

ADDRESSING AND PREVENTING CHILD ABUSE IN CUYAHOGA COUNTY: TOWARD A COORDINATED APPROACH



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FOR CHILD STUDIES



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Executive Summary

Too many children living in Cuyahoga County suffer from abuse or neglect. Even more alarming, the county's rate of confirmed abuse or neglect-related child deaths is significantly higher than the national average. Black and Brown children are disproportionately victimized and represented in these rates. **A suspected history of child abuse or neglect and/or domestic violence in the home are among the top risk factors for child homicides, and yet these risk factors and other early warning signs are too often missed by providers.** Additionally, there are reports of significant underreporting of child abuse during the COVID-19 pandemic, which has heightened the sense of urgency to protect children. A more comprehensive, coordinated approach for early identification and treatment of child abuse and neglect is required.

Cuyahoga County is uniquely resource-rich with three major hospital systems that come into contact with child victims of abuse. **The combined presence of MetroHealth, University Hospitals and the Cleveland Clinic, as well as local federally qualified health centers and community health centers, presents an opportunity to address child abuse in an impactful, county-wide strategy in partnership with the Cuyahoga County Division of Children and Family Services (DCFS) and the existing child advocacy center (CAC).** Cross-system collaboration with early warning mechanisms for child abuse detection and identification, improved referral, protection, and follow-up of cases, and coordinated information sharing across medical institutions and social service agencies would create a critical network to help prevent and reduce child abuse and neglect.

This report presents findings of an investigation of best practices to reduce and prevent serious incidents of child abuse and neglect. **Two well-established types of coordinated approaches to improving management of child abuse cases were identified:**

(1) a multi-disciplinary team (MDT) that operates via a CAC

(2) a medical child protection team (CPT)

Multidisciplinary teams generally include representation from law enforcement, child protective services, prosecution, medical services, mental health services, social work, victim advocacy, and, if available, a CAC. The CAC-MDT model that involves a medical team has been shown to be effective at providing support, advocacy, and services to victims and their families. Medical CPTs perform a number of essential tasks when working with victims of child abuse and neglect and their families, including medical consultations, communication of findings to appropriate agencies, multidisciplinary review of cases, forensic interviews, and expert testimony.

Given the abundance of hospital resources and the availability of a functioning CAC in Cuyahoga County, one of a range of models could provide a much-needed county-wide coordinated response that engages all essential system partners in a comprehensive child abuse prevention approach. Because of the complexity of individual cases, a comprehensive response requires a specialized coordinating approach. This coordinating approach may be achieved through various methods, including the highly effective use of CACs.

This paper concludes with a proposal for Cuyahoga County, recognizing its unique attributes, resources and challenges: a medical CPT – comprised of clinicians from one or more of the three local hospital systems – to work closely with the MDT based at the CAC for early identification of child abuse and neglect cases and to provide a coordinated response, including effective treatment and ongoing support to victims and their families. A uniform protocol for interagency data-sharing, a key component to a successful system-wide approach to aid in case conferencing and response, is necessary so that data from all medical systems will be accessible to inform real-time decisions. Ideally, a database to which all MDT and medical CPT members across hospitals have access will be developed to make client data available for informed decision-making, reduced duplication, and targeted service provision.

Building this coordinated systems approach requires a committed public-private partnership with an initial investment of dedicated funding and resources for planning and implementation. While this may be a formidable task, the payoff of helping to prevent child abuse and deaths in a racially equitable approach, while supporting vulnerable children and families in Cuyahoga County, makes this a worthy challenge.

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Key Acronyms

CAC: Child Advocacy Center

CFRB: Child Fatality Review Board

CPS: Child Protective Services

CPT: Child Protection Team

DCFS: Cuyahoga County Division of Children and Family Services

MDT: Multi-Disciplinary Team

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INTRODUCTION: PURPOSE OF THIS REPORT

This report describes the current landscape of child abuse and neglect in Cuyahoga County and the current system for addressing child abuse cases, as well as other models for a coordinated response and prevention of revictimization. The following review is informed by academic literature, research reports and interviews with key stakeholders: pediatricians, physicians, directors and staff of child advocacy centers from around the nation, as well as an advisory group of local experts who work in child welfare, pediatrics, advocacy, and research. It is intended to offer information that will advance an effort toward a county-wide, coordinated model for addressing child abuse that involves close collaboration among a team of medical practitioners (i.e., a medical CPT), a multidisciplinary team of key stakeholders (MDT), and a coordinating entity (i.e., typically the function of a CAC).

Our Challenge in Cuyahoga County: Current Social Problem of Child Abuse and Neglect and Uncoordinated System Response

THE URGENCY OF CHILD ABUSE AND NEGLECT

In 2018, almost 200,000 referrals were made to child welfare agencies across Ohio, and over 25,000 children were found to be victims of abuse and neglect. Examining the child abuse and neglect data for Cuyahoga County illuminates the critical need to improve the process of identification, response and prevention of harm. In 2018, there were 257,827 children in Cuyahoga County. That year, the Cuyahoga County Division of Children and Family Services (DCFS) received 21,557 referrals for child abuse and neglect^a, up from 20,429 in 2017 and 20,438 in 2016. The number of referrals screened in for child abuse or neglect was 14,036 in 2018. Total referrals investigated were 15,570 (includes dependency and family in need of services) of 24,220 calls. Table A illustrates the types of abuse and the corresponding number of children who were victims of each type in 2018.

TABLE A. CUYAHOGA COUNTY CHILD ABUSE & NEGLECT, 2018²

Key Child Abuse and Neglect Statistics, 2018	
Total Investigations	14,036
Type	<i>Distinct Counts of Children^b</i>
Substantiated physical abuse	1,699
Substantiated neglect	1,283
Substantiated sexual abuse	227
Emotional maltreatment	80
Medical neglect	52
Abuse or neglect-related child deaths	8

In Cuyahoga County, there were a total of 185 total child deaths in 2018 and 174 child deaths in 2019. Of these deaths, a disproportionate amount were Black children – 120 in 2018 (approx. 65%) and 115 (approx. 66%) in 2019. In 2018, there were 11 homicide deaths among children; child suspected history of abuse/neglect or domestic violence

a Does not include dependency or families in need of service referrals. The number of referrals does equate to number of children or number of families.

b Each child is only counted once. Children may have multiple referrals and multiple findings.

in the home remained top risk factors associated with child homicide. In addition, in 2018, 29 of the 185 children died as a result of unintentional injuries, with 18 of these cases having suspected history of abuse, neglect, or domestic violence in the home.³ In 2019, there were 27 unintentional injury deaths.³ In that same year, 4 children died due to abuse and 5 children died due to neglect, compared to 5 abuse and 3 neglect deaths in 2018. **The rate of confirmed abuse or neglect-related child deaths in 2018 was 3.0 per 100,000 children, much higher than the national rate of 2.39 per 100,000 children in 2018. In Cuyahoga County, the rate of child death has been consistently higher than the rest of the state for over a decade.** The COVID pandemic has made this issue even more urgent with significant concerns of the underreporting of child abuse during this time period.⁴

Economic and Human Cost of Child Maltreatment and Neglect

The cumulative effects of trauma, poor mental and physical health outcomes, educational setbacks, and other challenges due to child maltreatment can have lifelong consequences for child victims of abuse and neglect. The economic impacts, in addition to the human and societal costs, are also significant. A study by the Centers for Disease Control and Prevention (CDC) found that the total cost resulting from nonfatal and fatal maltreatment in the United States was estimated at \$585 billion (2008 USD).⁵ This same study revealed that the average cost per victim of nonfatal child maltreatment over their lifetime involved a range of different types of costs. These include: childhood health care costs (\$32,648), child welfare costs (\$7,728), criminal justice costs (\$6,747), special education costs (\$7,999), and adult medical costs (\$10,530), totaling \$210,012 in 2010 USD.⁵ Another more recent study found that the economic burden of child maltreatment was as high as \$2.0 trillion (2015 USD). In terms of cost per child, **research has found that the lifetime cost for nonfatal child maltreatment was \$831,000 per child, and the lifetime cost for fatal child maltreatment was \$16.6 million per child**, which includes the value of victims' lost work productivity (2015 USD).⁶

The Current System of Child Abuse Investigation and Response in Cuyahoga County

In Cuyahoga County, child abuse and neglect cases are referred to the DCFS from various sources – family, neighbors and Ohio's mandated reporters, who include but are not limited to: attorneys, child care workers, foster parents, nurses, physicians, hospital interns and residents, psychiatrists, school authorities and staff, and social workers.⁷ Generally, the following process occurs:

- **Screening:** A referral is made to the DCFS hotline by phone, email, letter, Facebook Messenger, or as a walk-in. The hotline staff determines whether the report requires an emergency or non-emergency response, which is reviewed by Child Protection Specialists.
- **Referral:** Cases involving sex abuse of a child 12 years or young or children of any age who are victims of human trafficking meet the criteria for referral to the Canopy Child Advocacy Center in Cleveland (Canopy). Canopy coordinates comprehensive services for the client through their Multidisciplinary Team from referral to case resolution. DCFS handles all other child abuse and neglect cases from referral to case resolution.
- **Investigation:** Currently, there is limited collaboration between the coordinating agency (Canopy or DCFS) and a hospital system. Typically, a hospital will refer a client to DCFS and allow DCFS to "take it from there", or a hospital will be engaged as needed by Canopy or DCFS to provide services for a client.

See Appendix 1 for a flow chart of the general process for child abuse referrals to DCFS and Canopy.

Child Fatality Case Studies

The Cuyahoga County Office of Early Childhood undertook a review of 2018's Child Fatality Review Board (CFRB) cases and identified the following real-life examples to better illustrate gaps in the child welfare context. The following three child case studies highlight medical negligence and are intended to help others understand the types of cases where a medical CPT as part of a coordinated multi-system approach could have resulted in a different outcome. The

CHILD ABUSE SCENARIO (PART 1) – THE INITIAL REFERRAL

This scenario, presented as a 7-part hypothetical case throughout this report, illustrates an alternative response to our current approach. It is a fictional, but realistic, representation of how a child abuse or neglect case may play out in Cuyahoga County if there is a coordinated response model with a medical child protection team (CPT) and multidisciplinary team (MDT).

A call is made by a neighbor into children’s services and relays the following information:

Johnny (age 7) was playing with a neighbor when his shirt lifted and revealed what appeared to be a handprint and scratches on his back. Johnny told his friend he was often hit by his dad with his hand and belt because he is a ‘bad boy who can’t listen.’ Still, Johnny did not seem scared to go home.

The Division of Children and Family Services (DCFS) opens the case and visits Johnny’s mother the next day to assess safety and possible next steps. His mother discloses that she is aware that Johnny gets hit with the belt. She says the last time he saw his dad was yesterday while she was at work, before he played with the neighbor’s son. Since Johnny bathes himself, she hasn’t seen any marks and says she does not believe he has marks.

The caseworker does a child-focused interview and affirms the information provided by the referent. The caseworker has Johnny raise some of his clothing, sights bruising, and becomes increasingly concerned for serious physical abuse. There are bruises with patterns, in clusters and in multiple colors, sizes, shapes, and visible locations. After a consult with the DCFS supervisor, it is determined that these injuries and the threat of further harm to Johnny are serious.

names and other identifying information have been removed to protect the confidentiality of the families. These case examples contain only actual facts surrounding actual deaths without additional editorial comment. See Appendix 2 for the full case examples.

- **Case Example 1:** Child under 10 years old known to the child protective services system with history of asthma. Official cause of death was asthma, although there was circumstantial evidence of medical neglect.
- **Case Example 2:** Child under four years old hospitalized for much of the first year of their life due to congenital anomalies. Cause of death was blunt force trauma due to homicide.
- **Case Example 3:** Five-month-old child who was born two weeks late and as an infant had several missed pediatric appointments. The cause of death was failure to thrive with severe malnutrition and dehydration.

Community Efforts

Across the county, many community-based agencies and organizations offer invaluable services: residential and day treatment, emergency shelter, alternative school programs, trauma-informed therapy, child and family-focused therapy, and other mental health treatment. Of specific interest for this report, DCFS and local hospitals have implemented innovative, supplemental approaches to help address the critical needs related to child abuse and neglect in Cuyahoga County. In addition to the Child Advocacy Center model discussed later in this report, examples of local initiatives include the programs below.^c

^c The current report focuses on coordination among three hospital systems in Cuyahoga County: Cleveland Clinic, MetroHealth, and University Hospitals. It should be noted that there are a number of other institutions and entities in the County, including community clinics, that serve children and their families that also present opportunities for a more comprehensive coordinated effort.

HOSPITAL-BASED CHILD ABUSE PROGRAMS

- **The Child Advocacy and Protection Program at University Hospitals:** This program utilizes a team approach that includes a physician, a nurse practitioner, and a social worker who specializes in child abuse. The team provides medical and psychosocial assessment services to suspected child victims of physical and/or sexual abuse. In addition, the Child Advocacy and Protection team consults with school systems, insurance groups and Medicaid, and government agencies to advocate for improvement of these systems to better identify and address child abuse.
- **MetroHealth Alpha Program:** The Alpha Clinic program serves children who may be victims of sexual abuse by providing medical assessments by an experienced pediatrician, nurse, child life specialist and social worker. The Alpha Team at the Clinic provides inpatient evaluation and consultation when there is concern for child abuse and neglect.
- **Cleveland Clinic Foundation Child Protection Team:** The Cleveland Clinic Foundation (CCF) CPT is a committee that meets regularly to review medical cases and hospital policies. The Cleveland Clinic health system has a child abuse and neglect policy that guides the assessment and management of child patients who are victims of physical, sexual or medical abuse. The CCF CPT pediatrician and an inpatient social worker provide inpatient evaluation and consultation when there is concern for child abuse and neglect.

OTHER VIOLENCE PREVENTION AND INTERVENTION PROGRAMS

- **START (Sobriety Treatment and Recovery Teams) and Ohio START (Sobriety, Treatment and Reducing Trauma):** These child welfare programs support families where parents have substance use disorders by providing intensive case management, behavioral health services, and family peer mentors. In Cuyahoga County, START links families to services that support children and their families in order to overcome addiction, prevent child maltreatment and stabilize families.
- **Hospital-based Violence Prevention Initiatives:** While not explicitly designed to address child abuse or prevent child abuse, the following hospital-based initiatives are valuable parts of the community response to intervening and preventing community violence.
 - The Antifragility Initiative at Rainbow Babies and Children’s Pediatric Trauma Center: This program serves pediatric victims of violence and aims to reduce violent injury recidivism using trauma-informed care principles from bedside engagement. This effort is in collaboration with the Center on Urban Poverty and Community Development at the CWRU Jack, Joseph & Morton Mandel School of Applied Social Sciences, Cleveland Peacemakers Alliance, and Frontline Services.
 - Violence Interrupters at MetroHealth Medical Center: The program serves all victims of violence in the MetroHealth emergency department and provides conflict resolution, case management, and links to support through outreach workers. This is a partnership among the Northern Ohio Trauma System, MetroHealth Medical Center and the Cleveland Peacemakers Alliance.

Although these initiatives are important community collaborations, they are isolated within the three major hospital systems in Cuyahoga County – MetroHealth, University Hospitals, and Cleveland Clinic – and service agencies. Each of these initiatives provide important care and services to youth; however, they do not share information or formally collaborate. Strengthening county-wide coordination among our major hospital systems, in partnership with DCFS, rather than relying on the existing patchwork of responses, would foster a more protective community response and reduce the danger of abuse victims and at-risk children falling through the cracks.

Moving Toward a Solution

Child maltreatment is clearly a pressing issue in Cuyahoga County. Numbers of child deaths are alarmingly high, with many of these child deaths being suspected – but not confirmed – child abuse or neglect cases. This suggests that

CHILD ABUSE SCENARIO (PART 2): THE MEDICAL CPT RESPONSE

With the CFS Supervisor's backing, the caseworker calls in a 'Health Alert' referral to the child protection team (CPT). The CPT care management nurse investigates and, with assistance from the CPT social work and pediatric medical providers, determines that it is best to bring Johnny to the CAC for a Nurse Examiner Specialist Safety Triage (NESST), rather than to the emergency room. The CFS supervisor, case worker, clinical psychologist, advocate, forensic interviewer and law enforcement staffing the CAC are consulted on this recommendation and concur. The case worker helps coordinate transportation for an immediate appointment.

When Johnny and his mother arrive, the CAC advocate brings them to the healing room for introductions. An explanation of the medical examination process, a tour of the examination suite and an opportunity for questions are provided. Johnny and his mother then settle into the healing room while the nurse practitioner, forensic nurse, and case worker have a private discussion elsewhere regarding the CFS's concerns and the family history (e.g., previous CFS reports for abuse and neglect).

early warning signs of maltreatment may have been missed, and better early warning systems for detection and identification, as well as improved referral, protection, and follow-up of these cases could save lives. In order to better address the issue of child abuse and neglect in Cuyahoga County, cross-system coordination and alignment may be necessary. The Cuyahoga County Child Fatality Review Board (CFRB) recommends that collaboration and information sharing among medical institutions and social service agencies be developed as a county-wide, systems-coordinated response, which will lead to enhanced intervention for children who are at high risk. Despite great efforts to address the issues outlined above, the general system of care for victims of child abuse remains disconnected. In Cuyahoga County, while a few specialized programs exist, they are focused on select populations or select issues and, in most cases, do not coordinate resources among the major hospital systems in the area. A more effective endeavor will require an evidence-informed approach facilitated by county-wide institutional efforts that bring together different stakeholder expertise to support victims and their families, from medical treatment to emotional support and legal system support and advocacy. The combined presence of MetroHealth, University Hospitals and the Cleveland Clinic presents an opportunity to address the issue of child abuse in an impactful, county-wide way, in partnership with other community organizations and agencies.

AN OPPORTUNITY FOR IMPACT: COORDINATED TEAM-BASED MODELS FOR ADDRESSING CHILD ABUSE

There are two well-established types of coordinated approaches to addressing child abuse cases: multi-disciplinary teams (MDTs) that operate via a child advocacy center (CAC)^d and medical or hospital-based child protection teams (CPTs). Historically, multidisciplinary approaches to addressing child abuse have been established in a range of ways, varying by state.^e In 1986, the Children's Justice and Assistance Act was adopted with the aim of providing federal funding to assist states in developing, establishing, and operating programs designed to improve the handling of

d The Child Advocacy Center (CAC) approach to MDTs was first realized in the mid-1980s when Alabama Congressman Robert Cramer convened law enforcement, criminal justice representatives, child protective services, and medical and mental health workers to establish one coordinated team (National Children's Alliance, 2019).

e As early as 1970, Montana passed legislation suggesting the need to establish child protection teams (Jacobson, 2002). Pennsylvania (PA Code Title 23, chapter 63), Florida (FL Code Title V, chapter 39, 39.303) and Oregon (ORS 418.747) are among some of the states that have mandated that a multidisciplinary team be established in each county and that members of the team share complete child abuse case information with one another. The state provides funding; federal support is also available via the Child Abuse Prevention and Treatment Act and the Children's Justice and Assistance Act of 1986 for locations with mandated MDTs.

child abuse cases. The focus was on limiting additional trauma to the child and improving responses, specifically the investigation and prosecution of child abuse cases.⁹ While MDTs were subsequently established in many regions, federal law does not require the creation of a multidisciplinary team or child protection team in each state. Instead, state legislation typically delegates the authority to create and manage MDTs to a county-level agency, which results in differences in approach and implementation of MDTs across states.¹⁰

Multidisciplinary Teams (MDTs)

Multidisciplinary teams generally include representation from law enforcement, child protective services, prosecution, medical services, mental health services, social work, victim advocacy, and, if available, a child advocacy center.¹¹ This team of professionals works together from the first report until the case resolution to provide a well-coordinated investigation and response, and to minimize the potential for re-traumatization to the child.¹⁰ In some cases, the MDT is established as an administrative practice of a private agency. This process involves a memorandum of understanding (MOU) or some other written interagency agreement signed by members of the MDT. Across the United States, the processes and protocols for how MDTs work with DCFS/CPS and address child maltreatment cases range widely.

MDTs offer a number of benefits for child victims and their family members. Overall, research shows that a coordinated response from community agencies is important to MDT effectiveness.^{12–15} The CAC-MDT model is the preeminent approach within the field of child abuse investigations; this approach has been shown to be effective at providing support, advocacy, and services to victims of child abuse and their families through the utilization of an MDT.^{16–19} Child advocacy centers have been shown to demonstrate value to a community: in a survey of its MDT members and caregivers, the National Children’s Alliance found that almost all (97%) caregivers believed they received resources to support their children and would recommend the CAC to a someone else who was dealing with a similar situation, and 98% of multidisciplinary team members believed children benefit from the collaborative approach of the MDT. Other benefits of MDTs include:

- For child victims: reducing the risk of system re-traumatization and stress through streamlining the interview process, limiting the number of interviewers and helping prevent risk of future abuse.²⁰
- For caregivers or family members who are not the accused: providing one centralized point-of-contact that they can consult throughout the investigation and greater access to community resources.²¹
- For children, caregivers and families: increasing access to services.^{12–14, 22}

About the Child Advocacy Center (CAC)

More than just a physical space, a CAC functions as an interagency response hub that coordinates and manages a multidisciplinary team.²³ The CAC model facilitates recorded and/or taped forensic interviews, collaboration with community partners, therapy, medical exams, courtroom preparation, victim advocacy, case management, and other additional services focused on minimizing stress and re-traumatization of child victims.¹⁵ In this way, CACs embed a MDT approach by design.

Over the last few decades, hundreds of CACs in the United States have been accredited by the National Children’s Alliance. Accredited CACs must adhere to national standards for evidence-based operations and ensure that children receive consistent care in a child-friendly location.²³ Criteria for case acceptance (from CPS or another source) at a particular CAC are determined by assessing the needs of the community, gauging the existing resources available to the community, and determining the capacity of their MDT to respond to cases. CACs may work closely with one or more hospital systems to deliver effective medical care.

In addition to the benefits of reducing re-traumatization, stress, and risk for future abuse, the CAC-MDT approach offers the following benefits:

CHILD ABUSE SCENARIO (PART 3): TRAUMA-INFORMED EXAM

A medical history, physical exam, and forensic photo-documentation are obtained in a trauma-informed process respecting modesty. Johnny's vital signs are stable, but he is underweight. He is asked 'what happened?' as each skin injury is itemized. In this way, Johnny provides his own medical history that is documented in quotations. The exam uncovers multiple types of injuries in varying stages of healing, which the professional staff believe are consistent with recurrent physical abuse. It is noted that he has very few bruises in areas common to active children, so it is unlikely he has easy bruising. Nevertheless, blood tests screening for easy bruising and poor wound healing are obtained for thoroughness, in case it is ever suggested that Johnny bruises or wounds easily.

A chart review shows multiple 'no-show' appointments with Johnny's pediatrician, a tentative diagnosis of ADHD and non-attended referrals for behavioral pediatrics, gastroenterology, and nutrition. He had recently presented to the Emergency Department with his father for a chin and lip laceration from a reported fall at the playground. He was prescribed stimulants but never went up from the first step of dosing. Johnny has been quite attentive, interactive, focused and well behaved for the entirety of the visit. Since there are no concerns with Johnny's mentation or cognition, and no other medical conditions or symptoms of abuse or illness noted, there is no indication to refer for higher acuity hospital-based care.

- Increased coordination when investigating cases of child abuse compared to non-CAC facilities²⁰
- Faster case resolution time^{24,25}
- Increased support to the subsequent criminal prosecution process²⁴⁻²⁵
- High levels of child and parent satisfaction with CAC services^{21,27}

Importantly, CACs with the capacity to provide onsite medical and mental health services show additional benefits. Specifically:

- Children are more likely to receive physical examinations, medical testing, and mental health assessments at CACs compared to community centers, ensuring they receive appropriate and necessary care.²⁸
- On-site mental health services, in addition to other basic CAC functions, aid in reducing the stress for child victims and their caregivers during the investigation phase.^{20,29}

Below are two examples of successful partnerships among hospital systems and MDTs, in which the hospitals have developed a collaborative relationship with the local CAC in order to prioritize the health and wellbeing of children in the course of a child abuse investigation and response. Philadelphia and Dallas offer examples of the CAC-MDT model in large urban areas with multiple hospital systems, similar to the greater Cleveland area.

Philadelphia Children's Alliance (Philadelphia, PA)

When a report of child abuse is made, the Philadelphia Children's Alliance (PCA) coordinates the investigation with an MDT approach. Members of the PCA MDT include: Philadelphia Police Department Special Victims Unit, Department of Human Services, Philadelphia District Attorney's Office, Children's Hospital of Philadelphia, and St. Christopher's Hospital for Children. The PCA MDT was formalized by a Memorandum of Understanding (MOU) signed by all partners, who have strong working relationships, including the two hospital systems. The PCA plays a key role in ensuring partners work collaboratively and hold partners accountable. The PCA is co-located in a building with the Philadelphia Department of Human Services and has a medical space that is staffed different weekdays by physicians from each of the hospitals where child victims are seen and treated.

The PCA reviews and tracks all cases of child abuse via a formal process with the MDT. Aiding in this tracking and reviewing process is a database shared among PCA, Children’s Hospital of Philadelphia, and St. Christopher’s Hospital for Children. This has allowed the PCA and its partners to access essential demographic information and case information, such as the current status and disposition of cases, and investigation/ intervention outcomes from all involved agencies. Availability of this data also allows the PCA to aggregate local, regional, statewide and national statistics to use for advocacy, research, and legislative purposes in the field of child maltreatment.

Overall, as a result of the PCA, according to interim director Paul DiLorenzo, “children all across Philadelphia are safer from harm than they were before” and the process of addressing child abuse cases has gone “from one of further abuse and victimization to one of healing.”³⁰

Dallas Children’s Advocacy Center (Dallas, TX)

The Dallas Children’s Advocacy Center (DCAC) coordinates the investigation, prosecution, and medical, therapeutic, and counseling services for victims of the most severe child abuse in Dallas County. The DCAC Coordination Team oversees the MDT, which consists of 27 law enforcement agencies in Dallas County, Children’s Health Hospital, the University of Texas Southwestern Medical Center at Dallas, the Dallas County District Attorney’s Office, the Dallas County Southwestern Institute for Forensic Services, the Texas Department of Family and Protective Services (Child Protective Services, Child Care Licensing, Adult Protective Services), and the Department of Pediatrics at Children’s Health Hospital.

The Child Abuse Unit of the Dallas Police Department, six units of CPS, and a Dallas County Assistant District Attorney are all located at the DCAC, which aids the coordination, communication, and collaboration of cases. Of note, DCAC has a Chief Partner Relations Officer on staff, who ensures that partners are held accountable, collaborate effectively and extend additional effort when faced with particularly challenging cases. There is no medical clinic at DCAC; rather, victims are examined and receive medical care at the pediatric hospital, Children’s Health. While DCAC receives referrals from other hospitals in Dallas County, they only refer victims to Children’s Health, with whom they have a full partnership.

Since the DCAC was established, families in Dallas County “receive superior services for child abuse treatment... and have greater access to medical services and hospitals,” according to the former DCAC Director Lynn Davis.³¹ While DCAC does not have a coordinated data system with community partners, the state grants CACs the legal privilege of information-sharing with hospitals without parents’ permission, which aids the investigative process. In addition, the DCAC has a strong relationship with county police departments which has helped to reduce the likelihood of child abuse victims getting overlooked in the system.

Medical/Hospital-Based Child Protection Teams and Collaborations

In some places, multidisciplinary teams work closely with or include a CPT in a local medical center, usually a children’s hospital. A medical CPT is a team typically made up of pediatricians, nurses, and mental health care providers (psychologists and/or social workers) with specialized training who provide consultation to child welfare agencies in cases of suspected child abuse and neglect, and in some cases, provide medical services to victims from within their hospital system.¹²

Many children’s hospitals have established medical CPTs via hospital administrative policy.¹⁴ The National Association of Children’s Hospitals and Related Institutions (2011) states that all acute care children’s hospitals should, at a minimum, meet the recommendations for a basic level approach for the creation of a child protective team.³² This involves medical leadership administrative coordination, social work services, a physician, staff trained in the field of child abuse, representatives of community agencies that participate in case meetings, and available mental health professionals.³² Hospital-based CPTs vary by location. Children’s hospitals with more capacity or with more specialized expertise may also have a certified child abuse pediatrician as part of its medical CPT, an

CHILD ABUSE SCENARIO (PART 4): FORENSIC INTERVIEW

As the medical appointment concludes, the CAC advocate introduces the forensic interviewer and they assess the prospects of conducting the forensic interview that same day. Johnny is in surprisingly good spirits and has no reason to go to the hospital, so the interview can happen quickly. Law enforcement makes a child abuse squad detective available to view the forensic interview on the closed-circuit camera at the CAC.

The interviewer/caseworker and law enforcement confer with the CPT that in the absence of any other medical explanation, this type of bruising and lacerations indicate high velocity impacts that are diagnostic for physical abuse. The CPT staff answer questions and may opt to view the interview as well.

The forensic interviewer and law enforcement then work with Johnny to obtain detailed explanations of the injuries via age-appropriate, legally-defensible, and best-practice interview techniques. They learn that Johnny was not doing his homework or chores, and when sat down *'for a talk'* by his father, Johnny made faces at his father who then yelled, broke his tablet, *'whipped him'* with a belt and beat him with his hand. Johnny described earlier *'talks'* from a month previously that had ended similarly. The chin and lip laceration noted were actually from one of those situations when he was grabbed and thrown into the radiator, not on the playground as reported in the emergency room.

administrative team that operates as its own unit of the hospital, regular meetings to review present and ongoing cases, and/or a larger service network.³²

Child protection teams may function independently of an MDT and provide consultation or medical services as needed, or they may be more involved throughout a case by participating in regular case conferencing as a component of an MDT, starting at the point of report until resolution of the case. Depending on a city or region's needs, the hospital systems' capacity and interest in partnerships, and the presence of a CAC, there is a wide spectrum of models of MDTs and medical CPTs with different structures and functions. The following examples focus on existing hospital-based CPTs, as this model is most relevant to Cuyahoga County, given the presence of three major hospital systems, MetroHealth, University Hospitals, and the Cleveland Clinic, as well as Case Western Reserve University School of Medicine.

Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC)

The MPEEC in Chicago is a coordinated network of physicians and child abuse experts representing five hospitals in Illinois. The MPEEC is focused on identifying and eradicating child abuse by giving medical providers access to child abuse pediatricians who might not otherwise have access in their communities. The MPEEC is directed by Dr. Jill Glick at University of Chicago Medicine Comer Children's Hospital, where the consortium is managed. The MPEEC has a strong relationship with Illinois DCFS and the Chicago Police Department, providing expert medical opinion and guidance, ultimately reducing errors and allowing DCFS to build a medically-informed case in courts.³³

Yale DART

Yale Medicine's Programs for Safety, Advocacy, and Healing Detection, Assessment, Referral and Treatment (DART) program is one example of an effective model of early detection. The DART team is comprised of a group of clinicians with specific expertise in child abuse that evaluates injured children to determine whether the injuries are from child abuse or the result of an accident. DART provides consultations to all four of the hospitals in the Yale New Haven Health System. In addition, providers from other health systems can also call DART for medical advice and consultations. In any case involving suspected abuse, DART recommends a written report to DCF. This system prevents reports being made to DCF that are due to accidental injuries and ensures that available

resources can be used to address cases where risk of harm is present. DART engages a clinical pathway to trigger suspicion of abuse within Yale New Haven Hospital, evaluating injured children under a year of age for a certain list of injuries, such as bruises or oral injuries. If these injuries are present, the practitioner contacts DART for an evaluation. The goal of the clinical pathway is to more effectively recognize maltreatment, increase abuse detection in the highest risk groups, and prevent implicit bias.³⁴

MUSC Children’s Health Child Abuse Program

Medical University of South Carolina (MUSC) Children’s Health Child Abuse program serves children who have suffered from physical, sexual, emotional, and psychological abuse and neglect. The MUSC Child Abuse team includes pediatricians, specially-trained nurse practitioners, pediatric nurses trained in sexual assault evidence collection, and faculty members for consultation. Pediatricians who work in the program are certified American Board of Pediatrics subspecialists in child abuse care. The program has three clinic locations in South Carolina at three CACs and offers consultation to other MUSC health and outreach clinics. The MUSC Child Abuse team and each CAC engage in regular MDT case conferencing that involves physicians, nurse practitioners, social workers, mental health practitioners, law enforcement, and the South Carolina Department of Social Services. In addition to outpatient care at the CACs, the MUSC Child Abuse team works as needed in the hospital with abused children, providing immediate and follow-up care.³⁵⁻³⁶

Best Practices for Early Identification and Harm Mitigation with MDT and Medical CPT Models

QUALITIES OF EFFECTIVE CAC-MDTs AND MEDICAL CPTs

Literature and consensus among child abuse professionals and child welfare professionals identify the following features of effective and successful CAC-MDTs and medical CPTs.

CAC-MDT

Essential components of a CAC-MDT, as outlined by the National Children’s Alliance standards (2017),¹ include:

- Committed team members from law enforcement, child protective services prosecution, medical services, mental health services, victim advocacy, and a child advocacy center
- Clear boundaries between each multidisciplinary role and/or function
- A formal written interagency agreement (i.e., MOU) signed by all MDT members
- Written protocols, guidelines, or policies that clearly outline the functions of the MDT including the roles and responsibilities of each member as well as information sharing and confidentiality protocols
- Involvement by all MDT members in cases as appropriate and necessary
- Effective and timely sharing of information between members, consistent with the legal, ethical and professional standards of practice
- Regular (e.g., annual) training, educational opportunities and/or professional development provided for MDT members focused on investigation, prosecution, and service provision for children and their non-offending caregivers

Medical CPT

There is less literature examining best practices for medical CPTs, although a 2010 study that specifically examined factors that contribute to hospital-based CPT effectiveness found that the essential tasks an effective CPT should perform are medical consultations, communication of findings to appropriate agencies, multidisciplinary review of cases, forensic interviews and expert testimony.¹³ In order to facilitate these essential functions, the authors found the following features to be important:

- Adequate support staff, space, and equipment provided by the hospital
- Protected time and financial support allocated for team members to be a part of the CPT
- Demonstrated support by the hospital of the CPT activities, including a willingness to collaborate with community agencies and improve hospital systems to better provide care for victims of child
- Good communication between CPT team members
- Strong CPT leadership
- Multidisciplinary professionals on the CPT team and active interdisciplinary collaboration, such as including professionals from different disciplines to discuss cases, exchange ideas and experiences, and work together to examine and interpret cases and data
- Opportunities for continuing education on child abuse and neglect for CPT team members
- A shared sense of collegiality, mutual trust, and respect by CPT team members
- Regular self-assessments by CPTs of their program processes and outcomes

Other key features of effective CAC-MDTs and Medical CPTs include:

- Interagency collaboration in the form of peer review of cases and regularly scheduled meetings to aid in early identification of potential abuse and to review existing and new cases¹⁴
- Video recording the forensic interview during the initial evaluation, which can assist in reducing child re-traumatization by preventing the need for additional interviews^{12, 14, 22}
- Consistent and ongoing education and training for all team members, which aids in early identification and child trauma mitigation¹⁴
- Policies that require standard clinical pathways (like head-to-toe examinations or injury surveys for all children under 18 years of age) to assist in early and more accurate identification of child abuse and neglect^{14, 37–39}
- Research shows that standard clinical pathways reduce socioeconomic disparities in evaluation³⁹
- Consultation with trained child abuse medical providers immediately following suspicious findings from the examination or survey¹⁴
- Redacting demographic information from cases during review, which can assist in reducing bias that contributes to socioeconomic and racial disparities (this practice is currently done by the Multidisciplinary Pediatric Education and Evaluation Consortium in Chicago)³³

CHILD ABUSE SCENARIO (PART 5): TRAUMA-INFORMED ADVOCACY

During the interview, Johnny’s mother indicates that his father doesn’t actually live with them but visits to help while she is at work. The caseworker has Johnny’s mother agree that the father should no longer be allowed in the home. If he is present, Johnny will have to stay with a relative. His mother indicates a willingness to protect Johnny and develops a plan for her own mother to watch him while she is at work. There are no court-ordered visitations that need suspension. With his mother’s understanding of the seriousness of what has happened, and her cooperation with the safety processes, there is no plan for CFS to remove Johnny from the home.

The victim advocate and caseworker discuss mental health needs and supports for children and families who have experienced child abuse and domestic violence with Johnny’s mother. She is appreciative and accepting of these services; the process to set them up starts.

BARRIERS TO AN EFFECTIVE SYSTEM-WIDE COORDINATED APPROACH

Developing community consensus on the value of and need for adopting a system-wide coordinated approach as a foundational element to child abuse prevention is no small challenge. Even after a community commits to such a coordinated approach, other barriers that exist may require attention. These barriers include confidentiality and related issues around datasharing, organizational conflicts, and communication challenges. Possible issues with confidentiality that arise are misunderstandings of the laws on confidentiality and the use of confidentiality as an excuse to not share information, commonly due to mistrust between members.¹⁰ One solution to this is a provision in The Child Abuse Prevention and Treatment Act which permits states to establish laws that authorize federal, state, and local government agencies to share child abuse data amongst those involved in an investigative team to facilitate the legal child protection process.¹⁰ In Arizona, California, Maryland, Minnesota, Nebraska, New Mexico, Oregon, Utah, Wyoming, and the District of Columbia, all reports made initially to a CPS agency must be also be reported to a law enforcement agency, and reports made to law enforcement must be reported to the CPS agency. In Ohio and 15 other states^f, law enforcement and CPS are required to share information and coordinate child abuse investigations in order to minimize the number of times children are interviewed. Arkansas, Delaware, Missouri, New York, Pennsylvania, Vermont, and Virginia require MDTs that conduct child abuse assessments for victims and provide services to families to share information.⁴⁰ Other barriers to team effectiveness are a lack of collaboration among partners and an inability to effectively solve conflicts.^{10,13} Strong team leadership, team member engagement, morale, and communication practices all prevent poor collaboration and improve conflicts.¹³ In addition, poor staffing of an MDT or medical CPT team can lead to burnout and inhibit the effectiveness of staff.^{10,13}

OVERCOMING BARRIERS: ENVISIONING A COORDINATED MEDICAL CPT-MDT APPROACH IN CUYAHOGA COUNTY

Considering the abundance of hospital resources and the availability of a functioning children’s advocacy center in Cleveland, the discussion below presents options for what a coordinated model could look like that is expanded beyond the current approaches in Cuyahoga County. A county-wide response that engages all the essential system partners in a comprehensive child abuse prevention approach requires a specialized coordinating function. Child Advocacy Centers have been highly effective in facilitating this key function, in addition to providing other trauma-informed supports. In Cuyahoga County, Canopy was opened in 2018, after nearly two decades of various attempts and efforts. Given its mission and statutory purpose, utilizing the existing CAC in Cuyahoga County offers a promising vehicle for instituting a coordinated response among hospitals and a centralized MDT for addressing and preventing child abuse and neglect.

Drawing on existing hospital and child advocacy resources in Cuyahoga County, Table B highlights some key features of a more comprehensive, coordinated approach among the local hospital systems to address child abuse and neglect. For each of these models, the medical CPT – comprised of physicians and clinicians from one or more of the three local hospital systems – would treat clients on-site at the CAC unless medical issues required immediate emergency care at a hospital. In these cases, the CPT would still coordinate with the CAC and the MDT for follow up and other services. The client would be brought to the CAC for non-emergency supports and services.

^f Connecticut, Delaware, Indiana, Kansas, Minnesota, Missouri, Nevada, New Hampshire, North Carolina, North Dakota (in cases involving criminal abuse allegations), Ohio, Pennsylvania, Tennessee, Utah, Virginia, Wyoming

TABLE B. POTENTIAL MEDICAL CPT ORGANIZATIONAL STRUCTURES AS PARTNERS IN THE CAC-MDT

Key Features of Medical CPT Models*			
Medical Suite Staffing	System-Wide Coordinated Approach	Lead Hospital Coordinated Approach ^g	Single Hospital System Coordinated Approach ^h
<ul style="list-style-type: none"> Advanced medical consultant 	One advanced medical consultant from each hospital	One advanced medical consultant/ director from lead hospital who coordinates with CAC to operate and staff the medical suite	<p>One hospital system is formally part of CAC MDT – no other hospital systems are involved</p> <p>One advanced medical consultant/ director from a single hospital system who coordinates with CAC to staff the medical suite</p>
<ul style="list-style-type: none"> Pediatric sexual assault nurse examiners Nurse practitioner/advanced practice nursing (APN) Child abuse pediatrician/ advanced medical consultant 	Equal time commitment of staff time from each hospital	Varying time commitment of staff time from other hospitals	Single hospital provides staff

*CAC ROLE: In each model, the CAC will provide a full-time medical coordinator and clinic operations manager, engage the CPT as part of MDT, hold the CPT accountable as part of MDT, and refer clients to hospital of choice as desired and needed by the client and family.

DATASHARING AND INFORMATION FEEDBACK LOOPS

A key component of a system-wide approach to addressing child abuse is interagency datasharing. At minimum, datasharing agreements could aid in case conferencing, so that when the MDT (including the medical CPT) meets to discuss cases, all data from all medical systems can be used to inform decision-making. Ideally, a database to which all MDT and medical CPT members had access would be designed so that all components of a client’s case could be accessed for informed decision-making and service provision. For example, mental health specialists could access a shared dataset to stay up-to-date on cases and follow up with DCFS caseworkers as needed for relevant information, like checking to see if the family was receiving continued services from another provider. Further, gathering targeted child abuse data could potentially lead to datasets that are predictive of problems, serving as flags for DCFS and medical providers. Comprehensive datasets on child abuse data could also provide information and data to help secure funding from a range of resources.

A shared database of child abuse cases and/or electronic health records to identify potential abuse cases can be a major asset to tracking cases, supporting families, and for advocacy and policy change. Information-sharing via accessible databases would also help facilitate improved flows of communication among members of an MDT and other stakeholders working on child maltreatment cases, as the Philadelphia Children’s Alliance demonstrates. Another successful example of a shared information infrastructure is Cincinnati Children’s Hospital’s Integrated Data Environment to Enhance Outcomes in Custody Youth (IDENTITY). Geared toward providing information to better

g The Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) is an example of a similar model, although MPEEC does not work directly with CACs.

h University Hospitals Child Advocacy and Protection Program and Yale DART offer illustrative examples of similar approaches, although these two models do not work with a CAC.

Current Canopy Operations

The development and sustained engagement of a comprehensive MDT is an integral part of the Canopy approach. Canopy's MDT is made up of the Cuyahoga County Division of Children and Family Services (DCFS), the Journey Center for Safety and Healing (previously the Domestic Violence and Child Advocacy Center), Cleveland Rape Crisis Center, FrontLine Services, Cuyahoga County Prosecutor, and Cleveland Division of Police. In addition, 35 police departments in Cuyahoga County, including Cleveland Division of Police, have signed an MOU to work with Canopy. Canopy also has relationships with the International Association of Forensic Nurses, Family Justice Center, Cuyahoga County Witness Victim Service Center, and the Cuyahoga County Human Trafficking Task Force. The goals of Canopy are:

1. Promote safety and justice by removing barriers to resources for children, youth, and families impacted by child sexual abuse.
2. Ensure involvement of a highly skilled multidisciplinary team in child abuse cases.
3. Reduce re-victimization of children and youth.
4. Leverage resources and link individuals to comprehensive, culturally-relevant, and trauma-informed services.
5. Foster resiliency, recovery and facilitate long-term health and well-being.

Currently, due to capacity limitations, Canopy primarily coordinates and provides services for child sex abuse cases involving children 12 years old and younger and all child victims of human trafficking.* When Canopy receives a referral for a case that meets the criteria, the MDT is engaged and Canopy staff and partners provide services to the child and their family, tailored to their unique needs and circumstances. From the beginning of a case until its final resolution, the Canopy MDT engages in regular case conference and case tracking to ensure that they meet the child and family needs. MDT representation varies depending on the details and needs of each specific case. See Appendix 1 for more details on the case process. For medical services, Canopy provides referrals to local hospitals, other health centers or clinics that provide medical care.

POTENTIAL CANOPY EXPANSION VIA THE MEDICAL SUITE AND A MEDICAL CPT

The Canopy facility has a medical suite that is available, but not yet utilized. This medical suite presents an opportunity to provide medical care to families onsite, with multiple potential benefits. The medical suite is designed to feel safe and be comfortable for traumatized clients and allows clients to receive a more timely, specialized medical examination. The co-location of other services at Canopy offers the physician or practitioner the opportunity to consult in real time with other Canopy staff and partners in order to deliver the best care possible. By working with a client onsite, a medical professional could avoid duplication of questions that can potentially re-traumatize the client, as there would be an opportunity for the medical professionals to view the specialized forensic interview live or on video recording.

The implementation of the fully-staffed medical suite, currently in progress as Canopy expands, will allow medical professionals to prioritize case conferencing and communication with Canopy staff and the MDT. Obtaining and preserving medical evidence will integrate closely with other aspects of the forensic process, aiding in building a client's case. Closely working in proximity with MDT partners will allow medical professionals to better develop thorough reports and statements on behalf of the client, such as for other agencies, for court, and for expert witness testimony. Further, involving specialist medical professionals in the MDT can help prevent future claims of an insufficient medical evaluation.

Ideally, the medical suite at Canopy would offer comprehensive services under strong leadership of an advanced medical consultant, managed by a full-time medical coordinator and a full-time clinic operations manager as part of a Child Protection Team (CPT). Medical examinations of abused clients would be conducted by specialists: clinicians from Cleveland Clinic, MetroHealth, and University Hospital, including pediatric sexual assault nurse examiners (Pediatric SANE), a nurse practitioner or advanced practice nurse (APN), and a child abuse pediatrician/ advanced medical consultant.

Notably, while Cuyahoga County has a number of experienced pediatricians who specialize in child abuse and provide invaluable care to the community, data from the American Board of Pediatrics (2019) 41 indicates that there are no board-certified child abuse pediatricians in the county. Having a responsive and accessible medical service (including board certified subspecialty child abuse pediatricians, general pediatricians, nurse practitioners, nurses and health social workers demonstrating specialized competence, as well as experience in child abuse pediatrics) would further aid in the process of sharing case information, reviewing cases, and coordinating planning, ultimately benefiting children and families.

**Canopy is interested in expanding to provide support and resources for all forms of child abuse in the future.*

CHILD ABUSE SCENARIO (PART 6): CASE CONFERENCING

Over the next week, the CPT forensic nurse and nurse practitioner present their findings during a peer review meeting with the advanced medical consultant and members of the CPT. At peer review, the other clinicians consult the medical documentation and conclude they are diagnostic of abuse. They also agree the child is medically healthy and likely doesn't have ADHD, and note that the blood test results have ruled out a contributing medical condition that explains the bruises. The completed high-quality medical work and documentation are shared with the prosecutor, who determines that probable cause exists that Johnny's injuries are from criminal child maltreatment too excessive to be justified as corporal punishment.

The CPT representative on the MDT provides a summary of the medical information and is available to answer or forward questions to the advanced medical consultant. Fortunately, the timely forensic interview and the CAC co-location of services, including the CPT medical providers, have helped provide a clear and complete purpose-written peer-review-backed medical report with documentation and opinion diagnosing child physical abuse. This helps the other agencies of the child abuse response team take action now, before additional harm occurs and before circumstances or cooperation changes.

serve children in protective custody, users of IDENTITY can access up-to-date health information from electronic health records and matched child welfare information from the State Automated Child Welfare Information System (SACWIS). The IDENTITY system provides caseworkers and medical providers comprehensive access to clients' case histories, allowing them to make informed decisions and better coordinate care.⁴ Improving cross-sector, cross-hospital communication systems with access to shared data will lead to service quality improvement, ultimately benefitting child victims and their families, and saving overall costs.

FUNDING

Adequate funding is essential to building a fully coordinated systems approach in order to better prevent and support more child abuse victims in Cuyahoga County. Diversifying public and private sources of funding is necessary to creating a sustainable long term coordinated effort. For example, both Dallas (DCAC) and Philadelphia's (PCA) programs receive support from government grant contracts, grants and contributions from foundations, private donations, and other revenue sources. Child welfare experts and pediatricians interviewed for this report assert that while addressing child abuse at a system-wide level will require upfront investment, prevention-approaches generally lead to larger return on investments and serve ultimately as a benefit to society.ⁱ

The National Association of Children's Hospitals and Related Institutions (2011) offer a number of suggestions for creating sustainable funding for hospital-based child protection teams.³² Several of these suggestions for funding sources are also relevant for the development of a financially sustainable medical CPT as part of a system-wide MDT that could operate via Canopy as the coordinating entity:

- Establish an accurate coding system for child maltreatment services to ensure optimum reimbursement from third-party payers for the clinical functions performed in treating a child who is suspected of having been abused.
- Partner with other organizations or hospitals to seek grants and other funding that may be more accessible to cooperative groups than a single organization.
- Develop contractual relationships with law enforcement, CPS, state attorneys general and other referral agencies.

i This point was raised in meetings and interviews by experts in the field. This report was not intended to review the literature specific to ROI/ value and return of preventative programs for children.

- Solicit one or more grants of varying sizes from local, state and/or national organizations focused on multiple aspects of child abuse and neglect.
- Pursue targeted funding aimed at specific aspects of child health and safety.
- Explore funding for graduate medical education when the hospital is home to an accredited child abuse pediatrics fellowship.
- Develop multiple research grants that support particular research projects and the time of some of the center's medical staff.
- Request state funding from criminal proceeding fees or a stable appropriation or budget line item from the state

CONCLUSION

This paper has presented information to aid in developing a robust collaboration between DCFS, three hospital systems, the existing CAC, and other key stakeholders in Cuyahoga County. This paper does not cover the depth of rich medical resources available to families in the county, including free and income-based services offered by entities such as Neighborhood Family Practice, Northeast Ohio Neighborhood Health, Circle Health Clinic, and many others. As these institutions provide care for some of the county's most at-risk children, they undoubtedly also have pediatric expertise that, if folded into a coordinated effort, would contribute greatly toward improved systems for addressing and preventing child abuse. Moving forward, building collaboration among all child-serving institutions will be imperative in developing a coordinated, county-wide system that addresses child abuse.

The urgency of our children's well-being is paramount and the opportunities for partnership are clear. Building on existing services and models appears to be the most straightforward path toward collaboration. In particular, since its establishment, Canopy has offered a promising model of coordinated care and wraparound services for victims of abuse through its MDT. As the child abuse and child fatality data suggest, the current siloed approaches are not enough to reduce the rates of abuse, neglect and death in Cuyahoga County. Rather, a coordinated county-wide approach, engaging the major hospital systems in a collaborative partnership, involving the development of a medical CPT that operates as part of an MDT through a CAC would prioritize the needs of child abuse victims and their families, ensure prudent use of taxpayer dollars, and provide a critical service to the greater Cleveland community.

CHILD ABUSE SCENARIO (PART 7): CASE MONITORING

Services for the family continue throughout the legal process. Since Johnny's mother indicated that she was ready to fully engage him with mental health and support services, but has not shown interest in services for herself, the victim advocate plans to devote further effort to supporting her. The advocate also will assist her in obtaining a protection order.

The MDT will reconvene in two to four weeks to ensure all involved agencies utilize the shared information, treat the consequences of physical abuse and neglect, hold accountable those responsible, and enable nurturing, safe parenting to take place. Collectively, these actions will contribute substantially to protecting Johnny from further serious harm or fatal maltreatment.

Moving Forward

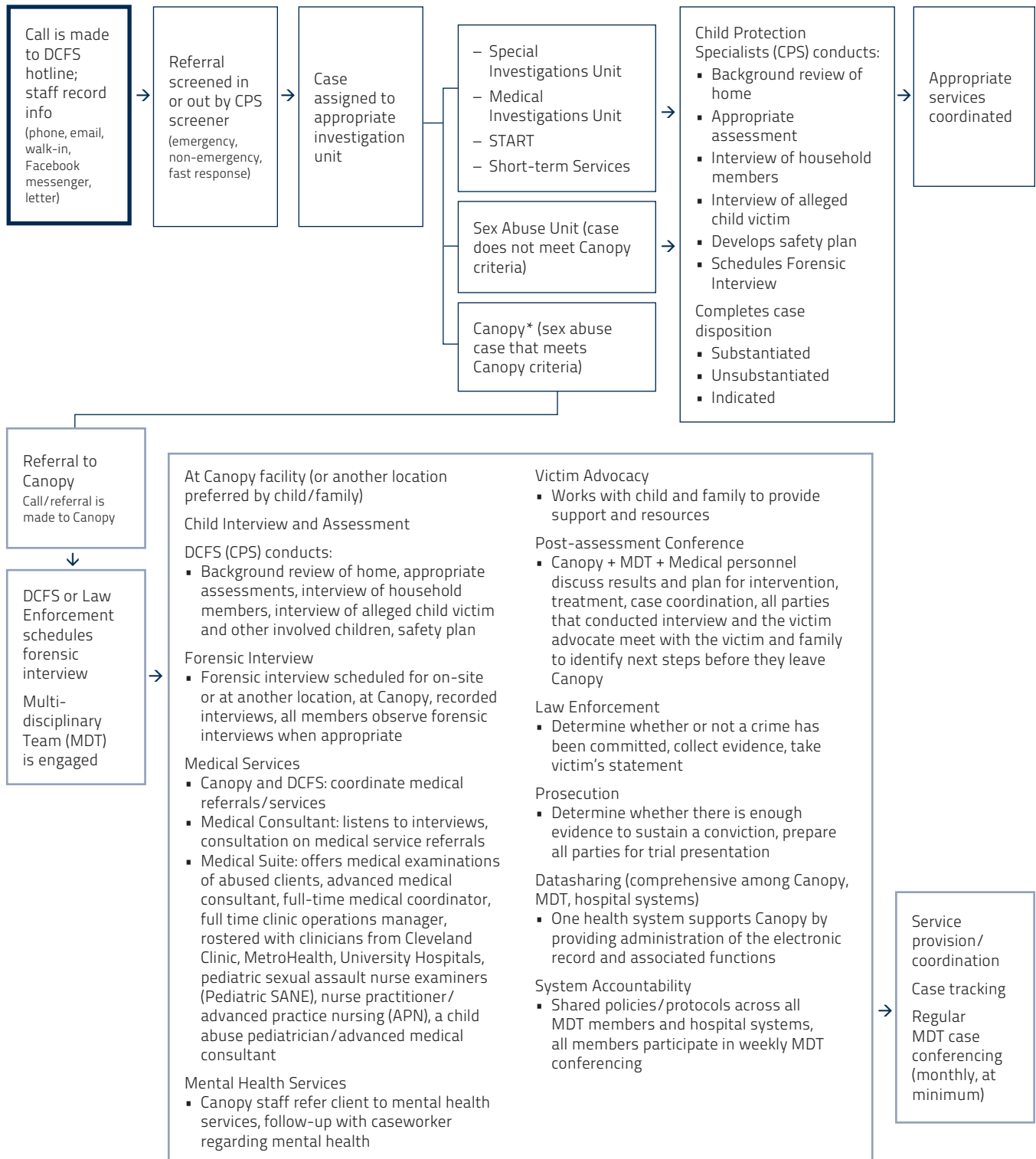
Cuyahoga County and health system leadership are encouraged to jointly assemble a core team with a clear charge and timeline to create a plan for moving forward, with the following priorities:

- Build collaboration among greater Cleveland hospital systems and other key stakeholders to develop a coordinated county-wide system to better address and prevent child abuse.
- Identify opportunities and barriers for interagency data sharing to help operationalize an early warning system, a key component to a system-wide approach to addressing and further preventing child abuse.
- Engage potential public and private partners to diversify and strengthen revenue sources to create a sustainable long-term coordinated effort.

Appendices

APPENDIX 1

DRAFT MODEL: CHILD ABUSE REFERRAL, INVESTIGATION, ASSESSMENT PROCESS (CCDCFCS and Canopy)



*Criteria includes human trafficking and will eventually include physical abuse cases

APPENDIX 2

Child Protection Teams – Opportunities for Prevention: Case Examples

Each case example below represents an actual child in Cuyahoga County and the circumstances contributing to their death. Any detail that could identify the child has been removed, and inconsequential details have been changed to support confidentiality. They are presented here only to illustrate how a Child Protection Team might have made a difference, not as a critique of any individual or organization's role.

Overview Information: Case Example #1:

Age: <10

Cause of Death: Severe Asthma

Known History:

The child had a multi-year struggle with asthma and was not newly diagnosed. The child was well-known to the child protective services system, which had investigated multiple reports on the child over the prior years. Some reports were determined to be substantiated and some unsubstantiated. Investigated items included multiple reports of medical neglect, as well as reports of neglect, emotional maltreatment and abuse. As a toddler, three of the referrals were for missed appointments, weight loss, and medical attention needed for failure to thrive (possibly related to food allergies that were limiting nutrition options.) Several of the medical neglect referrals were determined to be substantiated.

Circumstances Preceding Death:

Three Years Prior to Death: The child's last known visit with a pulmonologist occurred about one year before the death. At this appointment, a prescription for a 6 month's supply of asthma controller and rescue medication was given. During the two years preceding this appointment (two to three years prior to the death) there had been multiple visits to the emergency department – and two hospitalizations – due to asthma. Also during this time was a history of missed appointments and indications that the child's school was concerned about the management of his asthma and his access to treatment.

Ten Days Prior to Death: Approximately ten days before the child's death, child protective services contacted the hospital system where the child had received care to inquire if they were getting care and if the asthma was under control. Lacking a signed release from the parent, the hospital claimed it was unable to answer any questions. Three days prior to the death, the child's school contacted the child's mother expressing serious concern about the asthma. The mother picked the child up from school, and the school nurse urged her to take the child to the hospital for steroid treatment. The mother indicated she would, but did not. She took the child home and administered a breathing treatment. She felt she saw improvement. She kept him home from school the following day. She intended to make an appointment with the doctor in a few days (on Monday), but did not. Over the weekend, she administered some over-the-counter cold medicines to treat what she perceived as cold symptoms. On Sunday, while she was at work, the child had an asthma attack and was found unresponsive. The police noted that the medications in the home included an inhaler to prevent attacks, a rescue inhaler, and allergy pills.

The Role of a Child Protection Team: The inability of systems that provide care and protection for children to share case information (in the absence of a signed release by the parent) is a relevant factor in this child's death. Medical CPT oriented social workers will report and liaise with authorities regarding medical neglect/non-adherence to appointments, prescriptions etc. They will seek the advice of the doctors and practitioners. The medical CPT helps various specialists come to consensus around the issues, give good solid detailed information about severity, chronicity, and risk as well as avoid giving mixed messages to the authorities. Additionally, given the multi-year history of concerning issues seen in this case, it is likely a medical CPT would have been involved well prior to this point. Neither the hospital nor protective services saw the whole picture of this child's dangerous and declining circumstances until after the child had died.

Overview Information: Case Example #2:

Age: <4

Medical Examiner Rulings

Cause of Death: Blunt Force Trauma

Manner of Death: Homicide

Known History:

The child was hospitalized for much of the first year of life due to multiple congenital heart anomalies and surgical repairs done during this time. Mom has a learning disability that makes reading and math a challenge, and it was noted that she was not attending classes at the hospital to learn how to take care of the child's medical needs. The child and family were well known to child protective services and over the next two years, the child was in and out of foster care. During this period, there were several referrals to child protective services for abuse, neglect, and dependency. Upon investigation, some were determined to be substantiated and some unsubstantiated. These referrals concerned the mom's ability to care for a child with complicated medical needs, hospital admissions for failure to thrive and weight loss, the mom not using necessary medical equipment, missed appointments, and a lack of utilities. The child was in foster care for about two years, until reunified with mom early in 2018 – with protective supervision.

Circumstances Preceding Death:

Six Months Prior to Death: Soon after reunification, the mother took the child out of state. There were concerns from the medical care providers in Ohio that the mother had not taken the child's necessary medical equipment or cardiac medications with her. There was an emergency custody hearing in Ohio and the child was placed with a foster parent from mid-May until mid-November.

Two Weeks Prior to Death: In mid-November, the child was placed (as mom requested) with her sister. One day later, the child was taken to Hospital #1 for edema under the eyes, blood and drainage from the ear, cough and a fever. He had a perforated eardrum, for which infection was the preferred diagnosis. Very shortly thereafter, the child was seen at Hospital #2 for foster care intake due to a change in placement. The child was not cleared for placement and was admitted overnight. He continued to bleed from the eardrum, and where the swelling had been, there was an open lesion below the eye and there was swelling in both eyes. Due to concern of an ongoing fever as well, a diagnosis of cellulitis was made. There was no child protection referral from Hospital #2. The child was discharged after a few days, but was not brought back for a scheduled follow up visit. About a week later, the child was in the care of the aunt's boyfriend while she ran an errand. The child became unresponsive and 911 was called. The child was taken by EMS to Hospital #3 and died in the emergency department. The fatality was investigated and abuse/neglect were substantiated. Other children living in the same home were removed by child protective services.

The Role of a Child Protection Team: A lack of training and lack of access to in-house expertise in abuse evaluation and documentation appear central to this case. Multiple providers missed signs of abuse that this child a physical assault could have caused the ear bleeding, face swelling and open lesion. Two personnel had thought about abuse as a possibility but were unsupported by an accessible specialist team to look further into it. However fleeting, those suspicions should have triggered deeper investigation and reports to child protectives services who could have taken action to curtail the current foster arrangement. Interactions at both Hospital #1 and #2 were missed opportunities for intervention and information sharing. An established CPT program would have provided an avenue for additional expert consultation and the automatic sharing of actionable information with protective services when abuse had been confirmed or strongly suspected. Tragically, abuse that was apparent before the death – and would very likely have been recognized as such by well-trained personnel – was only substantiated during a fatality review.

Overview Information: Case Example #3:

Age: 5 Months

Medical Examiner Rulings

Cause of Death: Failure to thrive with severe malnutrition and dehydration

Manner of Death: Natural

Known History:

This child was born at 42 weeks gestation and weighed 7 pounds, 3 ounces. A few days later she weighed 7 pounds, 8 ounces, and was experiencing jaundice. At 11 weeks old, she was seen by a different doctor and at a different location than previous care. She then weighed 13 pounds, 7 ounces. Her medical record notes she was breastfeeding well and had enough wet diapers. This doctor was able to get her seen by dermatology that day for severe eczema. She was started on antibiotics and wet treatments.

Circumstances Preceding Death:

From the date of the infant's birth up to 16 weeks old, there had been multiple appointment cancellations and "no shows" with her primary doctor. At this point she was brought in for what would be her last medical visit. It was noted that she now had lost weight and weighed 11 pounds, 13 ounces. During the appointment, her mother refused any immunizations and indicated she was exclusively breastfeeding. The mother also had eczema and said she was changing her diet to help. Since she was only eating vegetables, the mom was losing weight. She said she wanted to do natural or homeopathic care for the baby. A dermatology appointment was set for three days later, as well as a follow up appointment with the pediatrician for two weeks after that. Neither of these appointments were kept. Another follow up appointment, set for a week after the missed pediatric appointment, was also missed. At no point did these missed appointments (despite a diagnosis of severe eczema and noted weight loss) result in a referral to child protective services – even though warning signs of the mother's inability or unwillingness to engage in necessary medical care was evident and noted.

On the day of her death, she was groggy and her parents drove her to a hospital emergency room from their suburban home. On the way, she became unresponsive and her father attempted CPR. At autopsy, she weighed 10.5 pounds. On the day she died, three referrals were filed with child protective services, one from the hospital and two from the Medical Examiner's Office (the second was a duplication error). All three referrals were "screened out" because child protective services determined there were no other children in the home, and the matter did not meet the criteria for additional services. The medical examiner's office notified the suburban police department and provided information on the case.

The Role of a Child Protection Team: A collaborative community-wide medical CPT program that includes dedicated liaison staff within each hospital and major social service system can be essential when a child's caregiver disengages with needed care or moves between providers in different systems. Central to this case is the judgement call that must be made by providers in making a referral to child protective services. Missed appointments alone are not proof a child isn't getting care or that medical neglect exists. When an official report of suspected abuse or neglect is the only option available to providers, it may be easily dismissed as too drastic of an action in the absence of more proof. By way of analogy, most people wouldn't immediately pull a fire alarm because there was a whiff of smoke in the air. But they would mention it to a nearby security guard for investigation. A medical CPT program, with hospital in-house liaisons, provides an option to access additional assistance. Inter-agency coordination transfers those less obvious judgement calls to more highly trained staff who are informed by additional details and case histories that are unavailable to the initial provider.

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