neglect. We expect that this manual will continue to be updated and expanded. We see this as a work in progress and look forward to receiving suggestions for additional material or articles to include.

Jim Jacobs, PhD., is a clinical/forensic psychologist, a member of the Child Abuse Action Network and editor of the recently released 2nd Edition of the Multidisciplinary Decision Making Model for Child Abuse in Maine.

Child Death and Serious Injury in Maine 1995-1998
The Report of the State Fatality and Serious Injury Review Panel

Lawrence R. Ricci, M.D.

In September of 1999, the Child Death and Serious Injury Review Panel of Maine issued its second report since its inception in 1992. This most recent report covered the years 1995 through 1998 and revealed a number of important findings. Before discussing these findings however it is useful to review the origins and structure of the Panel.

In April 1991, the Department of Human Services, with the assistance of a number of professionals throughout Maine, initiated the multidisciplinary Child Death and Serious Injury Review Panel. This panel began formally reviewing cases in May 1992. The panel is configured to include representative leaders of the judiciary, forensic pathology, community mental health, pediatrics (as well as forensic pediatrics), family practice, nursing, public health, civil and criminal law, law enforcement, and public child welfare. The panel meets monthly and reviews at least one case each month.

Unique among statewide child death review panels, the Maine panel in addition to reviewing child deaths also reviews serious injuries. Maine also has a centralized forensic medical examiner system which participates fully with the panel. The panel is established in statute and is guaranteed confidentiality as well as subpoena power. Additionally the panel performs an in-depth retrospective review of all relevant records, supplemented by oral presentations by key involved service providers.

The purpose of the panel is to review cases of child fatalities and serious injuries, particularly those revolving around child abuse, to improve the present systems and foster education to both professionals and the general public.

Since the last report in 1995, the panel has reviewed an additional 25 cases involving 26 children in 1996, 1997, and 1998. Half were male. The average age was 3. However, 30% of children were under the age of 1 and 46% were under the age of 2. The majority of children were under the age of 5.

Seventeen children died from the following causes:
Neglect 7
Battered Child Syndrome 5
murder/suicide 3
neonaticide 1
suicide 1

Nine children lived. These included the following diagnoses:
Shaken Baby Syndrome 4
Munchausen Syndrome by Proxy 2
Torture 2

Fourteen cases had two adult caregivers in the home. In five cases, the biological father was identified as the abuser; in three, mother's boyfriend, and in another five cases, the biological mother was identified as abuser. Seventeen cases involved domestic violence and eight cases involved substance abuse.

The following were identified in a significant percentage of cases: domestic violence, substance abuse, inability to recognize and protect the children from sources of harm, inability to recognize and/or meet the child's needs, transient chaotic lifestyles including multiple moves and multiple caregivers, poor housing, unemployment, prior Child Protective Services involvement, unrelated and inexperienced caregivers of infants and young children.

The key points noted by the work of the panel included the following:

1. Shaken baby programs need to particularly target the most likely offender, the young adult male in the home.
2. Co-sleeping with infants can pose a risk of serious injury or death, especially when other risk factors, such as substance abuse, are present.
3. A large proportion of offenders who take a child's life by abuse or neglect receive minor legal consequences for their actions.
4. Several instances of medical provider failure to report child abuse/neglect delayed protective action were identified.
5. Early rapid collaboration between law enforcement and Child Protective Services is critical to child safety and successful prosecution.
6. Safety assessment of surviving siblings is critical.
7. Developing a court record of findings of fact may be critical to Department of Human Services' presentation of evidence and success of court cases.
8. Maine's advocacy system needs standards, accountability, supervision, and staff training.
9. Good supervision and peer review are required for all professionals involved in child abuse/neglect cases.
10. There is no profile of abusive or neglectful parents, but certain characteristics and risk factors are common, including domestic violence, substance abuse, prior Child Protective Services involvement, transient chaotic lifestyle with multiple unrelated caretakers.
11. Professionals involved in Child Protective cases need to be alert to their own biases towards parents who may appear to be "like us." Likewise, parental demonstrations of affection and caring for the child may sidetrack professionals from recognizing that the parent may also be endangering the child's safety.

In August of 1999, a study entitled "Under-Ascertainment of Child Abuse Mortality in the United States" was published in the Journal of the American Medical Association (JAMA). The authors of this study reviewed all North Carolina child deaths from 1984 to 1994. They determined that child abuse deaths were underreported by a factor of three to one. Of 220 child abuse homicides, only 68 were

coded as child abuse in the state child abuse statistics. Nationally, 2973 child homicides were reported over the same ten year period. However, if the same phenomenon which occurs in North Carolina is occurring nationally, the actual incidents of child homicides probably number around 9500. The North Carolina study also noted that over the same ten year period the number of deaths increased 10% per year. Males were the perpetrators in 65% of cases and a biological parent in 63%.

As can be seen by the analysis, there were far too many abusive injuries and deaths in Maine since the last report four years ago. Maine has made some progress but not nearly enough.
1. We have successfully joined with other New England states to form a consortium of Northern New England child fatality review teams and maintain a presence within the national network of child death teams.
2. We have conducted extensive educational programs for professionals inside and outside the state of Maine on child deaths.
3. A particular focus of these educational programs has been the structure and function of our unique team and educating professionals to better identify and intervene in high risk situations before death occurs.
4. The Department of Human Services, with the support of the Child Fatality and Serious Injury Review Panel, has initiated a risk assessment protocol to help identify and intervene effectively in high risk cases.
5. The state forensic service, along with the panel's support, has developed a child maltreatment risk and impact evaluation procedure to determine the risk parents pose to their children and to develop intervention plans.
6. Collaborative case investigation involving law enforcement, Child Protective Services, and medical providers has improved remarkably in the last four years, thanks in large part to the efforts of the panel members.

Yet the panel and Maine continue to struggle. Successful prosecution has been inconsistently applied, both in Maine and the nation. It should be no less serious to injure or kill a child than to injure or kill an adult. Unrelated males in the home with child caretaker responsibility pose an ongoing risk to many of our most vulnerable citizens. The work of the panel continues with the hope that our next report will show continued improvement in our protection of Maine's children.

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Failure to Thrive

Hannah Pressler

Infants thrive physically and functionally. Physically, infants grow in length, weight, and head circumference. Head circumference is directly proportional to brain growth. Functionally, infants experience cognitive, motor, social, and affective development.

Failure to thrive is a term that describes children who are usually less than two years of age whose physical growth does not meet the norms set for their age and sex that are based on the standard growth charts of the National Centers for Health Statistics (NCHS). Failure to thrive is an imprecise diagnosis that is used when the underlying cause of the child's growth failure has not yet been identified. Accepted clinical definitions for failure to thrive include a drop in the child's weight to below the fifth percentile for age; a drop in weight across two major percentile groups; weight for height that is below the fifth percentile on a weight to height curve or a weight that is 20% or more below the ideal weight for an infant's height When calculating growth charts for the premature infant it is important to correct the plotted growth parameters for their gestational age. Traditionally failure to thrive has been divided into two categories, organic and nonorganic. Children with organic failure to thrive do not grow because they suffer from an underlying illness that alters their physiologic functioning. Children with nonorganic failure to thrive appear to have no organic illness that causes alteration in their physiologic functioning. This dichotomous view of failure to thrive is simplistic. Children who are failing to thrive may have a variety of problems both organic or physical and nonorganic or environmental that impact their weight gain. Children with nonorganic failure to thrive are malnourished because they have inadequate caloric intake. The malnutrition associated with organic failure to thrive may be secondary to conditions that impede adequate caloric intake or interfere with absorption of nutrients or may be caused by environmental factors that interfere with optimal caloric intake.

The failure to thrive evaluation focuses on the assessment and treatment of a child's malnutrition. It is important to determine the type of failure to thrive so that an individualized family psychosocial evaluation and treatment plan can be developed. The medical component of the evaluation should include a thorough medical history that incorporates mother's prenatal history including any history of substance abuse and infectitious diseases and family history with the child's newborn history, completion of growth charts, physical examination, developmental assessment and laboratory evaluation.

Laboratory evaluation

The laboratory evaluation aids the examiner in identifying underlying medical problems that may contribute to the child's poor growth. These tests should include:

1. The complete blood count, sedimentation rate, urinalysis and urine culture help evaluate the presence of anemias, inflammatory processes and occult urinary tract infection.
2. A blood chemistry panel or electrolytes and renal panel can screen out renal disease and renal tubular acidosis.
3. Blood tests for syphilis and human immunodeficiency virus
4. Tuberculosis skin testing

5. Sweat test to rule out cystic fibrosis
6. Radiographic studies can include bone age and if there is also concern about the presence of physical abuse a skeletal survey. For the child with persistent vomiting or spitting up, a contrast study can look for gastrointestinal obstruction.

A nutritional assessment should include the child's caloric intake and calculated caloric needs to grow as well as an evaluation of the nutritional knowledge, beliefs, needs and resources of the family. It is important to elicit a detailed diet and feeding history. In many instances the mother will claim that the child is receiving more than adequate calories. In a few cases parents will report that the baby is on a very bizarre diet. History should include a description of how formula is mixed and if the infant or child drinks milk, what percent milk is used. If the infant is breast fed, a description of breast feeding technique, frequency and duration is important and a breastfeeding observation is helpful. Does the child spit up or vomit after feeding? Elicit family dietary beliefs and concerns about weight gain and a description of what mealtime is like in the home.

A feeding observation can provide a tool to evaluate both the nutritional and social environment that affects the child and can also help identify the child with motor problems that interfere with the child's oral intake. A social assessment provides information concerning family structure, resources, education and needs.

It is often difficult to think of reporting parents who are trying to meet the needs of their child to the Department of Human Services when there is no overt pattern of abuse or neglect. This task is especially difficult for the empathetic health care provider who does not want to endanger their relationship with the family. When reporting, it is essential to inform the family that the report is not punitive nor should it be used in a threatening manner. In an especially chaotic family, psychological evaluations of the caretakers can be included in the family assessment.

The provider needs to determine if the child can be followed as an out-patient or requires hospitalization. The child with failure to thrive may initially require hospitalization to correct an acute nutritional deficit but it is important to realize that the management of that child does not end with discharge from the hospital. These families often require intensive social support.

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The Pediatric Rapid Evaluation Program

Written by the PREP Team

Children entering foster care suffer higher rates of serious emotional, behavioral and medical problems, than do children of the same socioeconomic background. Their care is often compromised by a lack of coordination and communication between a child's care providers and child welfare professionals. Background information and medical records are often difficult to obtain. Continuity of care is frequently disrupted when children are moved from one home to another. Stress, trauma, and attachment difficulties associated with abuse and neglect frequently complicate assessment, service delivery and successful foster placement.

For example, 15 year-old Brenda (fictitious name) was placed in foster care two weeks after her birth mother committed suicide. Plans for Brenda to live with an aunt had broken down, when Brenda became seriously depressed and irritable. Homeless, Brenda attempted suicide and was hospitalized. Medical records were unavailable and the psychiatric staff was limited to the aunt's report that Brenda suffered from mental retardation, cerebral palsy, attention deficit disorder and epilepsy. Brenda clarified that sleeping pills were the only medication that she had taken. Psychiatric evaluation indicated borderline intellectual functioning, bereavement, probable posttraumatic stress disorder, and no evidence for ADHD. She was discharged to a group home, where plans were in process for more permanent placement. Brenda described feeling threatened, angry and alone.

This case involved five changes in residence and perhaps as many changes in primary care providers. Evaluations proceeded without the benefit of previous information. There was little opportunity for integrating information across disciplines.

In 1988, the Child Welfare League of America developed Standards for Health Care Services for Children in Out-of-Home Care. The League's guidelines recommend that every child entering foster care receive five components of care:

1. An initial health screen to identify immediate health needs.
2. A comprehensive health assessment that should take place within one month of the child's placement and should include information obtained from the child's caseworker, foster parents and biological parents.
3. A developmental and mental health evaluation to identify special needs.
4. Ongoing monitoring of the child's health status while in foster care.
5. A "Medical Passport" document listing the child's medical and mental health history and treatment providers that would travel with the child from placement to placement.

Maine and most states adopted similar guidelines, however, their implementation remains a challenge. To respond to the unmet medical and mental health needs of foster children, Maine's Department of Human Services and Maine General Medical Center's Edmund N. Ervin Pediatric Center combined forces in 1998 to develop and pilot a screening and follow-up system for children entering foster care in Kennebec and Somerset Counties. Programs from around the country were reviewed and the best features of each were incorporated into an innovative project. The Pediatric Rapid Evaluation Program [PREP] began evaluating children in February 1999, and is about to complete its first year in operation. Approximately 100 children have been screened to date.

PREP has four components:

1. Collecting information including medical, mental health, and school records in order to assemble a complete medical record, which is given to DHS and the child's primary care provider.

2. Reviewing each child's medical record, performing a complete physical evaluation, summarizing the medical history, making recommendations for ongoing care, and providing an 8-month follow-up.
3. Assessing developmental progress, stress/trauma experience, psychosocial functioning and coping strategies, and making recommendations regarding foster care, counseling, and further assessment.
4. Providing information to DHS, primary care providers, foster parents, mental health providers, etc. that improve coordination of services and continuity of care.

Within two weeks of the first evaluation, PREP produces summaries of pediatric and psychosocial assessments and a medical history, followed by a letter to foster parents introducing the child and providing suggestions for care. Unlike similar programs in other states, we do not attempt to provide ongoing primary care to these children. We are here to support the primary care physician by improving communication and access to information and to ensure that the child receives necessary care in spite of disruptions in their out-of-home placement.

For Brenda, this involved contacting the birth father who had not seen her for twelve years to learn that she had been on seizure medication for her first three years and had been diagnosed with a "benign brain tumor". The PREP physical examination was significant for dysfunctional uterine bleeding, bilateral hand weakness and skin markings consistent with the neurologic disorder, neurofibromatosis. Review of medical history indicated that she was missing some essential immunizations and had not had dental care for over five years. Complicated bereavement and posttraumatic stress disorder were identified, recommendations were made for counseling, and suggestions were provided to foster parents to help support Brenda within their home. Follow-up identified that a number of recommendations had been implemented and that Brenda was eventually doing quite well in foster care.

In summary, the Pediatric Rapid Evaluation Program (PREP) provides children entering foster-care with a medical and mental health evaluation. Our data is given to the child's primary care provider and DHS caseworker who can use our information to develop the child's medical passport. Our 8-month follow-up system helps identify children who have been through the program but continue to have unmet needs. We hope the information we provide can be used to improve the match between the child and foster parents, thus reducing the number of placements prior to permanence. We have developed a database to enhance evaluation and data management and we hope to continue to refine the efficiency and cost-effectiveness of the program. We are working with the service delivery network to strengthen the depth and variety of trauma-focused treatment resources available to child victims of abuse and neglect.

The PREP Team is comprised of: Stephen Meister, MD, Mark Rains, PhD, Penny McKenna, RN and Sue Beane, Medical Secretary. If you would like more information on PREP, please contact them at:
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TRAUMA IN CHILDHOOD AND ADOLESCENCE CONFERENCE

DMHMRSAS and DHS are jointly funding, and will collaboratively sponsor a day long clinical conference on Trauma in Childhood and Adolescence. The conference will be held on June 1 in Portland at the Sheraton Tara Hotel.

Bessel van der Kolk will be the Keynote speaker, and will present two hour and a half workshop sessions as well. The focus of the conference is clinical issues pertaining to the assessment and treatment of the varied aspects of childhood abuse and trauma. Morning workshops will focus on assessment techniques, afternoon workshops will focus on treatment/intervention. In addition, there will be workshops which specifically address the integration of assessment and treatment.

Workshop topics will be presented by clinicians from Maine, as well as National experts in the field of childhood trauma. Selected workshop topics include: the neurobiology of childhood trauma, assessing and treating adolescents who have been involved with the juvenile justice system, treating children/ youth who have a history of sexual offending, the impact of witnessing/being actively abused within situations of domestic violence, specific treatment techniques such as EMDR for children, specific play/ expressive techniques. Youth who have experienced abuse/trauma and/or commitment to the Maine Youth Center will have an active voice in the conference and will present a two hour panel discussion.

Enrollment will be limited to 400 participants. Conference proceedings will be available to those who are unable to attend.