[redacted]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families

Hospital-Based Responses to Child Abuse and Neglect

National Center on Child Abuse and Neglect

Washington Hilton
Washington, DC

May 18 - 19, 1992

National Center on Child Abuse and Neglect

[redacted]

Developed by Francis X. Sullivan, DAE Corporation

Foreword

An increasing number of reports cite the alarming numbers of children who suffer abuse and neglect each year. Recent figures indicate as many as 1.7 million reports of child abuse annually. The point of entry for assistance for many abused children is the hospital. They may have been brought by ambulance, parent, or police officer following a battering, neglect of their medical needs, or an allegation of sexual abuse. What happens to them at the hospital and upon later discharge was the focus of this Symposium.

The *Hospital Based Responses to Child Abuse and Neglect Symposium* was organized to address the complexity of issues faced by hospitals and staff in providing emergency, evaluation, treatment, referral, and planning services for abused and neglected children. In an era of decreasing financial resources, hospitals are struggling to provide these special services and programs to their communities. The theme of the need for cooperation and information sharing with Child Protective Services was evident throughout the sessions. The obstacles and frustrations, as well as the rewards and successes, of programs across the country were the focus of the discussions.

To foster this dialogue, four panels were convened representing a range of experienced hospital based programs. The first panel discussed the initial identification of abuse by hospital personnel, and the training hospital staff need to ensure proper identification and treatment of abused and neglected children; this panel also noted the role of the child abuse team attorney regarding reporting of child abuse, release of information, and relationship with guardians. The second panel reviewed issues surrounding the care provided to children as inpatients highlighting several community based programs. The third panel addressed the role of multidisciplinary teams including such topics as their relationship to the hospital, organization, regionalization, and discharge planning. The fourth panel outlined hospital-community partnerships in service provision, research, and prevention.

Suggestions for the future evolution of hospital-community responses were discussed. The participants called for a new paradigm to foster a commitment to serving abused and neglected children. We hope these procedings will assist other communities in improving services for abused and neglected children in the years to come.

David W. Lloyd
Director
National Center on Child Abuse
and Neglect

TABLE OF CONTENTS

Hospital-Based Responses to Child Abuse and Neglect
National Center on Child Abuse and Neglect
Washington Hilton
Washington, D.C.
May 18-19, 1992

INTRODUCTION

This meeting reexamined the role of the hospital in medical issues related to child abuse and neglect such as the use of Suspected Child Abuse and Neglect (SCAN) teams, and the role of hospital child abuse and neglect teams in prevention. The 1988 National Study of the Incidence and Prevalence of Child Abuse and Neglect (NIS-II) showed that hospitals have the highest rate among agencies in reporting child abuse and neglect. While hospitals cannot fulfill their role in child protection if they only see themselves as healthcare providers in a narrow technical role, many hospitals are facing fiscal problems, and many are examining the profitability of each hospital component in addition to examining the services that the entire hospital provides to the community.

This meeting is particularly relevant for the National Center on Child Abuse and Neglect (NCCAN) in light of the Initiative on Child Abuse and Neglect developed by Louis Sullivan, M.D., Secretary of Health and Human Services. The Initiative includes a public awareness campaign, meetings in the 10 Department of Health and Human Services (HHS) regions to involve grassroots organizations, a memorandum of understanding between eight domestic departments to increase interdepartment efforts, and a working group to improve coordination of child abuse and neglect activities within HHS.

The following issues were put forth for consideration at the meeting:

- The continuum of hospital involvement;
- Administrative and fiscal concerns;
- Training, including teaching and inservice, at all levels;
- The hospital's relationship to the family;
- Community concerns over the rates of child abuse and neglect;
- Cultural sensitivity;
- Community outreach for prevention
- Use of multidisciplinary teams (MDT's); and
- Interagency coordination outside the hospital.

NCCAN ACTIVITIES: David Lloyd, Esq., Director

Changes in Legislation

Several legislative changes to the Child Abuse and Prevention and Treatment Act were made during the recent session of Congress. In addition to its other research programs, NCCAN must conduct research on cultural diversity. NCCAN also is required to maintain a peer review system for research grants. The categories of fundable demonstration projects now include those directed to the recruitment, training and use of volunteers.

Beginning in Fiscal Year 1994, NCCAN's Basic State Grant program will focus on Child Protection Services (CPS) programs. States must submit detailed plans that outline how they will focus on improving CPS programs. Funding for the Basic State Grant also will change when total appropriations for the program reach $40 million. At that time, States will only be able to use 15 percent of their appropriation for general purposes.

The Challenge Grant program has been renamed and given a new purpose. It is now called the Community-Based Prevention Grant. Recipients must now concentrate on community-based prevention programs. The new funding structure for the Prevention Grant calculates each State's award money based on a combination of an amount based on the number of children in the State with a minimum of $30,000 and the amount of money collected by the State trust fund.

The Children's Justice Act grant programs, which uses funds from the Department of Justice to examine the systemic handling of child abuse and neglect cases, now includes civil court cases and child fatalities as topics. Grantees also must address interstate issues, State and Federal issues, and State and tribal issues.

Current NCCAN Activities

NCCAN is improving its capacity to disseminate information and is revising its User Manual series. Topics in this series include the role of mental health professionals in treatment, child sexual abuse, and substance-abusing parents. NCCAN also is developing a detailed workplan with the Clearinghouse and the two resource centers (the National Resource Center on Child Abuse and Neglect in Denver, Colorado; the National Resource Center on Child Sexual Abuse in Huntsville, Alabama) to avoid duplication of activities and to ensure that the resource centers serve as an outreach arm of NCCAN.

NCCAN also is continuing several data collection initiative. NCCAN is convening a review panel to examine the results of the first two National Incidence Studies (NIS I and NIS II) and preparing to pilot-test NIS III. The National Child Abuse and Neglect Data System (NCANDS) published its first set of working papers this year and currently is piloting its detailed case data components.

NCCAN also is involved in major initiatives on "living will" legislation and religious exemption provisions. Laws in some States might be interpreted to allow parents to file living wills for the medical treatment of their underage children. NCCAN is working with States to ensure that "living will" statutes do not permit medical neglect of minor children. Termination of life support could be viewed as medical neglect unless the child is fully emancipated.

NCCAN is concerned that some States are misreading religious exemption provisions. The NCCAN definition allows States to exempt parents from a finding of neglect of a child's medical needs due to the parent's religious practices, but it does not allow them to exempt such a failure to meet the child's medical needs from the definition of neglect. Also, some State statutes can be read to place spiritual healing and conventional medical practice on the same level. For purposes of protecting children from neglect of their medical needs, this is impermissible.

Fiscal Year 1993 Plans

In Fiscal year 1993, NCCAN will continue to address the problems of child fatalities due to abuse and neglect. It also will devote effort to reviewing home visitation as a prevention program. Home visitation can succeed in reducing the incidence of child abuse and neglect, but it must be carefully thought out. Few studies exist to show whether home visitation can prevent child abuse and neglect over the long term, so NCCAN will be seeking to build and evaluate studies to test this proposition.

The Interagency Research Committee of the Federal Interagency Task Force on Child Abuse and Neglect is working to identify gaps in Federal funding of child abuse and neglect research. This initiative will mesh with a National Academy of Sciences study, supported by a grant from NCCAN, that is developing a research agenda in child abuse and neglect for the field. NCCAN will work with the Administration on Developmental Disabilities to coordinate the role of State Protection and Advocacy Systems created by the Developmental Disabilities Assistance and Bill of Rights Act of 1992 in conjunction with CPS systems' role in protecting children with disabilities from maltreatment.

IDENTIFICATION OF CHILD ABUSE AND NEGLECT CASES AND INITIAL HOSPITAL RESPONSE

Carolyn Levitt, M.D.: Service Integration

Dr. Levitt discussed the problem of integrating child abuse services at the Midwest Children's Resource Center within Children's Hospital of St. Paul, Minnesota. The Midwest Children's Resource Center was started in response to the problems created by child sexual abuse cases. The initial focus of the Center was on child sexual abuse, but it also dealt with physical abuse. As the Center grew, it was severed functionally and geographically from the hospital.

Purpose: In 1991, the Center saw 818 children, approximately 15% of whom were physical abuse or neglect cases. The Resource Center system brings together services to focus on abuse, to diagnose it properly, to support children throughout the community, and to testify to diagnoses in court. This system enables the hospital to provide the services that communities need and provide leadership as the child's case progresses through the system. However, some children who came into the hospital did not receive any services because the Center is not informed about them. The hospital president requested the Center to develop the SCAN team approach. This top level commitment was crucial to the project's success.

Approach: The Resource Center Committee met monthly to review cases and functioning of the process. Members of the committee included a physician consultant and a pediatric forensic pathologist (who also serves as the hospital's quality manager). The committee's goals were to find, identify, and recommend an integrated system to care for children who present at Children's Hospital with suspected child abuse and neglect; to understand better the impact of child abuse and neglect cases on Children's Hospital; and to identify the resources necessary to manage these cases. When the committee began to implement its findings, the medical community did not object to working with a child abuse consultant on all cases involving suspected abuse.

When designing the process, committee members identified the following areas of importance:

- Team approach;
- Consistent 24-hour care response;
- Communication between the referral and investigating communities;
- Availability of competent medical management;

- Standardized approach; and
- Safe disposition.

The task force created flow charts to clarify emergency room and inpatient treatment procedures. This identified areas where procedures were unclear, and it identified duplicative efforts, clarified roles, and noted areas needing clearer communication.

Personnel: Intake access must be 24 hours a day, 7 days a week. The staff uses cameras to document injuries. A triage approach is used. The intake specialist need not be a professional but someone who was trained within the hospital system. R.N. case managers are assigned, and an M.D. consultant is always available. The R.N. case manager interviews families and makes the collateral contacts and documents as appropriate. Social workers assess neglect that does not have a medical component; they are involved in crisis intervention. There should be a child abuse physician specialist and an associate. They serve as role models for the residents who must learn to report abuse immediately so the case can be investigated while there is still a "crime scene" and the possibility of remorse on the part of the abuser.

Costs: The efforts of the SCAN committee to bring in all hospital cases suspected of abuse and neglect have resulted in almost twice as many patients in the first quarter of this year. The program would like to be able to pay for its services through fee-for-service. About two-thirds of the child abuse center's funding is fee-for-service; the rest comes from philanthropy. The program does not have trouble raising money from philanthropists because of its relatively large fee-for-service base. Still, professionals in the field should be able to bill for their time, including the time spent working on the multidisciplinary teams. Using a medical model also increases the likelihood of insurance reimbursement.

Stephen Ludwig, M.D.: Training Medical Personnel

Dr. Ludwig discussed the training that hospitals and medical schools provide to identify and respond to child abuse and neglect. In the early 1970s, care for abused and neglected children was poor. Hospitals did not identify or report cases, so it was determined that training individuals to identify abuse and neglect was critical. He described the different types of training Children's Hospital of Philadelphia (CHOP) developed to train professionals in child abuse casework. CHOP has 85 pediatric residents and more than 100 medical students. All receive training in identifying child abuse and neglect.

Some individuals have a difficult time with this type of training and may not be suitable for work in this area. These include those who are afraid

of abused children and their parents, those who are ineffective in dealing with abuse-related problems, and those who are not interested in child abuse cases (typical for sub-specialty professionals). Some hospital based workers who were abused themselves may overidentify cases with their own experience of abuse. These workers need mechanisms to help them cope with this stress. In every case, patients need protection from abusive or overintrusive professionals. However, it is unrealistic to expect a high level of mastery from impaired residents in baseline work in child abuse and neglect; they may display inappropriate boundary setting or may even take some sexual interest in their patients.

Training Programs: The Hospital and medical school provide training options in child abuse and neglect casework at several levels. All medical students receive 2 hours of training in recognizing and identifying abuse and neglect. This training stresses the horror and the "humanness" of child abuse and neglect, and emphasizes the physician's responsibility to identify abuse and neglect. Senior-level medical students may take a 1-month elective that provides in-depth information on child abuse and neglect and on community responses to it. This elective is especially important for those interested in family practice, community based CPS workers, police laboratory, court medical examiner work, and multidisciplinary teams.

Pediatric residents participate in conferences, programs, and consultations that stress both the cognitive and the emotional aspects of abuse and neglect. Residents also may elect to spend 1 month in intensive work on abuse and neglect cases within a community based practice.

Finally, CHOP offers 1 year of fellowship training after residency for those who have a career interest in the field. The current Fellowship training only includes pediatricians, although a semester-long course mixing disciplines (including doctors, nurses, and social workers) had been offered in the past. The current course deals mostly with a clinical approach, focusing mainly on physical and sexual abuse with some work on emotional abuse and child neglect. A research project is expected of each Fellow. Funding a fellow for 1 year costs about $40,000.

In the future, CHOP would like to offer a core curriculum in child abuse training for every medical, nursing, and social work student. In addition, more encouragement is needed to bring professionals into child abuse and neglect clinical practice as careers.

Several special areas of training are presented to familiarize students with the terms and procedures. Students are introduced to legal proceedings through a mock trial. They participate in physical examinations for sexual

abuse using protocols, and they review physical findings with residents. They are trained in cultural sensitivity and they conduct a home visit. They also learn about the emotional impact of child abuse and neglect; there is discussion about the relative costs of taking care of a well-child who has been abused and the child who needs a transplant.

Weaknesses and Suggestions: Communications may not always occur within the same hospital. For example, trauma center staff frequently do not have enough information about the child; the child abuse worker may not hear about some injured children from other units until it is time for discharge.

In addition to pediatricians and those with particular interests in child abuse and neglect, surgeons and other medical field sub-specialists can be trained to identify cases based on the particular evidence their fields provide. Every nursing, social work, and medical student should receive training. Child abuse and neglect education is not linked to other types of child education as closely as it should be. Training programs also should try to identify people who will make child abuse and neglect work a career interest and provide training for them. In New York State, all mandated reporters take a 2 hour approved child abuse and neglect course in order to be relicensed.

Secondary-level community hospitals which do not have training programs often do not have sufficient resources for service delivery; they need to be linked to child abuse centers. Alternatively, satellite centers could be set up to serve a wider regional area with connections to a centralized child abuse resource center.

Joint Commission on Accreditation of Health Care Organizations (JCCO) standards should stress the need for standards for all hospitals. Protocols should be broad in their coverage. To better serve and identify abused and neglected children, each community hospital should have basic protocols to identify cases of child abuse and neglect and to link them to community centers.

Hospital administrators also must be involved so they can understand why it is critical for hospitals to provide these services; their concerns about their image and adverse public relations when offering child abuse and neglect training and services should be recognized. These administrators must also consider government regulations and how to respond to them.

Finally, basic research into how the injuries occur is necessary to aid doctors in identifying cases. This research must be presented to doctors and other workers in a manner which makes it readily usable.

Tobey Lawson, Esq.: Role of the Clinical Attorney

Ms. Lawson discussed her experiences working as the only attorney on a Washington, D.C. hospital-based multidisciplinary team. This role differs greatly from the usual role of a hospital attorney. Whereas the hospital general counsel only considers the best interests of the hospital and therefore focuses on malpractice issues and contracts, the legal counsel for the hospital-based child protection team must balance the needs of the hospital against the child's needs.

Reporting: The central question for the team's attorney is when to report abuse and neglect. Since physicians are mandated reporters, it is essential that they understand the reporting laws and the consequences of acting on their responsibilities. Reporting must be unbiased; reporters cannot distinguish by race or social class, nor can they fail to report because the abuser promises to reform. Reporting must always be based on a good faith belief. Failure to report abuse or neglect carries sanctions, including a possible judgment of malpractice. The decision to follow up reports, however, rests with social service agencies or the police.

Release of Information: A clinically-based attorney also must deal with frequent requests for the release of information. Mental health and medical information is confidential; professionals should consult with the attorney before making a decision to release information. It is therefore important that professionals be careful about record documentation. The hospital always should consult counsel before releasing information because a wrong decision could be costly. Improper disclosure of records leaves the hospital open to a liability suit, but failure to disclose records may constitute contempt of court. Doctors should not record mental health information on hospital medical charts because the medical and mental health information have different release laws. Doctors also should be careful not to record preconceived notions; in Idaho v. Wright[1] the U.S. Supreme Court held that the physician's testimony as to a child's report of abuse was in admissible because it was based on an interview which did not provide sufficient procedural safeguards to assure the child's statements were trustworthy.

Doctors may be called to testify in family and criminal court cases. While family court is primarily concerned with protecting the victim, criminal court focuses on punishing the offender. In the criminal cases the prosecution often needs an expert witness to give opinions on matters beyond the common knowledge of the judge or jury. Mental health professionals can offer

[1]Idaho v. Wright, 497 U.S. 805, 111 L.Ed. 2d 638, 110 S.Ct. 3139

testimony regarding court-ordered evaluations of abused children, but they should not offer testimony about a child's truthfulness or whether a child has actually suffered abuse (what is often called the "ultimate issue"). The professional may also be asked to provide information in writing without testifying in court. The hospital professional, however, should not be concerned only with the findings but also with followup of case disposition and treatment. To make evaluation and testimony easier, the gap between legal and clinical definitions of child abuse and neglect needs to be closed; at the present time state definitions of child abuse for purposes of child protection and criminal prosecution may differ from those used by the hospital workers.

Courts must be sensitive to parental rights and family integrity. Child protective services cannot usually authorize non-emergency medical or mental health treatment, nor can hospitals prevent visitation, unless the parents give permission or there is a court order.

Additional Issues

Videotaping: Staff at the Montefiore Medical Center are not proponents of videotaping cases. Some participants at the meeting believed that word about the use of videotaping gets out quickly and videotaping sets up an immediate adversarial relationship with the clients. This raises the question of how a therapist can forge a therapeutic alliance if the client resents videotaping. In addition, the videotape can present problems in court. If the child does not disclose the abuse initially or discloses and then recants, the videotape will diminish the child's credibility. Although the doctor may lose information by not using videotape, patients will not trust the doctor if s/he uses videotape made without the client's consent.

Others voiced the opinion that one of the intake specialist is to perform triage and create a support system to assist abused and neglected children and this may involve use of videotapes. At the Midwest Children's Resource Center they believe that cases that are strong enough to go to court are strong enough to be videotaped. They tell clients the reason for the videotaping is because they need the information; the process continues without becoming adversarial. The role of the therapist in testifying is to educate the judge and jury about the child's condition, and videotapes assist in this role.

Subpoenas: Hospital professionals may receive subpoenas as either factual witnesses or as expert witnesses. Judges usually do not supervise the content of a subpoena. As soon as they receive a subpoena, hospitals should consult a lawyer, who then drafts a standard motion to quash the subpoena. A judge decides if the person summoned by the subpoena must appear in court. A recent decision in the District of Columbia, Brown v. U.S. prohibits

attorneys from issuing subpoenas without a judge's supervision. In any case, the response to a subpoena is a legal decision, and it should be made by a lawyer. However, it should be noted that the law is always changing, and any set response procedure may not always be appropriate.

Some professionals are concerned about the time commitment of subpoenas. It was suggested that upon receipt of a subpoena, the professional (or the hospital's attorney if that is appropriate) should immediately contact the person sending it; the professional and the attorney should then make arrangements for the court appearance and prepare testimony. A judge will usually accommodate a professional's schedule. However, if possible, the professional should request being 'on call' or being called when the appearance is certain rather than waiting at the courthouse day after day.

Release of Records: Parents hold privilege for their children and have a right to their records. If the nonoffending parent requests the records, hospital personnel should review the records with the parent. Requests from the alleged offender are usually refused, at least initially. It is often useful to have the nonoffending parent sign a release form. In some cases, a child is authorized by law to decide not to release his or her records to parents. These laws vary by State, but factors such as the child's age and the condition for which the child is receiving treatment are considerations. Again, the person deciding whether to release the records must know the law. It is difficult to avoid releasing medical information to offending parents, although it is easier to withhold mental health records from them. A guardian ad litem could represent the child in disputes over release of records.

Reporting Cases: The police in Washington, D.C., note that pediatricians in private practice underreport child abuse cases but they may be referring them to a child abuse center. In some other areas, private pediatricians are reporting more cases.

Prevention Activities: A major deficiency in prevention programs is that child abuse and neglect training frequently happens in a vacuum. Successful training is linked to other child and family development learning opportunities. Primary prevention is the most promising field, but few programs can fund it. It is imperative that there be a focus for funding prevention activities to avoid downstream effects. Teaching parenting skills is one promising approach. There is an untold potential in the integration of parent education programs with programs such as home visitation. It is also important to build strength in the community and respond to the cultural diversity in the community.

Outreach: One hospital has obtained a grant from a malpractice insurer to contact local hospitals and provide child abuse and neglect training for hospital professionals.

THE MALTREATED CHILD AS INPATIENT

Howard B. Levy, M.D.: Interdisciplinary Approaches

The number of hospital-based interdisciplinary treatment programs is increasing. The JCCO guidelines are strict regarding these programs, and the Illinois Domestic Violence Act specifically stipulates what services must be available for children.

Program Goals: At Grant Hospital in Chicago, the Pediatric Ecology program's mission is to understand, study, and lessen family dysfunction and family violence in a fiscally responsible manner. The Illinois Department of Public Aid funds the program, and the Crescent Corporation conducts the utilization review. Private individuals act as the steering committee. The program has about 970 inpatients per year. The outpatient unit has about 7,800 contacts per year that result in 1,600 patients per year. Each program has to find funding and convince funders that this is an important activity.

The nonhospital-atmosphere inpatient site holds 15 patients. It has two interviewing rooms with two-way mirrors and videotaping capability. (The Center informs all patients that they are being taped although no one except the professionals have access to the tapes.) The rooms are decorated to produce an atmosphere that will not be traumatic for children, and the outpatient facility is designed in the same way so that children will perceive the hospital as a safe setting.

More than half of the patients that the Center sees have been sexually abused. The children are getting younger, and they seem to have more complex problems.

Approach: The program uses an interdisciplinary approach to child abuse and neglect, approaching it through the topic of domestic violence. Quality assurance, risk management and monitoring are important. Dr. Levy does not believe in a free standing curriculum in child abuse and neglect. Teamwork is essential to the program's approach. Dr. Levy favors a trifurcated approach involving inpatient services, outpatient followup and assessment, and a sleep center where children can receive respite care through the night.

Interdisciplinary teams consist of representatives of the following disciplines:

- Child development;
- Psychology;
- Psychiatry;
- Nursing/child care;
- Pediatrics;
- Social work; and
- Law enforcement (as observers only).

Representatives of each discipline complete their own instruments. Quality control is maintained through peer review and chart review.

The most common disorders at Grant Hospital are dysthymic, adjustment and anxiety diagnoses. There is also a large number of major thought disorders and many of these come from children in the foster care system. Until recently there were no psychiatric disorders found. Parenting aspects are important considerations. At Grant Hospital they use a broad ecological model empowering parents to do good things and enhance communication.

Coordination with agencies also is emphasized. The program gets referrals from agencies because it can provide services quickly; 65 percent of the referrals come from the State Department of Children and Family Services. State workers must be involved in discharge planning. There is concern that the program should not become co-opted and turn into a prosecution unit rather than medical unit. The longer each center exists, the more time the professionals seem to spend in court; this is a serious cost effectiveness consideration.

<u>Outcomes:</u> Early outcome measures that the center is using include the following:

- Provision of services;
- Frequency of reabuse;
- Discovery of unsuspected types of abuse; and
- Identification of previously unrecognized medical and mental health disorders.

At this point, Grant Hospital is providing six times more services than before, with a re-abuse rate that is one-quarter of that in the state generally.

Leah Harrison, M.S.N., C.P.N.P.: Preparing for Discharge

The role of the Child Protection Center in identifying, tracking and preparing cases for discharge is an important yet difficult one.

Setting: Montefiore Medical Center in New York City, has a Child Protection Center. All children suspected to be victims of abuse or neglect are referred to the Child Protection Center. The Pediatric Division has 79 beds, including 14 intensive care beds. Most children are seen as outpatients, and they may be referred from within the Medical Center or from other sources, including the Child Welfare Administration (CWA), the New York Police Department, the New York Department of Education, or private physicians. In 1991 there were approximately 4,000 pediatric admissions with only 45 documented child abuses cases including three deaths.

Staff: The Child Protection Center's staff is small. It has a half-time pediatrician, one half-time psychiatrist, two social workers, two social worker interns, one nurse practitioner, eight trained volunteers, a secretary, and medical residents/fellows who rotate through the Child Protection Center. Children are not admitted without medical necessity. Once the children are admitted, Child Welfare Administration investigates the case and plans for release. Because CWA investigations can take a long time, these children often become boarders. It is not cost effective to use hospital beds in this way; there is also a danger of infection and the loss of familial bonds.

If a staff member suspects that a child had been abused, someone from the child abuse office must examine the child. However, hospital staff are reluctant to report child abuse. The hospital staff believe that they should have the responsibility for deciding to report cases rather than working with the child abuse office. A 1985 study by Hampton and Newberger[2] showed that hospitals fail to report almost half of the child abuse cases they find. Hampton and Newberger also showed that race and socioeconomic status affect the decision to report. Because staff members do not want to become involved in these cases, they may fail to chart their suspicions of abuse. The one exception to this is with seriously injured children in the intensive care unit. In those cases, staff members tend to become overly involved in these cases and may become frustrated with and angry at the families involved. The staff work hard to make sure the family fully understands the child's pain from the injuries.

---

[2]Hampton, R.L. & Newberger, E.H., 1985, Child Abuse Incidence Reporting by Hospitals: Significance of Severity, Class and Race. American Journal of Public Health, 75, 56-69.

Discharge: Preparing for discharge can be very difficult. CWA decides where to discharge a child when the child is medically cleared. The Child Protection Center works closely with CWA staff and outside agencies to arrange for discharge. Children do not learn that they are going home until definite plans are in place.

All forms of discharge have problems associated with them. Children who return home are hard to monitor, even if the Child Protection Center continues to provide services. Kinship foster care is problematic because parents often learn abusive behavior from their dysfunctional extended family, so the children may end up being abused again in these homes. Foster care uproots children, and the administrative system often is so poor that a child never meets the foster parents until they come to pick up the child. Children fear the unknown, and sending them into an unknown situation from an environment where they had felt safe frightens them. When placed, the children must deal with being uprooted, new schools, and the development of new friendships in addition to a new living situation.

Followup: Once a child is referred to the Child Protection Center, staff members enter information about the child into the computer. This information includes pertinent details of the child's history, records, and scheduled activities for the child. The system allows the staff to follow the progress of more than 800 children and have active involvement in the cases. Each staff member or volunteer enters his or her own information, and some information is obtained from agencies. The Child Protection Center maintains the child's file until the staff decides that he or she is out of danger. To date, no one has attempted to subpoena the computer records.

Outcomes: Since 1984, when the program was developed, families who have been served have called when in crisis and asked for assistance. This shows the long term impact and credibility of the program.

Georgette Constantinou, Ph.D.: Accessing Community Resources

As was true throughout the nation, the 1980's showed an unprecedented increase in the child abuse and neglect cases in Akron, Ohio. This sorely taxed the resources and strengths of the existing systems. Community-hospital cooperation helped to maximize effectiveness of the system.

Type of Program: The Children's Hospital Medical Center of Akron has 253 inpatient beds, including a 14-bed adolescent psychiatric unit, and a 10-bed unit for school-age patients. Typically, patients on the psychiatric units are offered milieu treatment, including a variety of therpeutic modalities.

However, a maltreated youngster can enter the hospital on psychiatric or medical units.

The entry of a maltreated child starts a cumbersome process that is taxing to the staff and to the child. These children are often those whom the system has not helped effectively in the past; they are hard to place, embittered and angry, and their behaviors can be difficult for staff to handle.

Hospital's Role: The hospital president, William Considine, former president of NACHRI (National Association of Children's Hospitals and Related Institutions) is a strong child advocate who views the hospital in a leadership role with respect to abused and neglected children. Hospitals must decide what their role should be in child abuse cases. Like many children's hospitals who are strongly geared toward child advocacy, it is easy to view the hospital solely as the place where children are taken away from parents. However, this hospital has worked hard to be perceived as the mobilizer of the community, and a goodwill ambassador.

Hospitals need to develop a process that either keeps abused children out of the hospital altogether (except in the most extreme cases of physical abuse) or gets them out quickly, once an accurate diagnosis has been made and a workable outpatient plan has been set in motion.

Training: Hospitals should assume a lead role in training the people who make the decisions in child abuse cases. The hospital has now trained the majority of protective service workers in the county and surrounding counties about child abuse and neglect as well as normal developmental processes. These trained workers then serve as troubleshooters for other workers.

Pediatric residents also receive training in how to care for the behavioral and emotional needs of families. Training primary-care pediatricians pays off for the hospital because many graduates remain in the area or move to smaller communities where they are instrumental in creating similar programs. Training from the hospital creates a pool of doctors, nurses, social workers, psychologists, child life specialists, psychiatrists, and others who are capable of dealing with maltreated children wherever they choose to practice. In January 1992, the hospital received a grant from the Ohio Department of Human Services to establish a task force to train clinicians to deliver mental health treatment to child victims of sexual abuse.

Community involvement: In the early 1980's, a local Coalition for Children at Risk identified a number of problems which existed in the delivery of services to abused children. Following that the Coalition received a $60,000 grant from a local community foundation to spearhead an initiative

which is still operative 10 years later. Children's Hospital took a leadership role in bringing disparate groups together to plan the dissemination of the grant funds and assist with administrative support. The Coalition took a three-pronged approach to improving systems:

- Protocols were developed to coordinate the responsibilities of the emergency room, police, protective service workers, and other agencies involved in responding to child abuse and neglect cases, with a strong mandate to decrease the number of interviews of the child.

- State of the art education was provided to professionals who provided direct treatment.

- The community-based program, the Family Recovery Center, was designed to serve as a diagnostic and treatment center for families that experienced child sexual abuse. The Center, which is still in operation, coordinates interdisciplinary specialists to provide diagnosis and treatment. The Center is staffed both by hospital professionals as well as by specialists on contract from their respective agencies. Contract staff work at the Center one night weekly to plan and deliver treatment, then return to their ongoing responsibilities, having received training and supervision. One result of the Center is the development of a court-ready forensic evaluation which is always child-advocacy based. Although the program is supported by grants and Title XX funds, clearly this is an expensive venture for the Hospital.

In addition, the Akron Summit Group was created in response to a local CPS case that resulted in a near fatality. This group is comprised of top executives of all the local agencies who meet four times a year to fine tune activities and examine gaps in service delivery. Among other functions, this group was responsible for convincing the county to find permanent funding sources for the Family Recovery Center. The executive of each agency attends the meeting personally; no subdesignees are permitted to attend. The Summit Group is now addressing a change in the local judiciary and will try to involve the court in its activities in child advocacy. The group is supported by philanthropic contributions and provides direction for child abuse initiatives community-wide.

Discussion

Evaluations: Forensic v. Therapeutic: These evaluations have

different purposes and must be kept separate to maintain integrity. The Akron program has funding through the Victims of Crime Act (VOCA) for a victim services coordinator. The position was created because of the number of unsatisfactory evaluations done in the community. The difficulty lies in keeping the position filled because it has a high burnout rate. At Montefiore, forensic evaluations are conducted by appointment, based on a medical model; Center staff frequently testify in court since the Center has a high load of cases.

Some participants expressed difficulty in differentiating between forensic and therapeutic assessment and note that the medical and legal players have more clearly defined roles; however, the mental health professional's role in this process needs further examination. Forensic assessment interviews become part of change for people. These interviews illustrate the importance of understanding the dynamic of abuse from a qualitative perspective. Unfortunately, however, most researchers have emphasized quantitative aspects of child abuse and neglect at the expense of the important qualitative aspects; as a result, there needs to be further research attention paid to the underlying dynamics of child abuse and neglect.

An additional dilemma is that the courts have dealt only with physical measures of physical abuse, minimizing the mental health aspects. But, evidence of probing by a mental health professional can discredit a child's testimony in court. It may be important for professionals to use the strong body of literature to convince juries that children are not highly suggestible and that shaping children's testimony is difficult. In this way professionals should educate the criminal justice system.

<u>Future Research Directions:</u> While a great deal is known about the pathology connected with child abuse and neglect, very little is known about children's resiliency and coping. In order to develop additional strategies, these aspects should be examined. Research should concentrate on how children cope with stressful life events, not only on the damage done to them.

While treatment outcome studies are needed, there is no consensus about what a healthy family or child is. In addition, studies cannot replicate what a therapist does with a caseload. Treatment outcome studies must measure the person providing the treatment as well as the subjects of the treatment. Concrete solutions are needed but the prevention studies that are needed are costly. In addition, outcome studies which also address family variables and interventions are needed. One way of addressing this is for clinicians to examine the decisions they make and articulate the criteria they use.

Discharge Planning: In some programs, four month followups have been tried, including measures such as satisfaction with clinic services and the professionals involved. Yet at the same time, the hospital is involved in discharge planning. Some professionals are skeptical that CPS will do a reliable job of placement and review of the home's safety, including frequent monitoring of whether the perpetrator is still or visiting the house.

There is disagreement over the hospital program's role in investigations. Some believe that if a program discharges a child, it must be sure that the child will be safe. If it is not sure, it should fight the decision to release the child. In these settings, CPS tends to listen when the program disagrees with a placement decision. Putting the reasons for disagreement in writing is especially effective. In Pittsburgh, the program uses two approaches. If program staff are not worried that the child will be seriously harmed, they protest the decision through normal administrative channels. If they are still concerned for the child's safety, they contact child advocates. In programs with decreased emphasis on investigation, the program discharges the child to a person who clearly is not the perpetrator. If the child is going to family members, the program makes sure that family members do not deny that the abuse happened. Pennsylvania law says that anyone can petition on a child's behalf, so CHOP threatens to go to the City Solicitor if it encounters problems.

On the other hand, others believe that programs should be active, but programs must stop short of doing CPS's work for it. Programs have to define their roles, and not focus on investigation. In some cases, a program cannot hold a child after CPS decides to release the child to his or her parent. The program is under pressure from administrators to send home children who are using beds that they are not paying for.

MULTIDISCIPLINARY TEAM RESPONSES

David L. Chadwick, M.D.: Networks of Facilities

In recent years the idea that hospitals should compete in a free-enterprise system has made it more difficult to provide child abuse and neglect services. Child abuse services are costly, sometimes not covered by insurance reimbursement, and time-consuming; when faced with budget cuts, many hospitals look toward the child abuse and neglect services as providing supplemental rather than vital and cost effective care. One element that disappeared in our society was health planning that provided the appropriate level of health care to serve a given population. A rational referral pattern might allow for increased accessibility of service.

Background: In late 1980's, the California Medical Association published a book entitled Regionalization of Health Care Services for Abused Children in California. This volume examined how health care services for abused children might be delivered throughout the State. This book set out the services levels required:

- Entry Level: Every mandated reporter is required to have some idea of when to be suspicious; experience and knowledge of the issue must be basic.

- Level One: This level of service usually occurs in a rural county with a population around 100,000 that is served by a single hospital. Personnel resources include a referral system involving pediatricians and family practice physicians who are taking care of the needs of most children in the area, a hospital, nurse, social workers, and the Department of Social Services. There would need to be at least one pediatrician interested in child protection who has postgraduate work in the field. This group would be the nucleus of a multidisciplinary team.

- Level Two: This level of service should support 1-10 level-one facilities through continuous availability, consultation, and other means. A referral pattern should develop. This network should have complete trauma diagnostic capabilities for all forms of child abuse and neglect. These capabilities include the following:

  - Pediatric imaging service;
  - Interviewing for sexual abuse, including video- and audiotaping capability;
  - Colposcopy and people trained to do it;
  - Therapeutic mental health services; and
  - Foster care specialists.

The healthcare system should maintain its own social work capability for the children who come in through the healthcare system because the evaluation at the bedside, outpatient facility, or emergency room often is the first contact the family has with the system.

Team Meetings: Since 1975, the Multidisciplinary Team at San Diego Children's Hospital has been meeting once a week for two hours providing interchanges about cases. The discussion usually focuses on the most serious cases or those in which there have been disagreements. The regularity of the

meetings shapes interactions and provides for familiarization with each provider's professional culture. More than anything, this has become a good habit. Law enforcement personnel come because they want the information that is available at the meeting. In other programs, law enforcement personnel attend only after being ordered by their Commissioner; this process is assisted by meetings between the team and the district attorney.

Mireille B. Kanda, M.D.: Role of the Multidisciplinary Teams

Multidisciplinary teams come in various forms, and these forms depend on location, needs, and founder's vision. No single model or magic formula exists. The mission of Children's National Medical Center (Washington, D.C.) is to treat medical and mental health issues and to advocate prevention. To raise the visibility and credibility of the Division of Child Protection (the team), it functions at the level of a hospital department.

Service Provision: One function of the Division is to provide services. It provides inpatient, outpatient, and outreach (called the Satellite REACH program); the mental health services include both therapeutic and prevention components with a heavy emphasis on parenting skills. The Division provides diagnostic and therapeutic services, group therapy, and a special program for juvenile sex offenders. Another aspect of the Division's services is a project that teaches parenting skills to women at Lorton Reformatory, and another provides services at a shelter for battered women. Many of these services were initially created through grant support and have now become fee for service programs with some support supplement.

Role within the Hospital: Because the Division is prominent within the hospital, it also functions as an advocate within the hospital. It advocates for children, and it may go against the needs of the hospital in issues such as bed utilization and boarder children. The Division also functions as the institutional watchdog because it is the designated reporting office for child abuse and neglect. The project counsels families, prepares children for court, and helps families and hospital staff navigate the court system without relying on the hospital's general counsel.

The project provides institutional quality assurance and risk management services to all 33 hospital departments in the area of child maltreatment. It does both internal and national training. It conducts research that is sensitive to cultural diversity and competency.

Administrative Concerns: Multidisciplinary teams have diverse needs in supervision. Professionals should be supervised by other professionals from their respective fields. Team participants should be careful not to overstep

boundaries into other people's fields. People working on the team must have a common philosophy and have primary allegiance to the team.

The Administrator must be bold, creative and willing to take risks. While nurturing staff, the administrators should encourage professional academic staff development, demanding productivity and competency.

While not in the team's mission statement, fundraising often becomes an issue. Programs may need to seek out endowments and other local contributions. Program developers need to bear in mind that not all services will be billable.

Toni Seidl, R.N., M.S.W.: Working of the Teams

The Multidisciplinary team at Children's Hospital of Philadelphia began in 1973 to address the complex social, psychosocial, economic and political forces impacting on families. Since that time, the professionals have devoted their time without consideration of compensation.

Initial Organization: The Team meets for 1 ½ hours each week to educate its members and review cases. Usually two cases involving seriously ill inpatients are the focus for the discussion. Followup sessions were scheduled. The team is chaired by the Social Work Director; the other members of the team include two SCAN physicians who rotate monthly, a SCAN nurse, an in-home services provider, the emergency room head nurse, a mental health liaison from a child guidance clinic, occupational and physical therapists, a pediatric resident, a floor nurse, a parent services coordinator, a neurosurgeon, a pathologist, an outreach social worker, a family worker provider, and a CPS liaison. The CPS liaison, however, has usually been an intern rather than a permanent staff member; unfortunately this may be a reflection of an ambivalent commitment by CPS. The team has not included psychiatric, legal, or law enforcement professionals; however, the team has access to the in-house hospital counsel. Team members teach an interdisciplinary course at the University of Pennsylvania.

Development Issues: When the program began, its members spent little time in court; contacts with the judicial system were informal in the family court system, not in the criminal courts, and were often by telephone. Fewer children were in foster care because more extended families were available to care for them. In 1982, attendance at team meetings fell off because of an increase in competing demands. The outreach program lost its broad-based funding and came to depend solely on funding from the Department of Social Services. The program thus became unable to make direct referrals. The SCAN team became a continuous clinic for some

families. Some second generation referrals are seen not necessarily for abuse but for at-risk factors.

In 1982, CPS was involved in a lawsuit and terminated its participation. The SCAN nurse was also lost. Today, the team remains an identifiable resource. Its members include the social work coordinator, social workers, a resident physician, and a social work intern funded by a private patron.

Services: Team members make daily rounds of their patients. They view the emergency room personnel as the gatekeepers for the system. The team does not do ongoing treatment, but it does offer excellent crisis intervention services. The team also runs a community clinic that is a sexual abuse center for children younger than 12. Using the clinic keeps the children out of the emergency room and offers more experience and comfort than would be available in the emergency room.

The team has a multidisciplinary function working towards collaboration. Each member must respect the boundaries of the different disciplines. S/he must learn to incorporate the assessment skills and priorities of other disciplines. The social work coordinator supervises two emergency room social workers and a trauma social worker. Approximately 800 children are reported for abuse each year; of these, 225 are referred as sexual abuse cases although the actual figure might be twice as high.

The departure of one member of the Team can be critical in terms of replacing that individual with someone equally committed and experienced in interdisciplinary approaches and child abuse work. In Ms. Seidl's experience, encouragement is needed to attract social workers, nurses and mental health professionals to the field.

Discussion

Outcome Evaluation: Some programs are evaluated on outcomes that include the reduction of number of days the child remains in the hospital, the reduction of inappropriate emergency room use, and case planning. Other programs try to match the hospital's mission in order to gain the highest level of support.

Discharge Planning: Some programs retain children when they cannot discharge the child to a safe environment where the child's needs can be met. In such cases, the hospital's overstay committee may complain about aborted discharge planning, but its complaints are dealt with by the team. This situation tends to occur when departments refer cases to the team only on the day that the child is scheduled to leave the hospital.

Regionalization and National Plans: A few years ago, a legislative sponsor was found for a regional approach in California to implement using Title V of the Social Security Act; shortly thereafter the State experienced fiscal difficulties and no new program emerged. However, de facto regionalization is occurring because good hospitals can provide tertiary prevention even while suffering a financial loss on a program. However, no planning, pattern, or legislation is in progress. To make any program work, continued advocacy is needed including in university training.

Fees: The child abuse field might be best served by learning from the neonatologists who found ways of being reimbursed for services. Although debate continues, some observers note that the field needs administrative structures such as sliding fee scales. Some view sliding scales as unacceptable if third-party payers are being billed and one fee is set and another is billed. However, a sliding subsidy scale that would provide a subsidy only after all other resources were exhausted would be acceptable. To work successfully with a sliding scale, some programs assess the financial need of the family and use a sliding fee scale as one of many options to provide services to people who have no insurance and little money. Having an eligibility worker on staff is important in charting coverage. Most programs are absorbing the costs and some rely on pastoral care services as a backup.

One program has found that 40% of its clients are Medicaid, 20% are self-paying, 30% have insurance coverage. Today, insurance companies are covering fewer and fewer services. This payor-mix needs further examination. To assist in payment for services, the child abuse and neglect field needs to codify the services provided involving the American Medical Association, State medical associations, the American Humane Association, and other sources and to develop acceptable reimbursement categories. Then the field would be able to create similar categories to those traditionally used in other fields of medicine, such as in the Surgeon's "Relative Value Scales," which became the "current procedural terminology."

Other techniques to sustain fees involve bringing paying children in from the suburbs to offer them treatment. Additionally, using baccalaureate-level social workers to connect clients to entitlement programs is helpful in containing costs. Lastly, one program negotiated a fee for evaluations with the Department of Social Services. Although this fee does not cover all the costs involved, it is better than receiving nothing at all. It is clear that creative efforts for obtaining payment are needed; there is sentiment that in a crunch for money, the assessment and care of abused children may not be a core part of managed health care programs. Having eligibility workers available in the hospital helps with the billing services.

Emotional Costs: It is important to define the emotional costs for staff, especially those who work with children every day. To address this problem, some programs direct experienced social workers to talk to staff about difficult cases. Some hospitals conduct in-house programs as well as employee assistance programs; the latter may be most beneficial since they are totally confidential and outside the management system. In these services, the question of what happens to children after the workers see them is discussed. The program gives aggregate information as feedback to intensive care and emergency room staff. Another way to address burnout is to have frequent support interaction with the frontline staff.

One downside to the specialized knowledge base and coherency of an established team is that the team may appear elitist to someone who comes in from the outside. Teams can lose touch with the hospital as well as the community when they get too technical and become a closed system; this can impair relations with other staff.

THE HOSPITAL IN THE COMMUNITY

Keith L. Kaufman, Ph.D.: Community-Hospital Research Collaboration

The focus of research is not just to answer a question but to foster advocacy, community education, intervention and initiatives in a hospital setting. Research includes experimental, epidemiological, and program evaluation projects with dissemination geared towards advocacy and education.

Sample Setting: Children's Hospital of Columbus is a 313-bed tertiary care facility. The hospital's Family Support Program provides comprehensive child abuse assessment services, treats victims of sexual abuse and their families, and treats adolescent sexual offenders. In 1990, the hospital's child abuse assessments totaled 1,240. Of these, 69 percent were assessed for sexual abuse, 24 percent for physical abuse, and 7 percent for neglect. The hospital also houses the Department of Pediatrics of Ohio State University and has its own research facility. Part of the hospital's mission is to be a community network with resources for interdisciplinary input and clinical data collection with research in mind.

Collaborative efforts: Collaboration between researchers, hospital staff and community agencies offers several advantages:

- Community agency staff can enhance study design or instrument development by offering insight into the characteristics of the population they serve.

- In some cases, community agencies represent the only access to the target sample.

- Collaboration may facilitate later adoption of clinical practices suggested by study findings, as agency staff may have a sense that they participated in its development.

- The agency may benefit through increased monetary compensation, enhanced client assessment protocols, or in increased ability to address program evaluation needs without expending agency funds.

However, several barriers may make these collaborations more difficult:

- Community agencies may have concerns about the effect of a research program on the staff's clinical productivity.

- Agency staff may perceive research as lacking clinical application or as targeting the wrong issues.

- Agency staff may see the research relationship as one-sided, with the researcher exploiting the agency without giving anything back.

- Hospital staff may resist giving up control over decisionmaking.

- There may be concerns about payment for additional time and duties.

It is possible to develop a continuum of collaboration based on who initiated the research, where data is collected, the composition of the research sample, and how the research findings are applied:

- Research initiated in the hospital, with data collection in the hospital, using a community sample and leading to community-focused prevention education.

- Research initiated in the hospital with data collection in the hospital and the community from a sample of community professionals and leading to a professional education effort.

- Research initiated in the hospital using a community-based or clinical sample and leading to general community education.

- Research initiated in the community-agency using data collected in the community incorporating hospital consultations and leading to program advocacy.

Hospitals can take the following steps to enhance collaboration:

- Learn about community agencies and settings;
- Involve agencies in study planning;
- Meet with agency staff early in the project;
- Contract with agencies to outline expectations and commitments;
- Offer reasonable remuneration to agencies;
- Plan for adequate resources to minimize disruption to agencies;
- Plan the schedule for the convenience of agency staff; and
- Provide agencies with study feedback and acknowledge them in publications and presentations.

Alice Kitchen, L.M.S.W.: Hospital-Community Task Forces

The real dilemma is the balancing act between the hospital's mission and the financial realities of reimbursement. While a hospital may have the expertise to provide the needed services, these services are time consuming, emotionally draining and costly.

Setting: Children's Mercy Hospital sees 156,000 outpatients and 6,700 inpatients per year. The Hospital is a pediatric acute care facility located in the metropolitan Kansas City area, which has a population of 1.5 million people.

Role of the Social worker: Social workers have a variety of responsibilities in addition to working with patients, families, and community agencies, including the following:

- Educating hospital staff about the role of CPS;
- Serving as a focal point for data collection;
- Reviewing protocols;
- Dealing with security and custody issues;

- Communicating with families about what the various professionals are doing;
- Working closely with risk management professionals; and
- Dealing with the media.

In recent years, with the media has resulted in a strain between the protection of families from intrusion and promotion of good public relations.

Background and foundation: Internal: Within the hospital key staff working on Child Protection Teams studied hospital services and patient/family needs over a period of nine months starting in 1988. As a result of the findings, recommendations were made. Yearly improvements or lack of improvement are documented and reviewed by Team members.

External: One outgrowth of the hospital's community-based approach was initiated as a result of a Task Force finding in 1989 documenting delays in discharge due to complications brought on by drug using mothers. Hospital staff then developed the Metro Drug Exposed Infants Tasks Force to study increasing problems of drug exposed infants. This task force was not composed solely of hospital administrative staff but represented a broad group of hospital and community elements. A juvenile court judge on the Task Force initiated legislation which incorporated the following recommendations:

- Key state agencies (social welfare, health, education, drug/alcohol) should work together to coordinate state resources, services and develop protocols;
- Substance abuse education for Obstetricians/ Gynecologists, Pediatricians, and Family Practice Physicians should be required;
- Physicians should refer drug-using pregnant women to health, social, and child welfare services; CPS cases should be held open at the physician's request until risks to child welfare can be resolved;
- Multidisciplinary teams should be formed to address local issues and coordination of services;
- Drug treatment should be available to pregnant and post-partum women;
- Prevention education for elementary and secondary school students should be available;

- The statewide prevalence of drug abuse should be studied;

- Drug treatment should be available to pregnant women; and

- A toll free hotline should be established to give information about available treatment and health care resources.

The Task Force participants must be willing to question deeply held beliefs. Mechanisms must be available to resolve conflicts between professionals from different disciplines; organizers must realize that conflict goes with the territory and be committed to sharing responsibility for work, taking risks, developing recommendations, and engaging local and state elected officials. All staff should be thoughtful educators. The results of the community approach included three separate substance abuse demonstration intervention programs for drug using women and their families, families at risk of becoming involved in the child welfare system due to drug use by a family member (Safe-TYES), and a comprehensive drug treatment program for drug treatment and Medicaid funding (C-STAR).

Hospital-Community Partnerships: The following actions would encourage the formation of hospital-community partnerships and improve service delivery:

- NCCAN and NACHRI should work together to examine how the medical coding of child abuse symptoms by

  diagnostic category can be quantified to better document the extent of the problem.

- Incentives should be provided for community hospitals to form partnerships in the community.

- A common vocabulary should be developed across all disciplines.

- More research should be conducted on the influence of poverty and despair as it relates to child abuse and neglect.

Frederick Green, M.D.: The Hospital's Service to the Community

"Hospitals are not only <u>in</u> but <u>of</u> the community...Child protection is a shared community response."

<u>Hospital Involvement:</u> Involving the hospital in community efforts doesn't just happen; the hospital needs to recruit people interested in primary as well as tertiary care. This requires a multidisciplinary, multicultural, multi-involved constituency or Board that is involved in different community areas, including volunteers, and corporate interests in its activities. The message must go out to people on the street, not just to those already committed to the issues.

<u>Issues for Urban Hospitals:</u> Most hospitals are located in cities. Many of these cities have special problems such as poverty and polarization. These factors create a cohort of at-risk, medically fragile children who have no chance to have a normal childhood. In the long run these children will have problems as adults. To serve the community, the hospital must provide sensitive and culturally relevant services with a view towards programs for the year 2000 and beyond.

The children's hospital is perceived as an expert in all forms of child welfare. It should be involved in all forms of community prevention, and its doctors must be involved in the political and social issues of the community. In Washington, D.C., the violence has become overwhelming. Sixty-eight percent of the victims admitted to hospitals have no insurance. Each can cost the hospital $1,000 to $268,000 per year, accounting for a total of $20.4 million last year in Washington, D.C., alone. Hospitals desperately need financial relief, but no source of relief is in sight. There are 106 Maternal Child Health programs across the country distributed across five Federal Departments. While this indicates that there is a lot of legislation and programming, it also indicates a lack of coordination.

Additional Issues

<u>Emotional Connection with the Community:</u> While the hospital is physically located in a community, its staff often live in suburban and rural areas. As a result, they are not connected with the civic problems downtown, and may not understand the problems facing the hospital's community. This situation is compounded by the fact that every hospital has what it perceives to be "desirable" patients. These patients look and talk like the service providers, and they have third-party payors. City hospitals, however, must serve the children in the city, many of whom do not fall into this category.

Service providers must follow children beyond the hospital walls and not let go of them.

In order to prevent itself from being insulated from community problems, hospitals must take action. Efforts should be made to hire staff from the community and enhance the emotional alliance between worker and institution. Hospitals must demonstrate their commitment to the community, their accountability to the State, and step out of their environments to address appropriate issues. One example is to use vacant facilities to serve as safe havens so that children do not occupy valuable hospital beds. In addition, changing incentives for professional advancement would be a big step. If salary and promotion depended on a professional's actions in the community, more professionals would be responsive.

A new mythology: Service providers need a "new mythology" where creativity is stressed, victimization of professionals is minimized and children are followed beyond the hospital walls. Instead of admitting those who are interested in established procedures, schools should look for students who would be willing to accept a "new mythology." Alternatively, students initially interested in primary care need to be exposed to role models in medical school who are concerned primarily with primary care; these role models would also be interested in the complex social factors of the community and patients and not just their physical survival. To encourage incoming students to pursue a "new mythology," attention must be directed as well to reducing the huge debt medical students incur; this debt often deters them from practicing and serving in fields which are not highly lucrative - child abuse and children's services rank high in this category.

To further the work of these role models, promotion systems should be encouraged to reward teaching. A doctor who serves in a hospital for 12 months has little undisturbed intellectual time for teaching. If the doctor also has to raise funds and battle the hospital administration for support, no time remains for research. Criteria for advancement and for salary increases need to be changed. The policies on promotion and tenure are sexist to the core. The clock for tenure consideration does not stop during pregnancy or for other family responsibilities. This is especially relevant because many people in child abuse programs are female. In some medical centers which reward teachers and clinicians with a different track, these professionals are seen as second-class citizens.

Not letting the child go is the important part of the "new mythology." In such a model, doctors would be less authoritarian and would share authority. Although the reporting institution should not let go of abused children, others share responsibility for protecting that child. However, in

some cases, in trying to get the hospital to respond to children's needs, some departments resort to economic blackmail-saying that they will hold the child (and thereby occupy a bed that a paying patient could use) until they are satisfied that the child will be safe.

The same resources and support that are given to biomedical and surgical facilities, need to be provided for child abuse programs. Research in social sciences would need to be a part of such efforts especially if a child abuse research network can be developed. In this way, the glory, optimism and productivity that is often found in other subareas of medicine might be created in children's medical services thereby attracting more practitioners in training as part of marketing the field to both the community and the hospital.

Advocacy and Image: While no hospital professional can control the entire process, the hospital may be able to track the parent and child through the system and serve as a family advocate. The legislative process must also be used to address complex social problems that lead to child abuse and neglect.

In addition, child welfare professionals do not know how to market the field of child protection. They need to show the public successful stories such as those which have been marketed by the fields of endocrinology and maternity by presenting a positive message. Child welfare services should show the public successful families that have been helped by child welfare services. To do this, successful programs treat their clients seriously and involve them in planning.

Effective hospital-based programs have the full support of top administrators, so professionals have to act as advocates to get that support. Also, hospital-based programs must join with the parents they serve to tell administrators what is important. Rather than only telling families what to do, child abuse programs need to work with families to define their needs. Effective lobbying and fundraising are needed along with an effective pediatric child abuse and neglect network.

SUMMARY AND CONCLUSIONS

Several themes dominate hospital based responses to child abuse and neglect;

- Child abuse is not simply a pediatric problem; it affects all of society.

- Many hospital-based programs are feeling an economic strain. The development of Diagnostic Reimbursement Groups (DRG) has resulted in an emphasis on discharge and short term hospital stays. This is problematic in child abuse and neglect service delivery when children's safety competes with DRG discharge policies and hospital concerns over reimbursement.

- The role of the hospital has changed, and this change has affected the hospital's public prevention efforts. Child abuse and neglect programs cannot be maintained if they have marginal status in the hospital. Likewise the burnout by workers needs to be addressed in order for programs to offer continuity of services. The role of the different professionals should be reviewed and collaborative complementary efforts expanded.

- A new conceptualization is needed to address the ethical issues, media and public relations, professional esteem and professional role advancement.

- Collaboration between the hospital and the community is the key to future strategies for child protection.

There are several strategies and recommendations to address the foregoing concerns.

Regionalization: States should regionalize and coalesce their limited resources.

Education, Training and Dissemination: Physicians should receive more education about child abuse and neglect issues during their training; continuing education should be required for re-licensure across professions. One way to promote these requirements would be through the JCCO.

Articles about the subject should appear in a broader spectrum of journals, instead of journals geared towards the child abuse and neglect

specialty groups; emergency medicine publications would be one example. Newsletters should also disseminate information and reprint key articles.

Programs need to provide support services for staff who specialize in child abuse and neglect cases in order to decrease the emotional toll and effects of burnout.

Conference proceedings should be presented to hospital Chief Executive Officers and to NACHRI. Continued in-depth discussions of issues facing hospitals in delivering child abuse and neglect services should be encouraged. Conferences and dissemination of findings should be made available to regional groups as well as invited symposia attendees.

Future Research: Future research for hospital based responses should focus on the development of abuse-specific protocols, and comparisons of treatment models. The national data archive should be used to a greater extent by investigators. The connection between research and good clinical practice needs to be made clear to practitioners. Multicenter comparisons would be another important area. Major literature reviews, such as the forthcoming Research Agenda from the National Academy of Sciences need to be widely disseminated to both the research and practice communities. Bibliographies must be readily available through Clearinghouses.

Fiscal Concerns: Practitioners need training in means of obtaining reimbursement. Victim restitution funds should be investigated as one source of reimbursement. Practitioners also could use information on fundraising, especially from private institutions and foundations.

Hospitals need information on how to use coding systems and how the incidence and prevalence numbers across the county/state/region can provide uniform clear information on child abuse. The hospitals need to find ways to make a non-revenue producing activity part of their planning. Some way of billing for non-clinical time under waivers of the Social Security Act Title XX would be another strategy.

Assistance and Evaluation: Community-based programs need a technical assistance system that they can access. Such a program could resemble the National Institute of Mental Health technical assistance programs; this strategy would directly enhance quality. Staff with experience in the field are needed. One example of a technical assistance program would be the development of a computer network for resource support.

Existing programs should be evaluated, as should programs that have failed; both the short term and long term positive and negative features of

these programs should be detailed to assist other communities in their efforts to provide comprehensive care. Partnerships between universities and hospitals might strengthen these evaluative components. A means of providing Federal technical assistance to programs should be developed; computer networks might be included in these assistance strategies.

System Change: The current system is a reflection of the emphasis on legal solutions to child abuse and neglect. This emphasis may not be serving children and needs to be addressed. There are widespread frustrations with the child welfare system which need to be addressed in the coming years. Child welfare agencies need to understand the mission and expertise of the hospital based programs. The emphasis on legal solutions to child abuse and neglect may not be the appropriate approach for today's society. In order to change the larger systems, hospital administrators need to be involved in creating the "new mythology."

Appendix A
Meeting Agenda

AGENDA

HOSPITAL-BASED RESPONSES TO CHILD ABUSE AND NEGLECT
A Symposium Sponsored by the
National Center on Child Abuse and Neglect

Washington Hilton
1919 Connecticut Avenue, NW
Washington, DC 20009
(202) 483-3000

May 18-19, 1992

Monday, May 18, 1992

8:00 a.m. **Registration and Continental Breakfast** *Monroe Ballroom East*

8:30 a.m. **Welcome and Introductions**

Wade F. Horn, Ph.D., Commissioner
Administration on Children, Youth, and Families

David W. Lloyd, J.D., Director
National Center on Child Abuse and Neglect (NCCAN)

Mireille B. Kanda, M.D., Director
Division of Child Protection, Children's National Medical Center

David Mrazek, M.D., Chairman of Psychiatry Department
Children's National Medical Center

9:30 a.m. **Break**

9:45 a.m. **Panel I: Identification and Initial Response**

Presenters: Tobey Lawson, J.D.
Carolyn Levitt, M.D.
Stephen Ludwig, M.D.

Moderator: Sheryl Brissett-Chapman, Ed.D.

11:15 a.m. **Break**

11:30 a.m. **Discussion by Presenters and Attendees**

12:30 p.m. **Lunch** *Monroe Ballroom West*
Speaker: David W. Lloyd, J.D.,
Director, NCCAN

2:00 p.m. **Panel II: The Maltreated Child as Inpatient**

Presenters: Leah Harrison, M.S.N.
Georgette M. Constantinou, Ph.D.
Howard Levy, M.D.

Moderator: Constance Battle, M.D.

3:30 p.m. **Break**

3:45 p.m. **Discussion by Presenters and Attendees**

4:45 p.m. **Adjourn**

Tuesday, May 19, 1992

8:30 a.m. **Continental Breakfast** ***Monroe Ballroom East***

9:00 a.m. **Panel III: Multidisciplinary Team Responses**

Presenters: David Chadwick, M.D.
Mireille B. Kanda, M.D.
Toni Seidl, M.S.W.

Moderator: Ann Langley, M.Ed.

10:30 a.m. **Break**

10:45 a.m. **Discussion by Presenters and Attendees**

12:00 noon **Lunch (on your own)**

1:30 p.m. **Panel IV: The Hospital in the Community**

Presenters: Alice Kitchen, L.M.S.W.
Frederick Green, M.D.
Keith L. Kaufman, Ph.D.

Moderator: Mary Carrasco, M.D.

3:00 p.m. **Break**

3:15 p.m. **Discussion by Presenters and Attendees**

4:15 p.m. **Summary and Conclusion**

Appendix B
Participant List

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT
Hospital-Based Responses to Child Abuse and Neglect Symposium

Washington Hilton
1919 Connecticut Avenue, NW
Washington, DC 20009
(202) 483-3000

May 18-19, 1992

Participant List

Sandra T. Azar, Ph.D.
Assistant Professor
School of Psychology
Clark University
950 Main Street
Worcester, MA 01610
(508) 793-7738
(508) 793-7780 FAX

Constance Battle, M.D.
Medical Director/CEO
Hospital for Sick Children
1731 Bunker Hill Road, NE
Washington, DC 20017
(202) 832-4400
(202) 529-1646 FAX

Sheryl Brissett-Chapman, Ed.D.
Executive Director
The Baptist Home for Children
6301 Greentree Road
Bethesda, MD 20817
(301) 365-4480
(301) 365-2536 FAX

Ronald T. Brown, Ph.D.
Associate Professor of
Psychiatry and Pediatrics
School of Medicine
Emory University
1365 Clifton Road, NE
Atlanta, GA 30322
(404) 616-4859
(404) 616-4755 FAX

Patricia Campiglia
Child Welfare Program Specialist
Children's Bureau
Administration on Children, Youth,
and Families
330 C Street, SW
Washington, DC 20013
(202) 245-0657
(202) 245-6721 FAX

Mary Carrasco, M.D.
Director
Family Intervention Center
Children's Hospital of Pittsburgh
3705 Fifth Avenue at DeSoto Street
Pittsburgh, PA 15213-3417
(412) 692-8675 or 8664
(412) 621-8605 FAX

David L. Chadwick, M.D.
Director
Center for Child Protection
Children's Hospital
8001 Frost Street
San Diego, CA 92123
(619) 576-5814
(619) 278-2365 FAX

Emily Cooke
Children's Justice Act Specialist
Program, Policy, and
Planning Division
National Center on Child Abuse
and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 205-8696
(202) 205-8221 FAX

Georgette M. Constantinou, Ph.D.
Manager
Division of Pediatric Psychiatry
Children's Hospital Medical
Center of Akron
281 Locust Street
Akron, OH 44308
(216) 379-8598
(216) 379-8140 Fax

Howard Dubowitz, M.D.
Assistant Professor of Pediatrics
School of Medicine
University of Maryland
700 West Lombard Street
Baltimore, MD 21201
(410) 328-5289
(410) 328-8163 FAX

Jennifer Duncan, M.S.W., L.C.S.W.
Project Coordinator
National Information Clearinghouse
for Infants with Disabilities and
Life-Threatening Conditions
7910 Woodmont Avenue, S-300
Bethesda, MD 20814
(301) 654-6549
(301) 986-4553 FAX

James Egan, M.D.
35 Wisconsin Circle
Chevy Chase, MD 20815
(301) 913-5953

Laura Feldman, M.S.P.H.
Assistant Director
for Government Realtions
National Association for Children's
Hospital and Related Institutions
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355
(703) 648-1589 FAX

Martin Finkel, D.O.
Medical Director
Center for Children's Support
School of Osteopathic Medicine
University of Medicine and
Dentistry of New Jersey
Suite 3400
301 South Central Plaza
Stratford, NJ 08084
(609) 346-7036
(609) 435-8246 Fax

Joan Gaffney
Director
Clearinghouse Division
National Center on Child Abuse
and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 245-0709
(202) 245-6721 FAX

Frederick Green, M.D.
Emeritus Professor of Pediatrics
1409 4th Street, SW
Washington, DC 20024
(202) 484-6328

Leah Harrison, M.S.N., C.P.N.P.
Assistant Director
Child Protection Center
Montefiore Medical Center
111 East 210th Street
DTC-560
Bronx, NY 10467
(212) 920-5833
(212) 920-4467 FAX

Wade F. Horn, Ph.D.
Commissioner
Administration on Children, Youth, and Families
Room 2026
Switzer Building
330 C Street, SW
Washington, DC 20201
(202) 245-0347
(202) 245-6721 FAX

Mireille B. Kanda, M.D.
Director
Division of Child Protection
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-5682
(202) 939-4997 FAX

Keith L. Kaufman, Ph.D.
Assistant Professor of Pediatrics and Psychology
Ohio State University and Children's Hospital
700 Children's Drive
Columbus, OH 43205
(614) 461-2100
(614) 461-2633 FAX

Alice Kitchen, L.M.S.W.
Director of Social Work and Community Services
Children's Mercy Hospital
2401 Gillam Road
Kansas City, MO 64108
(816) 234-3719
(816) 842-7445 FAX

Ann Langley, M.Ed.
Senior Vice President
Pagonis and Donnelly
Suite 202
1620 Eye Street, NW
Washington, DC 20006
(202) 452-8811
(202) 659-5427 FAX

John Lantos, M.D.
Associate Director
Center for Medical Ethics
University of Chicago
Chief
Medical Staff
La Rabida Hospital
East 65th Street and Lake Michigan
Chicago, IL 60649
(312) 363-6700 est. 372
(312) 363-7160

Guadalupe G. Lara, M.S.W., C.S.W.
Director of Social Work
Children's Hospital of Michigan
3901 Beaubien Street
Detroit, MI 48201
(313) 745-5281
(313) 993-8835 FAX

Elizabeth Kepley Law
Director of Government Relations
Family Research Council
Suite 500
700 13th Street, NW
Washington, DC 20005
(202) 393-2100
(202) 393-2134 FAX

Tobey Lawson, J.D.
Associate
Miller and Martin
Suite 1000
Volunteer Building
832 Georgia Avenue
Chattanooga, TN 37402-2289
(615) 756-6600
(615) 267-0291 FAX

Carolyn Levitt, M.D.
Program Director
Midwest Children's Resource Center
Suite 200
360 Sherman Street
St. Paul, MN 55102
(612) 220-6090
(612) 220-6770 FAX

Howard B. Levy, M.D.
Director
Pediatric Ecology Program
Grant Hospital
550 West Webster
Chicago, IL 60614
(312) 883-2000 Ext. 2710
(312) 883-3967 FAX

Marsha Liss, Ph.D., J.D.
Special Assistant to the Director
National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 245-0438
(202) 245-6721 FAX

David W. Lloyd, J.D.
Director
National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 245-0586
(202) 245-6721 FAX

Stephen Ludwig, M.D.
Chief
General Pediatrics
The Children's Hospital
34th Street and Civic Center Boulevard
Philadelphia, PA 19104
(215) 590-2162
(215) 590-2180 FAX

Anthony Mannarino, Ph.D.
Associate Professor of Child Psychiatry and Psychology
School of Medicine
University of Pittsburgh
3811 O'Hara Street
Pittsburgh, PA 15213
(412) 624-3588
(412) 624-9194 FAX

Carol Mason
Manager of Child Protection Program
Children's Hospital and Medical Center
P.O. Box C 5371
Seattle, WA 98105
(206) 526-2194
(206) 527-3858 FAX

David Mrazek, M.D.
Chairman of Psychiatry
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 939-3922
(202) 939-4492 FAX

Dena Orr, M.D.
Assistant Medical Director
Division of Child Protection
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 939-4950
(202) 939-4492 FAX

Thomas Packard, Ph.D.
Pediatric Psychologist
Psychology Department
Children's Medical Center
1 Children's Plaza
Dayton, OH 45404
(513) 226-8401
(513) 463-5400 Fax

Robert H. Parrott, M.D.
Director Emeritus
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-4004
(202) 939-5989 Fax

John Pascoe, M.D., M.P.H.
Associate Professor of Pediatrics
University of Wisconsin Hospital
and Clinics
600 Highland Avenue
Madison, WI 53792-4116
(608) 263-9405
(608) 263-0440 FAX

Josephine Reifsnyder
Director
Program, Policy, and
Planning Division
National Center on Child Abuse
and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 245-0646
(202) 245-6721 FAX

Toni Seidl, R.N., M.S.W.
Social Work Coordinator
The Children's Hospital
of Philadelphia
Room 2170
34th and Civic Center Boulevard
Philadelphia, PA 19104
(215) 590-2067
(215) 590-2066 FAX

John Shields, M.A.
Executive Director
Barbara Sinatra Children's Center
39000 Bob Hope Drive
Rancho Mirage, CA 92270
(619) 340-2336
(619) 340-1851 FAX

Roland Sneed
Program Analyst
Office of Planning and Evaluation
Administration for Children
and Families
300 Independence Avenue, SW
HHH Building
Washington, DC 20201
(202) 472-4415
(202) 245-6916 FAX

Stuart Swayze, M.S.W., A.C.S.W.
Chief
Public Health Social Work
Maternal and Child Health Bureau
Child and Adolescent Branch
Room 18-A-39
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4026
(301) 443-4842 FAX

Robert L. Sweeney, D.O., F.A.A.P.
Chairman
Department of Emergency Medicine
American College of Emergency
Physicians
1945 Route 33
Neptune, NJ 07754
(908) 776-4510
(908) 776-4550 FAX

Wanda Thompson, Ph.D.
Coordinator,
Emergency Response Inpatient Services
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 939-4950
(202) 939-4492 FAX

Douglas Tynan, Ph.D.
Director
Psychology Training
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-5554
(202) 939-4492 FAX

Robert Wilson
External Affairs
Administration for Children
and Families
Suite 600
370 L'Enfant Promenade
Washington, DC 20447
(202) 401-9200
(202) 401-5770 FAX

Kathy A. Woodward, M.D.
Director of Community Health Services
Department of Adolescent and Young
Adult Medicine
Children's National Medical Center
111 Michigan Avenue, NW
Washington, DC 20010
(202) 745-3069
(202) 939-4492 FAX

Appendix C
Additional Readings

Hospital-Based Responses

"The Prevalence and Characteristics of Multidisciplinary Teams for Child Abuse and Neglect: A National Survey" by Barbara B. Kaminer, Ann H. Crowe, and Lisanne Budde-Giltner from *The New Child Protection Team Handbook* (1988) by D.C. Bross, R.D. Krugman, M.R. Lenherr, D.A. Rosenberg, and B.D. Schmitt. Permission to reprint granted by the publisher: Garland Publishing Company, 717 Fifth Avenue, 25th floor, New York, New York 10022.

"Hospital-Based Intervention in Child Abuse" by Arthur H. Green, M.D., from *Resident and Staff Physician*, volume 29, number 2, (February 1983). Permission to reprint granted by the publisher, Romaine Pierson Publishers, 80 Shore Road, Port Washington, New York 11050.

Several pages from the packet of materials "Suspected Child Abuse and Neglect (SCAN) Guidelines, Children's Hospital of St. Paul." This information was prepared by the Joint Task Force on Child Abuse and Neglect Committee under the leadership of Janice Ophoven, M.D. Permission to reprint granted by the publishing institution: Carolyn Levitt, M.D., Director, Midwest Children's Resource Center, Child Abuse Specialty Services, Suite 200, 360 Sherman Street, St. Paul, MN 55102.

"Financial Impact of DRG's on Abused Children" by B.M. Perry, J. Thomas, C. Rogers, and B. Jones, from *Restructuring Health Policy: An International Challenge* (1986) edited by John M. Virgo. Permission to reprint granted by the Atlantic Economic Society, Southern Illinois University at Edwardsville, Box 1101, Edwardsville, Illinois 6206-1102.

"Hospital-Based Intervention in Child Abuse" by Arthur H. Green, M.D., from *Resident and Staff Physician*, volume 29, number 2, (February 1983). Permission to reprint granted by the publisher, Romaine Pierson Publishers, 80 Shore Road, Port Washington, New York 11050.

Series on Violence in America

Hospital-Based Intervention in Child Abuse

In this article, one in a continuing series on Violence in America, guest edited by Dr. Norman B. Levy,* the author offers a guide to initiate a program that will help hospital-based physicians deal with the traumatic problem of child abuse.

Arthur H. Green, M.D., Dir., Columbia-Presbyterian Family Center (Child Abuse Program); Assoc. Clin. Professor of Psychiatry, Div. of Child Psychiatry, Columbia U. College of Physicians & Surgeons; Dir., Therapeutic Nursery, Presbyterian Hosp., NYC

The various forms of child maltreatment, indications of how child abuse could be detected through a careful history and physical examination, the major etiological components of the child abuse syndrome, the specific personality traits of the abusing parents, the characteristics of children that contributed to their abuse, and the environmental stresses that triggered their violent interaction were all discussed in an article that appeared in the May 1979 issue of *Resident & Staff Physician*. The article also summarized the typical psychodynamics encountered in abusing families and discussed treatment of both the parents and the children.

The incidence of child maltreatment has increased dramatically over the past four years. In 1977, the New York City Central Registry for Child Abuse stated that 24,400 cases of child abuse and neglect were reported that year. By 1980, this figure rose to 32,000, and in 1981 jumped to 43,000, amounting to a 34% increase in one year. There also has been an even larger increase in the national reporting of sexual abuse. In 1976, 1,955 sexually abused children were identified; in 1980, 25,000 such cases were reported, according to the American Humane Association's national survey on sexual abuse.

Although the causes of this "epidemic" are complex and might be associated with weakening of the family structure, an increased number of working mothers, and adverse economic factors, we are faced with the immediate task of breaking the cycle of family violence which seems to be transmitted from generation to generation. The high percentage of disorganized, multiproblem families involved in maltreatment requires a wide array of psychiatric, medical, and social services which usually are not available at any one treatment facility.

In the past, the problem of child maltreatment was dealt with by placing the child in a foster home or institution. This practice continued until follow-up revealed that many of the children had been reabused in their new setting. These children were often shifted from one home to another and appeared to be equally victimized by their "rescuers."

Their natural mothers became pregnant shortly after termination of their parental rights and continued their abusive behavior with their new offspring. Unfortunately, a huge foster care "industry" was created during this attempt to achieve an illusory cure. However, it is more efficient and cost effective to deploy our resources to attack the root causes of the child abuse syndrome operating in the parent, child, and environment rather than try to create a simulated "proper" home life. Hospitals and medical centers are logical sites for this type of intervention because only they can provide the comprehensive services needed to rehabilitate maltreating families.

The following model for a hospital-based treatment program for maltreated children and their fami-

*Dr. Levy is Director of the Liaison Psychiatry Division at Westchester County Medical Center and Professor of Psychiatry, Medicine, and Surgery at New York Medical College, Valhalla, NY.

Photo courtesy of UPI

lies is based upon the author's experience initiating and directing similar facilities at the Downstate Medical Center in Brooklyn and at the Columbia-Presbyterian Medical Center in New York. The hospital-based program is designed to involve abusing and neglecting families in a network of comprehensive, immediate, and long-term crisis-oriented mental health, social, and medical services from the moment of the identification of maltreatment, through the child's hospitalization, and following his discharge. The purpose of this intervention is to protect the child from further injury, strengthen the family and its child-rearing capacity, and provide psychological rehabilitation of the maltreating parents and their child victims. Contact with the parents is maintained until the quality of parenting becomes reasonably adequate to meet the physical and emotional needs of the children.

Such programs require a multidisciplinary team approach, involving the coordination of several clinical services from the medical center. The most important of these are the departments of pediatrics, child psychiatry, adult psychiatry, nursing, and social services. These disciplines should be represented in a child abuse committee, which reviews and evaluates all suspected cases of maltreatment and acts as a consulting body to the staff and administration of the hospital. The director of the program coordinates the services from the involved departments. Since a major portion of the interventions consists of psychiatric evaluations and treatment, the program can be directed most effectively by a child psychiatrist or an adult psychiatrist with some experience with children and parenting. The hospital-based treatment center should operate in close liaison with the local child protective service agency and the family court.

Role of Pediatrics

The pediatric inpatient and outpatient units identify and report all suspected cases of maltreatment to the state central child abuse registry, which, in turn, notifies the local child protective service agency. Children seen in the outpatient clinic or emergency room who are suspected of being maltreated are admitted to the inpatient service. These children receive a thorough pediatric evaluation and medical treatment for their injuries. The staff member filing the child abuse report, usually the pediatrician or emergency room nurse, states his reasons for making the report and notifies the parents of the need to hospitalize the child. The nurses and social workers are trained to observe the child's behavior on the ward and his involvement with peers and staff. They record the visiting patterns of the parents and the quality of the parent-child interaction. These observations may provide confirmatory evidence of maltreatment in cases where the injuries and history are equivocal. Infrequent parental visiting and expressions of fearfulness on the part of the child, such as avoidance or withdrawal from a parent or hospital personnel, hypervigilance, and "frozen watchfulness," may signal the presence of abuse or neglect. Some abused children will act in an extremely provocative manner, so as to elicit punishment from the staff. When asked to account for their injuries, some children are able to talk about their abuse if they have developed a trusting relationship with a staff member. After detecting and reporting suspected maltreatment, the most important role of the pediatric staff is to establish an initial therapeutic relationship with the abusing parents. Successful engagement of the parents in a supportive, noncritical relationship during the child's hospitalization will enhance their subsequent capacity to form a therapeutic alliance with members of the treatment program. Before the child is discharged, the psychiatric consultant from the treatment program should be introduced to the parents and child in order to assess their psychiatric status and suitability for involvement in the outpatient treatment program or therapeutic nursery. Following discharge, each child is assigned to his own pediatrician for periodic follow-up visits in the well-baby clinic or pediatric outpatient clinic for routine pediatric care. This follow-up care also will make it possible to identify any recurrence of maltreatment.

The pediatrician also is in a good position to prevent maltreatment. After the mother and newborn are discharged from the hospital, the pediatrician becomes the major link with the parent-child unit. Pediatric residents and attending physicians have an opportunity to identify parents at risk for maltreat-

ment while interacting in the hospital setting. Certain high-risk signals may be observed in the well-baby clinic, emergency room, and on the inpatient service. The most common high-risk signals are: parental intolerance to the baby's irritability or illness, inability to comfort the child, leaving a child unattended, nonresponse to a crying baby, hitting or humiliating a child, difficulty in feeding a baby, and holding or handling a baby inappropriately.

Certain types of parents may be considered to be "at-risk" for maltreatment of their children by virtue of physical or emotional problems that compromise their parenting skills. Parents who are psychotic or severely depressed, mentally retarded, alcoholics, drug abusers, teenagers, or who have a previous history of maltreatment may be placed in this category. A parent felt to be at-risk should be assessed by a social worker in order to determine the most appropriate type of preventive intervention. The pediatric social worker might be able to provide short-term counseling and parenting education. More difficult and problematic cases should be referred to the outpatient treatment program for more specialized intervention.

- *A pediatrician* with special interests and expertises in the area of child maltreatment should be designated as the leader of the pediatric child abuse team. He acts as a consultant to the emergency room and to pediatric house officers, nurses, and social workers. He collects historical data, interprets physical findings and laboratory results, coordinates follow-up pediatric care, and maintains communication with the family and protective services personnel. This pediatrician also should be responsible for staff training within the department of pediatrics and should act as co-chairman of the hospital's child abuse committee together with the psychiatrist-director of the outpatient treatment program.
- *The pediatric social worker* plays a pivotal role in establishing initial rapport with the family. While maintaining a therapeutic posture, the social worker assesses the family psychodynamics through careful observation and the subtle gathering of information. The worker maintains contact with the pediatric staff, child protective agency personnel, and various social agencies that might be involved with the family. He makes an assessment of the family's immediate and long-term requirements for child care, medical attention, household management, financial assistance, counseling, psychiatric treatment, etc. The pediatric social worker assists in the formulation of a postdischarge treatment plan.
- *Pediatric nurses* observe the child's behavior on the ward, record the visiting patterns of the parents, and document the quality of the parent-child interaction. They are in a position to develop a relationship with the hospitalized children and their families. Their observations should be made available to the pediatricians and pediatric social workers to assist them in postdischarge planning for the abused child and his family.

Role of Psychiatry

The psychiatrist acts as the director to the outpatient treatment program for the immediate and long-term therapeutic intervention with the maltreating families. The treatment program provides such therapeutic activities as counseling, supportive psychotherapy, group therapy, parenting education, home visiting, crisis intervention, and a 24-hour hot line. Psychiatric social workers, psychologists, and psychiatric nurses participate as members of the treatment team. The chief psychiatrist and program director coordinates the activities of all of the components of the treatment program, i.e., social services and mental health intervention with maltreating parents and the children, therapeutic nurseries for preschool children, and other specialized services in the medical center relevant to the specific needs of maltreated children and their parents. Among these services are family planning, pediatric well-baby care, adult and child psychiatry inpatient programs, and neurological, developmental, and speech and hearing evaluations for the abused children. The psychiatrist-director also consults with the child protective services, family courts, schools, and community organizations in order to facilitate the flow of referrals from outside the hospital, improve service delivery, and create favorable publicity for the program.

All families referred to the program are carefully screened and

evaluated by a team composed of a psychiatrist and psychiatric social worker. The families undergo a thorough psychiatric evaluation with consultation from other departments (e.g., neurology, pediatrics) when necessary. The evaluation consists of a diagnostic mental status assessment of each parent and the abused child and a thorough psychosocial investigation of the family by the social worker. The current living situation of the family is assessed by a home visit. Reports from the child's teacher or guidance counselor should be obtained if the child is attending school.

The results of the evaluation are presented at an intake conference attended by the staff of the treatment program. If the abused child and his parents are amenable and appropriate for the treatment program, they are assigned to the outpatient treatment program, where a variety of interventions are available to the child and parents. In cases where an infant or preschool child is the victim of maltreatment, the family is assigned to the therapeutic nursery.

If the parents are uncooperative and poorly motivated for therapeutic intervention, the child protective service agency should be notified so it can monitor the family closely while alternate intervention strategies are pursued. Some families might be served more appropriately by another specialized agency, e.g., substance abusing parents should be referred to drug abuse or alcoholism treatment programs and unsupported young teenage abusing mothers require the structure and close supervision available in a residential program.

Intervention with the Parents

The major objectives in the treatment of maltreating parents are to protect the children from further abuse and neglect and to strengthen the family and its parenting skills. To this end, intervention with the parents should be designed to modify the major components of the child abuse syndrome. These components include the personality traits of the parents that contribute to "abuse proneness," the characteristics of the child which make him more difficult to manage and enhance this scapegoating, and the environmental stresses that increase the burden of child care or deplete the childrearing resources of a family. This may be accomplished with the aid of the following treatment modalities.

- *Supportive Psychotherapy*—The therapist (psychiatrist, psychologist, psychiatric social worker, or psychiatric nurse) sees the maltreating parent once or twice a week. The psychotherapy is modified to suit the special needs of these parents. The therapist must be supportive and noncritical in order to overcome the parent's distrust of authority figures. The parent's excessive use of denial and projection, which leads to misperceptions and scapegoating of the abused child, must be interpreted gradually. If the psychotherapy is successful, the parent will be able to understand the link between his abusive practices and the maltreatment he had endured during his own childhood.

Continued on page 84

- *Counseling*—Counseling also is available to unsophisticated or poorly motivated parents who are less suitable for psychotherapy. It also might be offered as an initial intervention in preparation for subsequent psychotherapy. Counseling should be focused on such important areas as spouse and family relationships, childrearing, and vocational problems. Concrete issues, such as housekeeping, shopping, budgeting, and health care, may be managed effectively through a counseling approach.
- *Parenting Education*—A major goal of parenting education is to sensitize parents to the individual needs of their children, based on a better understanding of the child's physical and psychological development. This educative process attempts to modify the parents' misperception of their children, which results in inappropriate demands for precocious and premature performance. Parents also are taught routine child and health care practices. Parenting education may take place in small parent groups, during individual counseling sessions, or during the observation of parent-child interaction in a therapeutic nursery.
- *Group Therapy*—Group therapy can be beneficial to maltreating parents in several ways. It may act as a bridge to therapeutic involvement in extremely defensive and mistrustful parents who are threatened by a one-to-one relationship. It also may supplement ongoing individual counseling or psychotherapy. The realization that his problems are shared by others diminishes the parent's guilt and low

self-esteem. The permissive atmosphere of open discussion facilitates the expression of long-suppressed feelings of anger, pain, and distress. Finally, the establishment of personal ties with other group members fosters social contacts outside of the program.

• *Family Therapy*—Family therapy may be utilized with relatively intact maltreating families who have children who are old enough to communicate verbally. Family therapy may be initiated appropriately after preliminary individual treatment of the parents and children. A family systems approach can be extremely useful in identifying and reversing the pathological family interaction and aberrant communication commonly observed in abusing families. This modality also is effective in dealing with the major distortion in the roles of family members in cases of sexual abuse and incest.

• *Outreach Services and Crisis Intervention*—Outreach in the form of home visits and telephone contacts often is necessary to engage a resistant family during the initial phase of treatment. Home visiting also can be carried out during a period of crisis when the parent might be physically or emotionally unable to leave the house. A 24-hour a day hot line also is invaluable in such crisis situations as suicidal behavior, impending loss of impulse control, marital violence, and various other psychiatric emergencies. Planned home visiting may be utilized to assess the family's progress in treatment or to evaluate the degree of risk to the children at any given time.

Intervention with Children

The initial goal of intervention with abused children is to prevent further maltreatment and scapegoating; therefore, the delivery of comprehensive psychiatric and social services to abusing families must precede or accompany any direct psychotherapeutic involvement with the children. Once these children are in a safe environment, every effort should be made to assess and reverse the serious emotional and cognitive impairment associated with their traumatic life experiences. A variety of hospital-based services are available to the maltreated child.

• *Developmental and Psychological Evaluation*—Developmental evaluations of abused infants and preschool children are performed upon their entry into the program and may be repeated periodically. Psychological testing of schoolage children also is performed initially and at appropriate intervals. Differences between the test results obtained before and after the child's treatment may be used to measure the program's efficacy. A psychiatric evaluation is performed in order to establish a psychiatric diagnosis and to identify major areas of psychopathology and conflict in the child. During this evaluation, the child psychiatrist might recommend further specialized assessments, such as speech and language testing or a pediatric neurological examination, which are readily available at the medical center.

• *Crisis Nursery*—This facility, which may be housed in the pediatric inpatient area, provides 24-hour emergency shelter for infants and preschool children who are in extreme danger of parental violence or abandonment as a result of a family crisis. Children admitted to this type of program need not display the usual physical injuries or serious illness required for inpatient admission. The crisis nursery may admit these cases for 48 hours according to utilization review procedures, providing a report of suspected abuse or neglect is made to the state central registry. While the child is in a safe, protected environment, a vigorous assessment of the family should take place in order to formulate an immediate plan of intervention. If possible, an attempt should be made to stabilize the family by providing it with crisis-oriented supportive services. The child and family are evaluated by the treatment staff and referred to the therapeutic nursery following discharge if this plan is deemed appropriate. If the family crisis cannot be resolved, the 48-hour period may be utilized for the arrangement of emergency foster care for the child.

• *Therapeutic Nursery*—The therapeutic nursery serves as a resource for abused and neglected infants, toddlers, and preschool children and their families who are overburdened with childcare demands. The intervention is geared to remedy emotional, developmental, and behavioral defects that might have contributed to or resulted from the child's maltreatment. The program provides a highly structured therapeutic milieu for the children. They are taught socialization, cooperative play, and

self-care in eating, dressing, and toileting. They are provided with optimal sensory stimulation by trained teachers who supervise their play with developmentally appropriate toys and materials. The staff fosters their development of language and motor skills, encourages peer relationships, modifies their fearfulness and distrust, and enhances their self-esteem.

Specialized intervention also is directed toward the parent-child dyad. This intervention attempts to identify and change mutually frustrating aspects of the parent-child interaction, eliminate distortions in the parent's perception of the child, help the parents understand the child's cues and signals, educate the parents about the principles of child care and child development, and assist the parents in dealing with special problems of their children caused by physical, developmental, or behavioral impairment. The ultimate goal of this intervention is to promote a mutually satisfying and pleasurable interaction between parent and child that will allow the parent to derive satisfaction and self-confidence from the caretaking role. The program should be staffed by a full-time child care specialist with teaching and paraprofessional assistants. The therapeutic nursery also might utilize volunteer foster-grandparents who provide a supportive home-like atmosphere for the parents and children. These volunteers are stationed in the family room and serve food and drinks, engage the parents in arts and craft projects, and baby-sit for siblings of the nursery children.

• *Individual Psychotherapy*—Individual psychotherapy on a once or twice a week basis is provided for the schoolage child by the child psychiatrist and psychologists, nurses, and social workers trained in child therapy. Play therapy with younger children permits them to reenact and master the traumatic events associated with their maltreatment in a controlled setting. The most common psychological sequelae of child abuse and neglect are panic states associated with acute traumatic reactions, poor impulse control, depression and low self-esteem, self-destructive behavior, impaired object relations caused by a basic mistrust of others, extreme separation anxiety, and school difficulties associated with learning and behavior disorders. Certain modifications of therapeutic techniques are required to deal with these symptoms, with an emphasis on containment of drives and impulses, promoting verbalization as an alternative to motor discharge, enhancement of poor self-esteem, and the establishment of basic trust. One of the ultimate goals of psychotherapy is to effect changes in the child's pathological inner world by modifying pathological identifications and internalized representations of his violent parents, thereby preventing his transformation into an abusing parent in the following generation.

• *Group Psychotherapy*—Group psychotherapy may be utilized effectively as an adjuvant to individual therapy in older latency-age children, preadolescents, and adolescents who have experienced abuse and neglect. Therapeutic groups also have proven effective with girls who have been subjected to sexual abuse and incest.

• *Psychopharmacological Treatment*—Specific psychopharmacological agents may be indicated for maltreated children manifesting psychiatric syndromes that typically respond to drug treatment. For example, children with symptoms of depression, psychosis, or hyperactivity may benefit from tricyclic antidepressants, phenothiazines, and psychostimulant medications, respectively.

• *Psychoeducational Intervention*—A high percentage of abused and neglected children require psychological testing and educational assessment to document cognitive and learning impairments that contribute to their poor school adjustment. The presence of specific learning disabilities or behavior problems may require remedial intervention or placement in a special class. The child's therapist works in close liaison with the teacher and guidance counselor in order to gather detailed information about the child's school performance and behavior. The therapist provides consultation to the school regarding management of the child in the classroom. If necessary, a learning disability specialist should work in conjunction with the child's therapist and teachers.

Role of the Child Abuse Committee

The hospital's child abuse committee is composed of representatives from the departments of pediatrics, psychiatry, nursing, and social services. The committee

Continued on page 88

The Author

Arthur H. Green, M.D.

Dr. Green received his M.D. in 1955 from the University of Amsterdam. He did his internship at Maimonides Hospital in Brooklyn, New York and his psychiatric residency at Kings County Hospital in Brooklyn and at Roosevelt Hospital in New York City. He is currently Director of the Columbia-Presbyterian Family Center (Child Abuse Program), Associate Clinical Professor of Psychiatry, Division of Child Psychiatry, at Columbia University College of Physicians and Surgeons, and Director of the Therapeutic Nursery at the Presbyterian Hospital in New York City. He is Board-certified in both psychiatry and child psychiatry.

should be chaired jointly by the psychiatrist directing the outpatient treatment program and the leader of the pediatric child abuse team. The committee reviews and evaluates all suspected cases of maltreatment encountered in the pediatric outpatient department, emergency room, inpatient service, and in other parts of the hospital. It maintains a file of all reported cases and issues periodic reports indicating the number of families evaluated and the results of the evaluations. The committee also is responsible for the follow-up of cases not referred to the outpatient treatment program. The committee functions as a consulting unit to the hospital on all matters pertaining to maltreatment and should contain a representative from the local child protective service agency in order to coordinate the protective case supervision with the recommendations of the treatment team. Final disposition and case planning are discussed jointly by the treatment staff and the protective caseworker. The child abuse committee supplies the major coordinating link between the pediatric and mental health components of the program.

Advantages of This Program

A hospital-based program has the capacity to deliver and coordinate a wide variety of medical, mental health, social, and educational services to maltreating families. Duplication of these comprehensive services by a nonmedical agency would require the subcontracting of services to local hospitals, mental health, and child care centers at a much greater cost and would result in the investment of disproportionate efforts for interagency liaison and communication. Decentralization of services would require an unrealistic commitment of the parent's time and energy necessary for extensive multiagency contacts and travel. Patient compliance would be more difficult to monitor, with a predictable increase in dropout rates. The hospital-based program also has the capacity to initiate therapeutic contact with the family as soon as the maltreatment is detected, thus maximizing the potential for successful participation in the program. It is easier and more economical to initiate a hospital-based program because the nucleus of the treatment team can be formed with existing staff from the departments of pediatrics, psychiatry, nursing, and social services. ◀

Recommended Reading

Fontana V. The Maltreated Child. Springfield, Charles C Thomas, 1964.

Goldstan R. Observations on children who have been physically abused and their parents. Am J Psychiatry 122:440–443, 1965.

Gray J, Cutler C, et al. Child Abuse and Neglect: The Family and Community. Helfer RE, Kempe CH (Eds) Cambridge, Harvard University Press, 1976.

Green AH. A psychodynamic approach to the study and treatment of child-abusing parents. J Am Acad Child Psychiat 15:414–429, 1976.

Green AH. Child Maltreatment. New York, London, Jason Aronson, 1980.

Green AH. Psychiatric treatment of abused children. J Am Acad Child Psychiat 17:356–371, 1978.

Green AH, Power E, et al. Factors associated with successful and unsuccessful intervention with child abusive families. Child Abuse and Neglect 5:45–52, 1981.

Kempe RS, Kempe CH. Child Abuse. Cambridge, Harvard University Press, 1978.

Kempe CH, Silverman F, et al. The battered child syndrome. JAMA 181:17–24, 1962.

Klein M, Stern L. Low birth weight and the battered child syndrome. Am J Dis Child 122:15–18, 1971.

Martin H. (Ed) The Abused Child. Cambridge, Ballinger, 1976.

Solnit AR (Ed) The Child Protection Team Handbook. New York, London, Garland STPM Press, 1979.

Smith SM, Hanson R, Noble S. Parents of battered babies: A controlled study. Br Med J 4:388–391, 1973.

Smith C V, Hanson R. One hundred and thirty-four battered children: A medical and psychological study. Br Med J 14:666–670, 1964.

"The [redacted]alence and Characteristics of Multidisciplinary Teams for Child Abuse and Neglect: A National Survey" by Barbara B. Kaminer, Ann H. Crowe, and Lisanne Budde-Giltner from *The New Child Protection Team Handbook* (1988) by D.C. Bross, R.D. Krugman, M.R. Lenherr, D.A. Rosenberg, and B.D. Schmitt. Permission to reprint granted by the publisher: Garland Publishing Company, 717 Fifth Avenue, 25th floor, New York, New York 10022.

32. The Prevalence and Characteristics of Multidisciplinary Teams for Child Abuse and Neglect: A National Survey*

Barbara B. Kaminer, Ann H. Crowe, and Lisanne Budde-Giltner

Introduction

While the phenomenon of child maltreatment has been documented throughout history, attempts to address the problem and protect children from abuse and neglect are relatively recent. Kentucky was one of the first states to pass legislation in 1964 concerning child protection reporting. National legislation dealing solely with the reporting of child abuse, and related aspects of child protection, was not enacted until 1974. Thus, effective intervention strategies are still being conceptualized, implemented, and refined.

In 1982, the Kentucky Department for Human Resources entered into a contract with the Kent School of Social Work at the University of Louisville to develop multidisciplinary teams for child abuse and neglect in several communities throughout the state. The authors of this chapter were staff members of this project during its three-year duration.

For project purposes the following concepts of multidisciplinary teams were integrated into a working definition: a functioning unit

composed of professionals and/or representatives of service agenci work together to communicate, collaborate and consolidate kno from which plans are made, actions determined, and future de influenced.[1,2]

The very nature of child abuse and neglect requir involvement of many community resources. Health care, leg judicial services, law enforcement, and mental health interventic well as many others, are frequently required to provide protectio rehabilitation for the child and family. Most of these servic obtained outside the legally mandated protective service a Fragmentation of service delivery became a very real problem, single agency could provide the total array of services required. child abuse and neglect are complex problems, they need compreh and coordinated prevention, intervention, and treatment se provided by a multidisciplinary approach.

In recognition of this need, hospital-based multidiscip child protection teams were first developed in the late 195 Pittsburgh, Los Angeles, and Denver. These early teams gen consisted of a social worker, a pediatrician, and a nurse. These used a medical model approach to the management of the ph treatment and protection of the child. Community-l multidisciplinary teams came into existence a few years later and generally under the leadership of the child protection services welfare department. Both hospital-based and community-based have increased in membership and psychiatry, psychology, law education are now usually added to the original disciplines of med nursing, and social work. In some settings, still other discipline represented, such as law enforcement, the lay community, homeme the political arena, and others.[3,4]

Teams vary widely according to setting, functions, compos sponsorship, and other factors. Each community or agency utiliz multidisciplinary team develops a unique model based on comm needs and resources. Functions of teams generally fall within categories: treatment teams, case consultation teams, reso development or community action teams, and mixed model tean These models will be further defined and described with survey findi

Survey Methodology

Throughout the project period, an extensive review professional literature was undertaken. This search included a ger

of child abuse and neglect literature, with a special emphasis on ing material about multidisciplinary teams. From this activity, t staff concluded that professional literature on multidisciplinary yielded little information and few guidelines for those wishing to p teams. To better understand the options for team development, ject staff decided to undertake two national surveys to determine mber of existing teams and their general functions and policies.

The descriptive research method chosen for this study utilized l questionnaires which had the advantages of limited cost and accessibility. The first questionnaire (referred to as state onnaire) was designed to obtain general information from each of ty states. This data included the numbers of functioning teams in ate; the models they represented; if they were mandated by law; of authorization; state coordination and involvement in orientation or evaluation of multidisciplinary teams; presence of lentiality waivers; type of funding; and future plans.

A contact in each state was determined through correspondence each of the ten directors of the Regional Resource Centers for rom and Youth Service. A questionnaire and cover letter were sent se state officials in the spring of 1983 and resulted in 39 responses from the fifty states. Another mailing to the remaining 11 states uary of 1984 brought five additional responses, increasing the total responses (88%). In December of 1984, the last six states were cted and interviewed by phone. These three efforts resulted in a response rate to the state questionnaire and resulted in the tion of sufficient data from all 50 states to allow for adequate arison.

The state questionnaire asked respondents to identify existing s functioning in their states. From this list, a mailing was compiled e second questionnaire (referred to as team questionnaire). The questionnaire was designed to obtain more specific information rning individual teams rather than the broader areas covered by ate questionnaire. Through the team questionnaire, project staff ed to collect such data as: main team function, length of team ence, disciplines represented on teams and their influence, cteristics of team meetings, funding, orientation and evaluation, adership issues.

Team questionnaires were originally planned to be sent to a mum of four teams per state. As completed state questionnaires were ved, up to four teams listed were mailed a team questionnaire and a r letter. (Some states indicated they had fewer than four teams.)

Since responses varied from state to state, so did the number of questionnaires sent. For some states team questionnaires were not because states did not provide a list of team names and addresses. tionally, the last 6 states were contacted by phone in the final months of the project were not asked for team lists. Therefore, representation of states in the team findings is varied.

A total of 150 team questionnaires was mailed from spring 1983 to spring 1984. Three of these were returned as undeliverable. Therefore, there were 147 possible respondents. Eighty-nine questionnaires were returned (two uncompleted) and two teams responded with information in letter form. This is a total of 91 respondents, a 62% response rate. Again, this can be considered adequate in evaluation of results.

Survey Results

Responses to the state questionnaire indicated that all 50 states had at least one functioning multidisciplinary team. The range was from one team to 100 or more. The total number of teams identified was 901, thereby making the average of 18 multidisciplinary teams per state.

Table 32.1 shows the states that indicated they have multidisciplinary teams, the number of teams existing, and if the teams are legislatively mandated.

A nationwide survey conducted by the American Humane Association in 1979, as reported by Pettiford in 1981, also found a growing trend in the utilization of multidisciplinary teams. These survey results indicated that more than one third (36.9%) of local reporting offices were utilizing multidisciplinary teams.[7]

The development and utilization of multidisciplinary teams has been encouraged by the passage of federal legislation (Public Law 93-247, The Child Abuse Prevention and Treatment Act). This act stipulates that states which receive federal grants under this legislation must have operational multidisciplinary programs and services to ensure effective intervention in child abuse and neglect cases.[8,9]

The National Professional Resources Center on Child Abuse and Neglect of the American Public Welfare Association conducted a survey in 1981 of nineteen teams in sixteen states. They found that two factors most frequently led to the development of these teams: community action and legislative mandate.[10] As indicated in Table 32.1, twelve states reported that multidisciplinary teams were legislatively mandated. For the remaining 38 states, respondents indicated the following types of sponsorship or authorization:

TABLE 32.1 *Number of Teams and Legislative Mandates by State*

State	Number of Teams	Legislative Mandate	
		Yes	No
Alabama	6		X
Alaska	5 (minimum)		X
Arkansas	4*		X
Arizona	undetermined		X
California	5*		X
Colorado	42	X	
Connecticut	25*		X
Delaware	3		X
Florida	21		X
Georgia	6		X
Hawaii	3		X
Idaho	5*		X
Illinois	30	X	
Indiana	92	X	
Iowa	35		X
Kansas	4*		X
Kentucky	4		X
Louisiana	10		X
Maine	10		X
Maryland	23		X
Massachusetts	11	X	
Michigan	13*	X	
Minnesota	67*	X	
Mississippi	1		X
Missouri	undetermined	X	
Montana	27*		X
Nebraska	6 (minimum)		X
Nevada	3 (minimum)		X
New Hampshire	10		X
New Jersey	undetermined		X
New Mexico	4*		X
New York	4 (minimum)		X
North Carolina	undetermined*		X
North Dakota	26		X
Ohio	21*		X
Oklahoma	2		X
Oregon	10 (minimum)		X
Pennsylvania	undetermined	X	

TABLE 32.1 *Number of Teams and Legislative Mandates by State (continued)*

State	Number of Teams	Legislative Mandate	
		Yes	No
Rhode Island	1		X
South Carolina	56 (minimum)	X	
South Dakota	21		X
Tennessee	100 (minimum)	X	
Texas	23		X
Utah	14	X	
Vermont	14		X
Virginia	73		X
Washington	undetermined		X
West Virginia	5		X
Wisconsin	16		X
Wyoming	30	X	
	901 (minimum)	12	38

*Some respondents did not indicate the number of teams in their state, but the answer could be inferred from subsequent answers.

ONSORSHIP/AUTHORIZATION	RESPONSES*
ılic Agency Sponsorship	18
mmunity Sponsorship	12
te Sponsorship	12
spital Sponsorship	10
vate Agency Sponsorship	4
cal/County Mandate	1
her	4

lost respondents indicated teams operated under a mbination of sponsorships; therefore, responses total more ın 38.

G

ıe survey also requested information on the funding mechanisms to develop and maintain teams. Twenty-three states that no funding was available. Of the remaining twenty-seven ıding was reported from one or more of the following sources: ınds (17 states); state funds (15 states); local/county funds (15 ıntributions/donations (8 states); private foundations (4 states); ty payments for services (2 states) and other (4 states). The stionnaire yielded similar findings with 32% indicating a lack g for team development and operation.

IODELS/FUNCTIONS

everal models of multidisciplinary teams can be identified the literature. These fall into four basic categories as described

reatment Teams—A group of treatment experts who ollaborate on the diagnosis and treatment of the child and/or amily. This group of service providers shares responsibility vith child protective service workers for case assessment, liagnosis, treatment plan development, referral to treatment esources, and case follow-up.

ase Consultation Teams—A group of experts who collectively ırovide opinions and advice regarding child protection cases. The team reviews cases in terms of case management and liagnosis, and serves in an advisory capacity to primary workers around treatment planning and critical decisions. Technical assistance and support to service providers are also unctions of this team.

Resource Development or Community Action Teams—A group of service agency representatives, professional service providers, child advocates, and citizens who collectively work with local problems associated with child abuse and neglect. They address ongoing planning, coordination of services, community needs, community education/awareness, etc.

Mixed Model Teams—The combination of two or more of the above team functions by a single team; or two or more teams with different functions working within a central coordination mechanism.[5,6]

Respondents to the state questionnaire were asked to indicate which models could be identified in one or more teams in each state. The following list represents a total of more than 50 due to multiple responses: case consultation model (42 states, 85%); mixed model (31 states, 62%); treatment model (27 states, 54%); resource development model (26 states, 52%); other (9 states, 18%). (The models identified under the "other" category were: intake and closing screening, administrative case reviews, diagnosis only, public and professional education, investigation, state child protection team for institutional abuse cases, advisory group to state department of social services, public education.)

The random sample of individual teams was asked a similar question concerning the main team function on the team questionnaire. Of the 91 respondents, 48 (52%) reported being mixed model teams; 30 (32%) were case consultation teams; 7 (8%) were resource development teams; 1 (1%) was a treatment team; 1 (1%) and 4 (4%) respectively gave a response of "other" or gave no response.

Pettiford reports similar findings from a survey reported by the American Human Association in 1979. These data also indicated that case consultation is the most prevalent model of multidisciplinary teams utilized in child protective services. Of 461 local child protective services offices reporting that they used multidisciplinary teams, 58.77% indicated that their teams were advisory or consultative. Additionally, 22.6% reported their teams' functions as consultative, case review, and accountability in nature.[11]

Among the nineteen multidisciplinary teams surveyed by the American Public Welfare Association, all provided case consultation to child protective services personnel. The type of consultation provided was as follows: case assessment (19); case monitoring and review (18); and case closure (11). Along with these functions, 11 teams provided diagnosis and treatment, and two-thirds of the teams helped identify gaps and worked to develop or improve the service system in their communities. Public relations, education activities, and support for CPS personnel were cited as other team functions.[12]

TABLE 32.3 *Impact of Disciplines on Decisions to Return a Child Home*

Discipline	*Always*	*Usually*	*Seldom*	*Never*
Social Worker	30	18	4	—
Lawyer	16	21	12	4
Psychologist	15	28	11	3
Nurse	12	20	16	5
Judicial Representative	11	16	8	9
Physician	11	27	12	5
Psychiatrist	11	9	19	7
Public Health Representative	10	17	15	3
Educator	8	10	20	9
Law Enforcement Representative	6	15	21	5
Lay Representative	5	2	11	18
Politician	2	4	7	22
Developmental Specialist	1	18	13	8
Homemaker	1	7	17	9
Day Care Worker	—	3	16	15
Minority Representative	—	1	7	22
Others				
Mental Health	1	1	—	—
Clergy	—	—	1	—
Clients	1	2	3	—
No Answer	13			

TABLE 32.4 *Impact of Disciplines on Long Term Treatment Plans for a Physica Abused Child*

Discipline	*Always*	*Usually*	*Seldom*	*N.*
Social Worker	49	19	5	
Physician	24	26	11	
Psychologist	24	26	7	
Nurse	17	19	24	
Psychiatrist	15	10	16	
Lawyer	14	25	13	
Public Health Representative	14	23	15	
Judicial Representative	11	24	9	
Educator	7	22	22	
Law Enforcement Representative	7	16	24	
Lay Representative	5	7	13	1
Homemaker	4	4	23	
Developmental Specialist	3	18	18	
Politician	3	3	5	2
Day Care Worker	1	7	21	1
Minority Representative	—	4	9	2
No Answer	12			

TEAM COMPOSITION/MEMBERSHIP

Three basic alternatives for composition of a multidisciplinary team were identified: by discipline, by agency, or by function. An example of each is listed below.

DISCIPLINE	*AGENCY*
Social Worker	Child Protective Service Agency
Physician	Medical Center
Psychiatrist/Psychologist	Mental Health Center
Attorney	Legal Services
Human Development Specialist	School System
Law Enforcement	Police Department
Nurse	Health Department

FUNCTION

Family Therapist (e.g., social worker, psychologist, etc.)
Community Organization/Social Systems/Resources
Casework Specialist (with child protective service experience)
Child Development Specialist (e.g., educator, nurse, child psychologist)
Physician (e.g., pediatrician, family medicine)
Legal/Court System (e.g., attorney with knowledge of dependency docket, child advocacy experience, etc.)
Law Enforcement Officer

On the team questionnaire respondents were asked to identify team composition only by disciplines represented. Table 32.2 shows the number of respondents indicating each of the following disciplines included in their team composition.

Table 32.2
Disciplines Represented

Social Worker	86
Psychologist	65
Nurse	64
Physician	63
Lawyer	54
Educator	53
Public Health Representative	52
Law Enforcement Representative	52
Judicial Representative	38
Psychiatrist	23
Lay Representative	23
Developmental Specialist	20
Day Care Worker	11

Homemaker	11
Minority Representative	8
Politician	2
Other (clergy—7, clients—3, etc.)	32
No Answer	5

Every team that answered this question (N=86) has social representation. Other disciplines/professions that are represented least half of the respondents are psychologists, nurses, physi lawyers, educators, law enforcement, and public health representa In the 1981 survey by the American Public Welfare Associatio following eight major professions were identified as team discip social workers/case workers, psychiatrists/other mental h personnel, nurses, physicians, attorneys, police offi educators/teachers, judges/court staff. All but judges/court staff reported to be on at least half of these teams.[13]

The survey also included two rating scales to ascertai various disciplines' impact upon two hypothetical situations. respondents were asked to rate each discipline by its level of in (always, usually, seldom, never). The following tables show breakdown of the reported influence by each discipline in discussio returning children to their home environment after temporary placer

Table 32.3 addresses the short-term impact while Table addresses the extent of impact of each discipline on discussions of term treatment plans for the physically abused child.

Upon close examination the two grids show minimal varia In dealing with returning a child to the home the legally b disciplines (lawyer, judicial representative) appear to have i influence. In the situation involving long-term treatment for physically abused child, the physician appears to have greater im In both cases, however, the social worker ranked first in influence. ranking of most other disciplines also remained comparable.

LEADERSHIP

The reported influence of each discipline does not necess reflect the leadership of a team. For each meeting a leader is needc facilitate team discussion. This leader may be the same person each or may be rotated on a meeting-by-meeting, monthly, or some other b Teams also have various methods of leadership selection. A two- question on the team questionnaire dealt with leadership. Thirty-e respondents stated the position was a permanent one as opposed t indicating a rotating position. Only three answered that there wa identifiable leader.

Since only 24% of the nation mandates multidisciplinary teams, but 46% of the states provide such confidentiality waivers, it can be hypothesized that most of these waivers are generic in nature.

The survey conducted by the American Public Welfare Association in 1981 indicated that just over half (10) of the 19 teams surveyed operate under legislation which empowers them to handle confidential information.[14]

ORIENTATION/TRAINING

The authors of this chapter found, through experience in multidisciplinary team development, that it is important that all involved understand the functions and responsibilities of both team members and referring workers. Clarification and definition of terms and procedures are also important. Team members must understand the importance of openness, trust, and mutual respect for colleagues for the team to operate effectively. One approach to accomplishing this is the provision of initial orientation and/or ongoing training for teams.

Through the team questionnaire it was found that not all teams have a formal orientation process. Twenty-nine teams responded that members receive a formal orientation while the majority, 54 respondents, stated it was not available. Of the 20 that offer an orientation program, 26 are either responsible for the process themselves or their sponsoring agency is responsible. Thirteen of the teams state they have an orientation program at initial team development; eleven indicate they have a program for the entire team when a new member joins; eight hold orientation for the new members only; and seven indicate they have some orientation process at regular intervals. Methods used in orientation included informal sharing of information by team (23); formal presentation (15); recommended readings (15); simulated conferences (9); and audiovisual resources (8).

Eleven respondents to the state questionnaire indicated that formal orientation is provided at state level. Most of the states that reported some involvement related that it was on an informal basis. This included the provision of some written materials or state personnel participation with or representation on teams.

TEAM EVALUATION

Evaluation of a multidisciplinary team provides for the measurement of its effects against the goals it set out to accomplish. This contributes to rational decision making concerning team maintenance or

TABLE 32.7 *Confidentiality Policies*

State	*Waiver*		*Comments*
	Yes	*No*	
Alabama		X	Signed release forms and coding names.
Alaska		X	Signed release forms and coding names.
Arkansas		X	Team members sign confidential agreement.
Arizona		X	Confidentiality statutes cover th contracted by the state.
California	X		
Colorado		X	Teams are sanctioned by statute have access to pertinent inform regarding cases.
Connecticut		X	Release forms.
Delaware		X	Signed release from client.
Florida		X	Team members considered agent state.
Georgia		X	Client signed releases.
Hawaii	X		
Idaho	X		
Illinois	X		Some teams have own waiver fo
Indiana	X		
Iowa	X		
Kansas		X	Signed release forms.
Kentucky		X	Team members sign confidentiali agreement/release forms.
Louisiana		X	Team members become agents vi confidentiality law.
Maine	X		
Maryland	X		
Massachusetts	X		Members considered employees
Michigan	X		
Minnesota	X		
Mississippi		X	Team members are professionals providing services to child and family.
Missouri	X		
Montana	X		
Nebraska		X	Signed release.
Nevada		X	Team members sign a confidentia agreement.
New Hampshire	X		

In ascertaining the method used in choosing leadership, the most frequent answer was being elected by the team (24). The other choices were natural evolvement (14) and appointed from outside (6). This question was obviously incomplete since 20 respondents wrote in answers including appointed by sponsor (10) and employed (3).

OPERATIONAL FACTORS

The team questionnaire also considered operation mechanisms of teams. It is important to consider the time and other constraints of volunteer members in determining the length and frequency of meetings. A meeting of 2 to 2 1/2 hours is generally as long as people can be expected to work intensively and productively. On the team questionnaire, most teams (71) stated they have a limited time period for team meetings. The following table shows the answers received.

Table 32.5
Meeting Length

Usual Length of Meeting	*Responses*
One hour or less	21
1 to 1 1/2 hours	20
1 1/2 to 2 hours	26
2 hours or more	4

Meetings may be scheduled in a variety of ways including weekly, biweekly, monthly, or as needed. Respondents to the team questionnaire indicated that 83 of the teams meet on a regular basis while only three do not. In terms of frequency of meetings 41 (48%) meet monthly, 17 (20%) meet weekly, and 16 teams (19%) meet twice monthly. Additionally, one team reported meeting every two months, one team meets quarterly, and one hospital team meets three times weekly. There were also three respondents who stated they meet when needed. The range here varies from three times weekly to four times yearly. The most frequent answer, however, is monthly for nearly half the teams responding.

Realistic expectations of work to be accomplished at these meetings must be established for the team. A minimum of 30 minutes is usually needed to present and discuss a case. For new teams, 45-60 minutes may be needed for each case review. Respondents to the team questionnaire were asked to report how many cases were presented and/or reviewed at each meeting. Most answers corresponded to the length of the meeting (the longer the meeting, the more cases discussed). The following table gives the numbered responses.

Table 32.6
Number of Cases Presented/Reviewed at Team Meetings

Number of Cases	Responses
1 - 5	30
6 - 10	18
11 - 15	9
16 - 20	4
21 - 30	4
31 - 40	1
41 - 50	1
51 - 60	1
Over 61	2
No Answer	17

According to this information, the most frequent pattern of team me from this sample involves a 1 1/2- to 2-hour meeting held once a mo review 1 to 5 cases.

The team questionnaire also requested information on attendance. Seventy-six respondents indicated all members are ex to attend the regular meetings. Nine teams have other atten patterns. For example, one has a "sub-team" that screens all presented and chooses only a limited number for the whole te review.

CONFIDENTIALITY

Several questions regarding policies and procedures for functioning were asked on both questionnaires. Respondents to th questionnaire were asked to report on confidentiality policie procedures. State laws concerning confidentiality in child abus neglect cases may or may not specifically address the iss multidisciplinary team involvement. Table 32.7 summarizes respon the question of confidentiality. Twenty-three of the states conf that a confidentiality waiver is in effect. The remaining 27 state five alternatives employed by various teams:

signed release by clients (11 responses)
confidentiality agreements signed by team members (8 respo
coding case names/anonymity (6 responses)
teams under state sanction/agents of the state (6 responses)
no policy regarding this matter (3 responses)

enforcement officers. The most frequent pattern of team meetings involves a 1 1/2 to 2 hour meeting held once a month to review one to five cases. Team sponsorship is most often provided by public agencies. Over one-half the states provide some form of protection for teams regarding confidentially issues.

While this information appears to be the most comprehensive data on multidisciplinary teams available to date, there are many areas that warrant further study. Particularly, it would seem, more evaluative efforts need to be undertaken, including: analysis of types of cases referred to teams; comparisons of these to general caseloads of child protective services; outcomes of cases reviewed by teams as compared to similar cases not referred; whether or not the referring workers learn from team consultation and generalize the problem-solving approaches and recommendations to other cases, and whether or not team efforts strengthen community involvement in addressing the problem of child abuse and neglect.

The experience of these authors in developing and utilizing multidisciplinary teams demonstrated the value and effectiveness of such teams. It is highly recommended that efforts be continued to develop, maintain, and utilize multidisciplinary teams as an adjunct to the service system for child abuse and neglect. Development and utilization of multidisciplinary team approaches can also be adapted for use in other service settings or with other target populations. For example, consultation, treatment, or resource development teams could be creatively modified for use in the area of foster care, institutional child care, or adult protective services.

Note

* This study was supported in part by a contract from the Kentucky Cabinet for Human Resources with the Kent School of Social Work, University of Louisville, Louisville, Kentucky.

References

1. Brill, N.I. *Teamwork: Working Together in the Human Services.* Philadelphia: J.B. Lippincott Company, 1976.

2. *Child Abuse and Neglect: The Community Team, An Approach t Management and Prevention,* Vol. 3. DHEW publication No. (OH 30075. Washington, D.C.: Government Printing Office, 1975.

3. Schmitt, B.D. *The Child Protection Team Handbook: A Multidisci Approach to Managing Child Abuse and Neglect.* New York: G STPM Press, 1978.

4. Pettiford, E.K. *Improving Child Protective Services through the Multidisciplinary Teams.* National Professional Resource Center on Abuse and Neglect, American Public Welfare Association and Na Association of Social Workers, pp. 2-3, June 1981.

5. Chamberlain, W.A. *Multidisciplinary Child Abuse and Neglect Manual.* Athens, Ga.: Regional Institute of Social Welfare Research November, 1978.

6. Pettiford, E.K. *Improving Child Protective Services,* p. 4.

7. Pettiford, E.K. *Improving Child Protective Services,* p. 5.

8. Selinske, J. *A Survey of the Use and Functioning of Multidisci Teams in Child Protective Services.* Washington, D.C.: Nat Professional Resource Center on Child Abuse and Neglect, Ame Public Welfare Association, 1981.

9. Pettiford, E.K. *Improving Child Protective Services,* p. 3.

10. Selinske, J. *A Survey of the Use and Functioning of Multidisci Teams,* pp. 5-6.

11. Pettiford, E.K. *Improving Child Protective Services,* p. 5.

12. Selinske, J. *A Survey of the Use and Functioning of Multidisci Teams,* p. 7.

13. Selinske, J. *A Survey of the Use and Functioning of Multidisci Teams,* pp. 7-8.

14. Selinske, J. *A Survey of the Use and Functioning of Multidisci Teams,* p. 10.

TABLE 32.7 *Confidentiality Policies (continued)*

State	*Waiver*		*Comments*
	Yes	*No*	
New Jersey	X		
New Mexico		X	
New York		X	Coded case names.
North Carolina		X	
North Dakota	X		
Ohio		X	Some use coded names; others release form signed by client.
Oklahoma		X	
Oregon		X	State personnel can share information between agencies.
Pennsylvania		X	Sign confidentiality form/cases presented anonymously.
Rhode Island		X	Federal regulations do not require specific waiver.
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas	X		
Utah		X	No specific policy regarding issue.
Vermont	X		Some also used release forms.
Virginia	X		Also teams encouraged to sign confidentiality agreement.
Washington		X	Agreement from team members.
West Virginia		X	Signed agreement by team members/cases presented anonymously.
Wisconsin		X	Release forms; DHSS has introduced legislation which would give permission for information sharing among team members.
Wyoming	X		

adaptations. Both formal and informal approaches to evaluati provide valuable data.

Respondents to the team questionnaire indicated that thir teams (35%) indicated they do have some form of evaluation. stated that the team is most often responsible for this proce responses). Other answers regarding responsibility for the eval were team sponsor (10), state (5), and other (6).

In describing the various types of evaluations the most co answer was informal, ongoing evaluation (12 responses). Ten reported annual evaluations, some of which were verbal, some w Only five reported having formal evaluations performed and these by the teams' sponsors.

The team questionnaire also addressed the issue of longevity. Responses ranged from six months to 15 years. Tabl shows the distribution of teams by years of operation. As wou expected, the oldest reported team in this survey is a hospital-team in a state children's hospital.

Table 32.8
Team Longevity

Less than 1 year	2
1 year	10
2 years	12
3 years	10
4 years	12
5 years	12
6 - 10 years	23
11 - 15 years	2
No answer	8

The average length of team existence was 4.3 years.

Summary

The results of these surveys have provided some t descriptive data on currently functioning multidisciplinary teams child abuse and neglect. Findings indicate that teams exist in all states with the majority providing case consultation. Team compos varies widely, but usually consists of social workers, mental he professionals, physicians, nurses, lawyers, educators, and

ONSORSHIP/AUTHORIZATION	RESPONSES*
ılic Agency Sponsorship	18
mmunity Sponsorship	12
te Sponsorship	12
spital Sponsorship	10
vate Agency Sponsorship	4
cal/County Mandate	1
her	4

lost respondents indicated teams operated under a mbination of sponsorships; therefore, responses total more ın 38.

G

ve survey also requested information on the funding mechanisms to develop and maintain teams. Twenty-three states that no funding was available. Of the remaining twenty-seven ıding was reported from one or more of the following sources: ınds (17 states); state funds (15 states); local/county funds (15 ntributions/donations (8 states); private foundations (4 states); ty payments for services (2 states) and other (4 states). The stionnaire yielded similar findings with 32% indicating a lack g for team development and operation.

IODELS/FUNCTIONS

everal models of multidisciplinary teams can be identified the literature. These fall into four basic categories as described

reatment Teams—A group of treatment experts who ollaborate on the diagnosis and treatment of the child and/or amily. This group of service providers shares responsibility vith child protective service workers for case assessment, liagnosis, treatment plan development, referral to treatment esources, and case follow-up.

ase Consultation Teams—A group of experts who collectively rovide opinions and advice regarding child protection cases. The team reviews cases in terms of case management and liagnosis, and serves in an advisory capacity to primary vorkers around treatment planning and critical decisions. Technical assistance and support to service providers are also unctions of this team.

Resource Development or Community Action Teams—A grou of service agency representatives, professional service providers, child advocates, and citizens who collectively work with local problems associated with child abuse and neglect. They address ongoing planning, coordination of services, community needs, community education/awareness, etc.

Mixed Model Teams—The combination of two or more of the above team functions by a single team; or two or more teams with different functions working within a central coordination mechanism.[5,6]

Respondents to the state questionnaire were asked to indicate which models could be identified in one or more teams in each state. The following list represents a total of more than 50 due to multiple responses: case consultation model (42 states, 85%); mixed model (31 states, 62%); treatment model (27 states, 54%); resource development model (26 states, 52%); other (9 states, 18%). (The models identified under the "other" category were: intake and closing screening, administrative case reviews, diagnosis only, public and professional education, investigation, state child protection team for institutional abuse cases, advisory group to state department of social services, public education.)

The random sample of individual teams was asked a similar question concerning the main team function on the team questionnaire. Of the 91 respondents, 48 (52%) reported being mixed model teams; 30 (32%) were case consultation teams; 7 (8%) were resource development teams; 1 (1%) was a treatment team; 1 (1%) and 4 (4%) respectively gave a response of "other" or gave no response.

Pettiford reports similar findings from a survey reported by the American Human Association in 1979. These data also indicated that case consultation is the most prevalent model of multidisciplinary teams utilized in child protective services. Of 461 local child protective services offices reporting that they used multidisciplinary teams, 58.77% indicated that their teams were advisory or consultative. Additionally, 22.6% reported their teams' functions as consultative, case review, and accountability in nature.[11]

Among the nineteen multidisciplinary teams surveyed by the American Public Welfare Association, all provided case consultation to child protective services personnel. The type of consultation provided was as follows: case assessment (19); case monitoring and review (18); and case closure (11). Along with these functions, 11 teams provided diagnosis and treatment, and two-thirds of the teams helped identify gaps and worked to develop or improve the service system in their communities. Public relations, education activities, and support for CPS personnel were cited as other team functions.[12]

TABLE 32.1 *Number of Teams and Legislative Mandates by State*

State	Number of Teams	Legislative Mandate	
		Yes	No
Alabama	6		X
Alaska	5 (minimum)		X
Arkansas	4*		X
Arizona	undetermined		X
California	5*		X
Colorado	42	X	
Connecticut	25*		X
Delaware	3		X
Florida	21		X
Georgia	6		X
Hawaii	3		X
Idaho	5*		X
Illinois	30	X	
Indiana	92	X	
Iowa	35		X
Kansas	4*		X
Kentucky	4		X
Louisiana	10		X
Maine	10		X
Maryland	23		X
Massachusetts	11	X	
Michigan	13*	X	
Minnesota	67*	X	
Mississippi	1		X
Missouri	undetermined	X	
Montana	27*		X
Nebraska	6 (minimum)		X
Nevada	3 (minimum)		X
New Hampshire	10		X
New Jersey	undetermined		X
New Mexico	4*		X
New York	4 (minimum)		X
North Carolina	undetermined*		X
North Dakota	26		X
Ohio	21*		X
Oklahoma	2		X
Oregon	10 (minimum)		X
Pennsylvania	undetermined	X	

TABLE 32.1 *Number of Teams and Legislative Mandates by State (continued)*

State	Number of Teams	Legislative Mandate	
		Yes	No
Rhode Island	1		X
South Carolina	56 (minimum)	X	
South Dakota	21		X
Tennessee	100 (minimum)	X	
Texas	23		X
Utah	14	X	
Vermont	14		X
Virginia	73		X
Washington	undetermined		X
West Virginia	5		X
Wisconsin	16		X
Wyoming	30	X	
	901 (minimum)	12	38

*Some respondents did not indicate the number of teams in their state, but the answer could be inferred from subsequent answers.

TEAM COMPOSITION/MEMBERSHIP

Three basic alternatives for composition of a multidisciplinary team were identified: by discipline, by agency, or by function. An example of each is listed below.

DISCIPLINE	*AGENCY*
Social Worker	Child Protective Service Agency
Physician	Medical Center
Psychiatrist/Psychologist	Mental Health Center
Attorney	Legal Services
Human Development Specialist	School System
Law Enforcement	Police Department
Nurse	Health Department

FUNCTION

Family Therapist (e.g., social worker, psychologist, etc.)
Community Organization/Social Systems/Resources
Casework Specialist (with child protective service experience)
Child Development Specialist (e.g., educator, nurse, child psychologist)
Physician (e.g., pediatrician, family medicine)
Legal/Court System (e.g., attorney with knowledge of dependency docket, child advocacy experience, etc.)
Law Enforcement Officer

On the team questionnaire respondents were asked to identify team composition only by disciplines represented. Table 32.2 shows the number of respondents indicating each of the following disciplines included in their team composition.

Table 32.2
Disciplines Represented

Social Worker	86
Psychologist	65
Nurse	64
Physician	63
Lawyer	54
Educator	53
Public Health Representative	52
Law Enforcement Representative	52
Judicial Representative	38
Psychiatrist	23
Lay Representative	23
Developmental Specialist	20
Day Care Worker	11
Homemaker	11
Minority Representative	8
Politician	2
Other (clergy—7, clients—3, etc.)	32
No Answer	5

Every team that answered this question (N=86) has social representation. Other disciplines/professions that are represented least half of the respondents are psychologists, nurses, physi· lawyers, educators, law enforcement, and public health representa In the 1981 survey by the American Public Welfare Associatio following eight major professions were identified as team discip social workers/case workers, psychiatrists/other mental h personnel, nurses, physicians, attorneys, police offi educators/teachers, judges/court staff. All but judges/court staff reported to be on at least half of these teams.[13]

The survey also included two rating scales to ascertai various disciplines' impact upon two hypothetical situations. respondents were asked to rate each discipline by its level of in (always, usually, seldom, never). The following tables show breakdown of the reported influence by each discipline in discussio returning children to their home environment after temporary place

Table 32.3 addresses the short-term impact while Table addresses the extent of impact of each discipline on discussions of term treatment plans for the physically abused child.

Upon close examination the two grids show minimal varia In dealing with returning a child to the home the legally b disciplines (lawyer, judicial representative) appear to have influence. In the situation involving long-term treatment for physically abused child, the physician appears to have greater im In both cases, however, the social worker ranked first in influence. ranking of most other disciplines also remained comparable.

LEADERSHIP

The reported influence of each discipline does not necess· reflect the leadership of a team. For each meeting a leader is needc facilitate team discussion. This leader may be the same person each or may be rotated on a meeting-by-meeting, monthly, or some other b Teams also have various methods of leadership selection. A two- question on the team questionnaire dealt with leadership. Thirty-e respondents stated the position was a permanent one as opposed t indicating a rotating position. Only three answered that there wa identifiable leader.

Discipline	*Always*	*Usually*	*Seldom*	*Never*
Social Worker	30	18	4	—
Lawyer	16	21	12	4
Psychologist	15	28	11	3
Nurse	12	20	16	5
Judicial Representative	11	16	8	9
Physician	11	27	12	5
Psychiatrist	11	9	19	7
Public Health Representative	10	17	15	3
Educator	8	10	20	9
Law Enforcement Representative	6	15	21	5
Lay Representative	5	2	11	18
Politician	2	4	7	22
Developmental Specialist	1	18	13	8
Homemaker	1	7	17	9
Day Care Worker	—	3	16	15
Minority Representative	—	1	7	22
Others				
Mental Health	1	1	—	—
Clergy	—	—	1	—
Clients	1	2	3	—
No Answer	13			

... Impact of Disciplines on Long-Term Treatment Plans for a Physica... Abused Child

Discipline	*Always*	*Usually*	*Seldom*	*N.*
Social Worker	49	19	5	
Physician	24	26	11	
Psychologist	24	26	7	
Nurse	17	19	24	
Psychiatrist	15	10	16	
Lawyer	14	25	13	
Public Health Representative	14	23	15	
Judicial Representative	11	24	9	
Educator	7	22	22	
Law Enforcement Representative	7	16	24	
Lay Representative	5	7	13	1
Homemaker	4	4	23	
Developmental Specialist	3	18	18	
Politician	3	3	5	2
Day Care Worker	1	7	21	1
Minority Representative	—	4	9	2
No Answer	12			

Ascertaining the method used in choosing leadership, the most frequent answer was being elected by the team (24). The other choices were natural evolvement (14) and appointed from outside (6). This question was obviously incomplete since 20 respondents wrote in answers including appointed by sponsor (10) and employed (3).

OPERATIONAL FACTORS

The team questionnaire also considered operation mechanisms of teams. It is important to consider the time and other constraints of volunteer members in determining the length and frequency of meetings. A meeting of 2 to 2 1/2 hours is generally as long as people can be expected to work intensively and productively. On the team questionnaire, most teams (71) stated they have a limited time period for team meetings. The following table shows the answers received.

Table 32.5
Meeting Length

Usual Length of Meeting	*Responses*
One hour or less	21
1 to 1 1/2 hours	20
1 1/2 to 2 hours	26
2 hours or more	4

Meetings may be scheduled in a variety of ways including weekly, biweekly, monthly, or as needed. Respondents to the team questionnaire indicated that 83 of the teams meet on a regular basis while only three do not. In terms of frequency of meetings 41 (48%) meet monthly, 17 (20%) meet weekly, and 16 teams (19%) meet twice monthly. Additionally, one team reported meeting every two months, one team meets quarterly, and one hospital team meets three times weekly. There were also three respondents who stated they meet when needed. The range here varies from three times weekly to four times yearly. The most frequent answer, however, is monthly for nearly half the teams responding.

Realistic expectations of work to be accomplished at these meetings must be established for the team. A minimum of 30 minutes is usually needed to present and discuss a case. For new teams, 45-60 minutes may be needed for each case review. Respondents to the team questionnaire were asked to report how many cases were presented and/or reviewed at each meeting. Most answers corresponded to the length of the meeting (the longer the meeting, the more cases discussed). The following table gives the numbered responses.

Table 32.6
Number of Cases Presented/Reviewed at Team Meetings

Number of Cases	Responses
1 - 5	30
6 - 10	18
11 - 15	9
16 - 20	4
21 - 30	4
31 - 40	1
41 - 50	1
51 - 60	1
Over 61	2
No Answer	17

According to this information, the most frequent pattern of team me from this sample involves a 1 1/2- to 2-hour meeting held once a mo review 1 to 5 cases.

The team questionnaire also requested information on attendance. Seventy-six respondents indicated all members are ex to attend the regular meetings. Nine teams have other atten patterns. For example, one has a "sub-team" that screens all presented and chooses only a limited number for the whole te review.

CONFIDENTIALITY

Several questions regarding policies and procedures for functioning were asked on both questionnaires. Respondents to th questionnaire were asked to report on confidentiality policie procedures. State laws concerning confidentiality in child abus neglect cases may or may not specifically address the iss multidisciplinary team involvement. Table 32.7 summarizes respon the question of confidentiality. Twenty-three of the states conf that a confidentiality waiver is in effect. The remaining 27 states five alternatives employed by various teams:

signed release by clients (11 responses)
confidentiality agreements signed by team members (8 respo
coding case names/anonymity (6 responses)
teams under state sanction/agents of the state (6 responses)
no policy regarding this matter (3 responses)

Since only 24% of the nation mandates multidisciplinary teams, but 46% of the states provide such confidentiality waivers, it can be hypothesized that most of these waivers are generic in nature.

The survey conducted by the American Public Welfare Association in 1981 indicated that just over half (10) of the 19 teams surveyed operate under legislation which empowers them to handle confidential information.[14]

ORIENTATION/TRAINING

The authors of this chapter found, through experience in multidisciplinary team development, that it is important that all involved understand the functions and responsibilities of both team members and referring workers. Clarification and definition of terms and procedures are also important. Team members must understand the importance of openness, trust, and mutual respect for colleagues for the team to operate effectively. One approach to accomplishing this is the provision of initial orientation and/or ongoing training for teams.

Through the team questionnaire it was found that not all teams have a formal orientation process. Twenty-nine teams responded that members receive a formal orientation while the majority, 54 respondents, stated it was not available. Of the 20 that offer an orientation program, 26 are either responsible for the process themselves or their sponsoring agency is responsible. Thirteen of the teams state they have an orientation program at initial team development; eleven indicate they have a program for the entire team when a new member joins; eight hold orientation for the new members only; and seven indicate they have some orientation process at regular intervals. Methods used in orientation included informal sharing of information by team (23); formal presentation (15); recommended readings (15); simulated conferences (9); and audiovisual resources (8).

Eleven respondents to the state questionnaire indicated that formal orientation is provided at state level. Most of the states that reported some involvement related that it was on an informal basis. This included the provision of some written materials or state personnel participation with or representation on teams.

TEAM EVALUATION

Evaluation of a multidisciplinary team provides for the measurement of its effects against the goals it set out to accomplish. This contributes to rational decision making concerning team maintenance or

TABLE 32.7 *Confidentiality Policies*

State	*Waiver*		*Comments*
	Yes	*No*	
Alabama		X	Signed release forms and coding names.
Alaska		X	Signed release forms and coding names.
Arkansas		X	Team members sign confidential agreement.
Arizona		X	Confidentiality statutes cover th contracted by the state.
California	X		
Colorado		X	Teams are sanctioned by statute have access to pertinent inform regarding cases.
Connecticut		X	Release forms.
Delaware		X	Signed release from client.
Florida		X	Team members considered agent state.
Georgia		X	Client signed releases.
Hawaii	X		
Idaho	X		
Illinois	X		Some teams have own waiver fo
Indiana	X		
Iowa	X		
Kansas		X	Signed release forms.
Kentucky		X	Team members sign confidentiali agreement/release forms.
Louisiana		X	Team members become agents vi confidentiality law.
Maine	X		
Maryland	X		
Massachusetts	X		Members considered employees
Michigan	X		
Minnesota	X		
Mississippi		X	Team members are professionals providing services to child and family.
Missouri	X		
Montana	X		
Nebraska		X	Signed release.
Nevada		X	Team members sign a confidentia agreement.
New Hampshire	X		

TABLE 32.7 *Confidentiality Policies (continued)*

State	*Waiver*		*Comments*
	Yes	*No*	
New Jersey	X		
New Mexico		X	
New York		X	Coded case names.
North Carolina		X	
North Dakota	X		
Ohio		X	Some use coded names; others release form signed by client.
Oklahoma		X	
Oregon		X	State personnel can share information between agencies.
Pennsylvania		X	Sign confidentiality form/cases presented anonymously.
Rhode Island		X	Federal regulations do not require specific waiver.
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas	X		
Utah		X	No specific policy regarding issue.
Vermont	X		Some also used release forms.
Virginia	X		Also teams encouraged to sign confidentiality agreement.
Washington		X	Agreement from team members.
West Virginia		X	Signed agreement by team members/cases presented anonymously.
Wisconsin		X	Release forms; DHSS has introduced legislation which would give permission for information sharing among team members.
Wyoming	X		

adaptations. Both formal and informal approaches to evaluati provide valuable data.

Respondents to the team questionnaire indicated that thir teams (35%) indicated they do have some form of evaluation. stated that the team is most often responsible for this proce responses). Other answers regarding responsibility for the eval were team sponsor (10), state (5), and other (6).

In describing the various types of evaluations the most co answer was informal, ongoing evaluation (12 responses). Ten reported annual evaluations, some of which were verbal, some w Only five reported having formal evaluations performed and these by the teams' sponsors.

The team questionnaire also addressed the issue of longevity. Responses ranged from six months to 15 years. Tabl shows the distribution of teams by years of operation. As wou expected, the oldest reported team in this survey is a hospital-team in a state children's hospital.

Table 32.8
Team Longevity

Less than 1 year	2
1 year	10
2 years	12
3 years	10
4 years	12
5 years	12
6 - 10 years	23
11 - 15 years	2
No answer	8

The average length of team existence was 4.3 years.

Summary

The results of these surveys have provided some t descriptive data on currently functioning multidisciplinary teams child abuse and neglect. Findings indicate that teams exist in all states with the majority providing case consultation. Team compos varies widely, but usually consists of social workers, mental he professionals, physicians, nurses, lawyers, educators, and

enforcement officers. The most frequent pattern of team meetings involves a 1 1/2 to 2 hour meeting held once a month to review one to five cases. Team sponsorship is most often provided by public agencies. Over one-half the states provide some form of protection for teams regarding confidentially issues.

While this information appears to be the most comprehensive data on multidisciplinary teams available to date, there are many areas that warrant further study. Particularly, it would seem, more evaluative efforts need to be undertaken, including: analysis of types of cases referred to teams; comparisons of these to general caseloads of child protective services; outcomes of cases reviewed by teams as compared to similar cases not referred; whether or not the referring workers learn from team consultation and generalize the problem-solving approaches and recommendations to other cases, and whether or not team efforts strengthen community involvement in addressing the problem of child abuse and neglect.

The experience of these authors in developing and utilizing multidisciplinary teams demonstrated the value and effectiveness of such teams. It is highly recommended that efforts be continued to develop, maintain, and utilize multidisciplinary teams as an adjunct to the service system for child abuse and neglect. Development and utilization of multidisciplinary team approaches can also be adapted for use in other service settings or with other target populations. For example, consultation, treatment, or resource development teams could be creatively modified for use in the area of foster care, institutional child care, or adult protective services.

Note

* This study was supported in part by a contract from the Kentucky Cabinet for Human Resources with the Kent School of Social Work, University of Louisville, Louisville, Kentucky.

References

1. Brill, N.I. *Teamwork: Working Together in the Human Services.* Philadelphia: J.B. Lippincott Company, 1976.

2. *Child Abuse and Neglect: The Community Team, An Approach t Management and Prevention,* Vol. 3. DHEW publication No. (OH 30075. Washington, D.C.: Government Printing Office, 1975.

3. Schmitt, B.D. *The Child Protection Team Handbook: A Multidisci Approach to Managing Child Abuse and Neglect.* New York: G STPM Press, 1978.

4. Pettiford, E.K. *Improving Child Protective Services through the Multidisciplinary Teams.* National Professional Resource Center on Abuse and Neglect, American Public Welfare Association and Na Association of Social Workers, pp. 2-3, June 1981.

5. Chamberlain, W.A. *Multidisciplinary Child Abuse and Neglect Manual.* Athens, Ga.: Regional Institute of Social Welfare Research November, 1978.

6. Pettiford, E.K. *Improving Child Protective Services,* p. 4.

7. Pettiford, E.K. *Improving Child Protective Services,* p. 5.

8. Selinske, J. *A Survey of the Use and Functioning of Multidiscip Teams in Child Protective Services.* Washington, D.C.: Nat Professional Resource Center on Child Abuse and Neglect, Amc Public Welfare Association, 1981.

9. Pettiford, E.K. *Improving Child Protective Services,* p. 3.

10. Selinske, J. *A Survey of the Use and Functioning of Multidiscipl Teams,* pp. 5-6.

11. Pettiford, E.K. *Improving Child Protective Services,* p. 5.

12. Selinske, J. *A Survey of the Use and Functioning of Multidiscipli Teams,* p. 7.

13. Selinske, J. *A Survey of the Use and Functioning of Multidiscipli Teams,* pp. 7-8.

14. Selinske, J. *A Survey of the Use and Functioning of Multidiscipli Teams,* p. 10.

Children's Hospital
St. Paul

Midwest Children's Resource Center
Child Abuse Specialty Services
Suite 200, 360 Sherman Street
St. Paul, Minnesota 55102
(612) 220-6750

March 29, 1993

National Center on Child
Abuse and Neglect
Department of Health & Human Services

The enclosed information is a product of the efforts of a Joint Task Force on Child Abuse and Neglect at Children's Hospital, St. Paul, Minnesota. The membership of the group included selected representatives from inpatient nursing staff, Midwest Children's Resource Center (child abuse outpatient department) Child and Family Services, the Emergency Room and the Quality Assurance Department.

I present this information on behalf of the Task Force Committee members and particularly acknowledge the expertise and leadership of Janice Ophoven, M.D., a specialist in both the areas of child abuse and quality management process.

We are currently in the process of preparing to publish this information. This material should not be reproduced without the permission of Midwest Children's Resource Center.

Attached is a brochure of our Center for you to include with other materials. If you need additional information regarding our Center, please do not hesitate to contact me.

Sincerely,

Carolyn Levitt, M.D.
Director
Midwest Children's Resource Center

Suspected Child Abuse and Neglect (SCAN) Guidelines
Children's Hospital of St. Paul

Children's Hospital of St. Paul (CHSP) is committed to providing coordinated, high-quality care for suspected victims of child abuse. In support of this commitment, the hospital has developed the following guidelines.

1. **CHSP identifies Midwest Children's Resource Center (MCRC) as the department responsible for coordinating quality of care in SCAN patients**

2. **CHSP will develop and implement standardized SCAN documents/forms**
   - Implementation of SCAN Task Force forms and guidelines hospital wide
     - Pilot review of recommended Task Force forms and guidelines with review in 6 months
   - Ensure effective SCAN documentation
   - Promote conformity with definitions/terminology/diagnosis
   - Provide consistent, timely and appropriate communication to internal and external services and agencies

3. **CHSP will provide SCAN specialists to coordinate consistent SCAN service and ensure continuity of care**
   - Implement SCAN case management program
     - Recruit and train sufficient staff to service increasing caseload of CHSP SCAN acute care patients (ER/inpatient/outpatient follow-up/court)
     - Project 1.5 FTE (optimal 1 full time with PT support for off hours)
   - Provide appropriate training by child abuse and neglect (CAN) experts
   - Provide appropriate supervision - MCRC
   - Ensure candidates have appropriate prerequisite experience - PNP
   - Ensure appropriate availability of staff
     - Phone access with 15-20 minutes response time - 24-hour service/7 days/week
     - On-site availability within 30 minutes - 24-hour service/7 days/week

4. **CHSP will ensure effective communication and provide patient accessibility to SCAN specialists and experts**
   - Implement cellular phone system integrated with current MCRC model
   - Develop internal/external tracking system for SCAN documentation and case management (i.e. photographs, video/audio tapes, forms etc.) to be coordinated by MCRC
   - Provide Fax capability with 24-hour access

5. **CHSP will ensure patient accessibility to CAN experts**
   - Ensure availability of appropriate CAN experts (MD, PNP) with recognized credentials as medical - legal witnesses
   - Ensure appropriate availability of staff
     - Phone access with 15-20 minutes response time - 24-hour service/7 days/week
     - On-site availability within 30 minutes - 24-hour service/7 days/week
   - Increase currently available MCRC CAN expert staff
     - MD - increase by .5 FTE
     - PNP - increase by .4 FTE

6. **CHSP will ensure appropriate pediatric expertise for all SCAN patients**
   - Provide timely access to specialty consultants as necessary for competent evaluation, diagnosis and management of SCAN
     - Orthopedic, Ophthalmology, Neurology, Radiology, Critical Care, Pathology, Forensic Medicine, Odontology

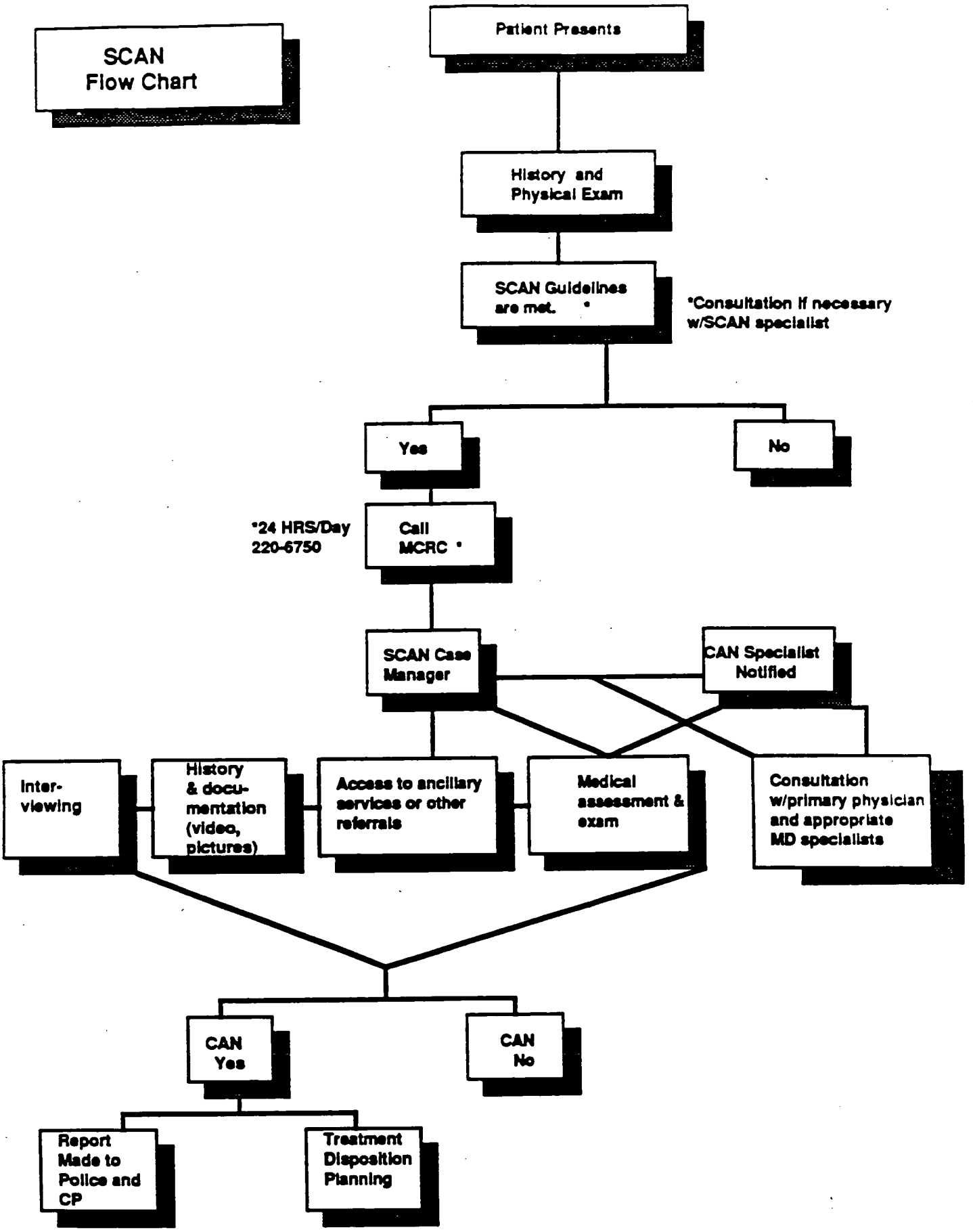
7. CHSP will provide appropriate training and resources hospital wide to ensure minimum standards of care for SCAN
   * Define minimum standards and guidelines for care
   * Collaborate with public relations to transform the work product of the SCAN Task Force into an on-going educational tool
   * Develop and implement process for hospital-wide/MD awareness
   * Provide internal training model for specific groups to include new employee orientation, unit specific training and outreach educational programs
   * Develop external training model to share the Task Force work product and recommendations to children's hospitals and programs nation-wide
   * Promote community/regional/national awareness of CHSP SCAN model and activities

8. **CHSP will ensure that appropriate standards of care are met for all patients entering the system**
   * Develop and implement a process for automatic referral to SCAN specialists (MCRC)
   * Develop and implement a process for automatic referrals to Child and Family Services
   * Develop and implement written guidelines and protocols to ensure consistent care at all service sites (includes sexual assault guidelines and protocol)
   * Provide arbitration by the SCAN team for any conflict in SCAN definition or patient care (to provide first for the safety of the child)
   * Provide a forum for system-wide education (responsibility of CHSP administration)

9. **CHSP will ensure that all SCAN patients will be identified in a timely fashion and appropriately referred for care**
   * Outpatient SCAN will be referred to MCRC
   * Selected units/personnel will receive additional training and resource development in the identification and management of SCAN patients

10. **CHSP will provide adequate resources for effective SCAN management**
    * Fourth floor will be designated as the med-surg units for noncritical care SCAN patients
    * Personnel
    * Video capability; including access to video surveillance if necessary
    * Access to colposcopy
    * Access to photographic equipment and support personnel
    * Others as defined

11. **CHSP will ensure quality of SCAN process**
    * Task Force members to develop and support SCAN steering committee
      - To ensure ongoing Quality Improvement
      - To "hold the gains"
    * SCAN data base to be established (explore existing systems and technology)
    * All patients evaluated for SCAN to be appropriately coded
      - Confidentiality and customer service impact must be studied
    * CHSP to remain committed to ongoing research in SCAN through support of the MCRC and associate programs


SCAN
Flow Chart
Patient Presents
History and
Physical Exam
SCAN Guidelines
are met. *
*Consultation if necessary
w/SCAN specialist
Yes
No
*24 HRS/Day
220-6750
Call
MCRC *
SCAN Case
Manager
CAN Specialist
Notified
Inter-
viewing
History
& docu-
mentation
(video,
pictures)
Access to ancillary
services or other
referrals
Medical
assessment &
exam
Consultation
w/primary physician
and appropriate
MD specialists
CAN
Yes
CAN
No
Report
Made to
Police and
CP
Treatment
Disposition
Planning

GUIDELINES ON WHEN TO CONTACT MCHC

(512) 220-5750

PHYSICAL ABUSE

Burns: suspicious pattern or unexplained burns

Fractures: without reliable, witnessed explanations (focus on children ≤3 yrs)
- long bones; single or multiple, mid-shaft or metaphyseal.
- -skull: complex, bilateral, multiple
- -ribs

Blunt abdominal trauma:
- -duodenal hematoma
- -pancreatic pseudocysts
- -bowel, spleen or liver laceration
- -mesenteric or retroperitoneal hematoma

Bruises:
- -in the very young child (≤ 9 months)
- -patterned : pinch, bite, grab, slap marks or loop/strap marks

Shaken Baby Syndrome:
- -subdural hematoma
- -retinal hemorrhage

All Unexplained CNS Insults/Injuries: (history does not fit the medical facts)
- -obtunded ,coma
- -seizures
- -Any CNS bleed in child <5 years excluding clear cut accidental circumstances.
- -+CT scan, +MRI scan, +skull fracture compatable with trauma.
- -unexplained apnea in infancy.

NON Accidental Poisoning

Pattern soft tissue injuries:
- - self defense wounds
- -cigarette burns
- -symmetrical injuries

Multiple injuries of various ages

Oral facial trauma

Lacerations indicative of child abuse

NEGLECT

Failure to Thrive

Medical Neglect
- -delay in seeking treatment
- -serious noncompliance

Drug use in pregnancy
- -Fetal Alcohol Syndrome
- -Cocaine

Injuries due to inadequate/failure to supervise

Cold injury

Cultural/parental/religious differences resulting in refusal of medically necessary care.

PHYSICAL EXPRESSION OF SEVERE PSYCHOLOGICAL TRAUMA

Conversion reaction
Anorexia nervosa inpatient <10 years
Suicidal gestures in which abuse is thought to be a contributing factor
Chemical addiction in patients < 12 years.

MUNCHAUSEN BY PROXY

Recurrent illnesses/findings not explained by medical diagnosis
Frequent visits to the ER and/or MD office for apparently innocuous complaints
Unexplained metabolic derangement suspicious for non accidental poisoning (salt, water, medication, overmedication)

SEXUAL

Suspicious genital and anal injuries
Childhood pregnancy (pregnant children <12 years)
Presence of sexually transmitted disease:
- -herpes
- -syphilis
- -HPV
- -HIV
- -gonorrhea
- -chlamydia

All patients who present as victims of familial sexual assault.
Presence of sperm and/or seminal fluid
Hymenal and perineal findings including:
- -laceration
- -large diameter of hymenal opening
- -bruising
- -warts
- -scarring

2. Acuity Response Guidelines

High Acuity Response Guidelines:

Intake Access:	24 hours/day; 7 days/ week [Intake Specialist]
MD Consultant Availability:	immediate [Child Abuse Specialist]
On Site MD Consultant Availability:	2 hours from intake [Child Abuse Specialist]
Documentation Availablity:	2 hours from intake [Includes Photodocumentation]

Intake Requirements:

The individual responsible for intake and frontline access for Child Abuse and Neglect consultation must fulfill the following requirements:

1. Experience in Child Abuse and Neglect [CAN] response systems
   - *medical*
   - *legal*
   - *pyschosocial*
   - *law enforcement*
   - *CPS*
2. Familiarity with medicolegal guidelines for managment of CAN
3. Ability to triage
4. Ability to manage the sensitive and confidential issues associated with CAN
5. Liason with the various professional communities

Child Abuse Specialist (MD)

The physicians designated as Child Abuse Specialist will comprise the following:

1. Child Abuse Training Program or Fellowship
2. Recognition by their peers as a Child Abuse specialist
3. Expertise in physical diagnosis and pattern recognition
4. Expertise in CAN case evaluation, management and recommendations
5. Recognized expertise as an expert witness
6. Expertise in the medicolegal management of CAN cases
7. Participant in the ongoing research and education in issues pertaining to CAN

Child Abuse Associate Specialist (MD)

The physicians designated as Child Abuse Associate Specialist will compromise the following:

1. Physicians in training in Child Abuse and Neglect - fellowship
2. Nurse specialist
3. MD with special interest in CAN with continuing education and special experience and training to qualify

Documentation Resources:

Program resources needed to support adequate and timely documentation include the following:

1. Photography services - photographer on call, photographic hardware, developing services, cataloging and retrieval process
2. Pediatric Pathology laboratory resources including Pediatric Pathologist
3. Pediatric Radiology services including Pediatric Radiologist
4. Case cataloging and data entry resources
5. Reporting services - clerical, transcription
6. Comprehensive current literature access

Moderate Acuity Response Guidelines:

Intake Access:	24 hours/day; 7 days/ week [Intake Specialist]
MD Consultant Availability:	immediate [Child Abuse Specialist]
On Site MD Consultant Availability:	24 hours from intake [Child Abuse Specialist or Associate]
Documentation Availablity:	24 hours from intake [Includes Photodocumentation]

Intake Requirements:
The individual responsible for intake and frontline access for Child Abuse and Neglect consultation must fulfill the following requirements:

1. Experience in Child Abuse and Neglect [CAN] response systems
   - *medical*
   - *legal*
   - *pyschosocial*
   - *law enforcement*
   - *CPS*
2. Familiarity with medicolegal guidelines for managment of CAN
3. Ability to triage
4. Ability to manage the sensitive and confidential issues associated with CAN
5. Liason with the various professional communities

Child Abuse Specialist (MD)
The physicians designated as Child Abuse Specialist will comprise the following:

1. Child Abuse Training Program or Fellowship
2. Recognition by their peers as a Child Abuse specialist
3. Expertise in physical diagnosis and pattern recognition
4. Expertise in CAN case evaluation, management and recommendations
5. Recognized expertise as an expert witness
6. Expertise in the medicolegal management of CAN cases
7. Participant in the ongoing research and education in issues pertaining to CAN

Child Abuse Associate Specialist (MD)
The physicians designated as Child Abuse Associate Specialist will compromise the following:

1. Physicians in training in Child Abuse and Neglect - fellowship
2. Nurse specialist
3. MD with special interest in CAN with continuing education and special experience and training to qualify

Documentation Resources:
Program resources needed to support adequate and timely documentation include the following:

1. Photography services - photographer on call, photographic hardware, developing services, cataloging and retrieval process
2. Pediatric Pathology laboratory resources including Pediatric Pathologist
3. Pediatric Radiology services including Pediatnc Radiologist
4. Case cataloging and data entry resources
5. Reporting services - clerical, transcription
6. Comprehensive current literature access

Low Acuity Response Guidelines:

Intake Access:	24 hours/day; 7 days/ week [Intake Specialist]
MD Consultant Availability:	immediate [Child Abuse Specialist]
On Site MD Consultant Availability:	7 days from intake [Child Abuse Specialist or Associate]
Documentation Availablity:	7 days from intake [Includes Photodocumentation]

Intake Requirements:
The individual responsible for intake and frontline access for Child Abuse and Neglect consultation must fulfill the following requirements:

1. Experience in Child Abuse and Neglect [CAN] response systems
   - *medical*
   - *legal*
   - *pyschosocial*
   - *law enforcement*
   - *CPS*
2. Familiarity with medicolegal guidelines for managment of CAN
3. Ability to triage
4. Ability to manage the sensitive and confidential issues associated with CAN
5. Liason with the various professional communities

Child Abuse Specialist (MD)

The physicians designated as Child Abuse Specialist will comprise the following

1. Child Abuse Training Program or Fellowship
2. Recognition by their peers as a Child Abuse specialist
3. Expertise in physical diagnosis and pattern recognition
4. Expertise in CAN case evaluation, management and recommendations
5. Recognized expertise as an expert witness
6. Expertise in the medicolegal management of CAN cases
7. Participant in the ongoing research and education in issues pertaining to CAN

Child Abuse Associate Specialist (MD)

The physicians designated as Child Abuse Associate Specialist will compromise the following:

1. Physicians in training in Child Abuse and Neglect - fellowship
2. Nurse specialist
3. MD with special interest in CAN with continuing education and special experience and training to qualify

Documentation Resources:

Program resources needed to support adequate and timely documentation include the following:

1. Photography services - photographer on call, photographic hardware, developing services, cataloging and retrieval process
2. Pediatric Pathology laboratory resources including Pediatric Pathologist
3. Pediatric Radiology services including Pediatric Radiologist
4. Case cataloging and data entry resources
5. Reporting services - clerical, transcription
6. Comprehensive current literature access

Carolyn Levitt, M.D., Director
Midwest Children's Resource Center
Fort Road Medical Building, Suite 200
360 Sherman Street
St. Paul, Minnesota 55102
(612) 220-6750

Midwest Children's Resource Center
Services and Consultation for Child Abuse

Midwest Children's Resource Center (MCRC) is a specialty center for child abuse services. A program of Children's Hospital of St. Paul, MCRC brings together a team of specialists who provide services and consultation upon referral from child protection and law enforcement agencies, physicians, therapists, attorneys and concerned parents.

Staff members at the center work closely with referral sources, e.g., legally mandated agencies, to facilitate involvement of key people in abuse cases, to promote sharing of information, to arrange case conferences for complex cases and to help in the management of high-risk cases. MCRC staff members emphasize the importance of working with local service providers to assist in building service systems for responding to the safety needs of abused children, and of creating treatment programs/options/alternatives for families.

MCRC's staff consists of a team of professionals who are skilled in the medical and psychological assessment of abused children. Heading the interdisciplinary team is Director Carolyn Levitt, M.D. Other staff includes child psychologists, pediatricians, nurse practitioners, a pediatric forensic pathologist, a child protection system specialist and legal counsel.

A full range of Children's Hospital pediatric specialists and subspecialists is available for consultation with MCRC staff members, as needed.

Evaluation services

Medical diagnosis and treatment

Medical diagnosis and treatment are provided both on a 24-hour emergency basis and for scheduled appointments. Services include medical evaluation, forensic medical consultation (pattern of injury and photographic documentation) and sexual abuse evaluation, as well as treatment of sexually transmitted diseases and pregnancy prevention.

Psychological assessment/treatment

Child psychologists, who are experts in child abuse, provide in-depth interviews and psychological evaluation, in addition to recommendations for type and extent of treatment. The psychological analysis of child abuse symptoms emphasizes the child's developmental level.

In addition, child psychologists provide consultation regarding problem cases and refer children to a network of experienced professionals and services. Some children are seen for ongoing therapy as MCRC caseload permits.

MCRC's Toll-free Professional Consultation Line
1-800-422-0879

Consultation services

Case reviews for medical, psychological and child protection service delivery

Cases may be referred for multidisciplinary review, to be performed by staff from areas of medicine, forensic pathology, child psychology, child protection and law. Staff members specialize in consulting about preschool children who are at high risk for abuse. The staff also is available to provide information on current case literature and research.

Pediatric forensic pathology consultation

The services of a pediatric forensic pathologist are provided for complicated law enforcement investigations or civil cases to document the cause, mechanism and severity of an injury. Neutral consultation is offered to assess medical data for the court or for either party in a criminal or civil case.

Toll-free professional consultation line

A service for professionals working in child abuse, the consultation line is answered 24 hours a day, 7 days a week. Physicians, child protection personnel, law enforcement officers, therapists, attorneys and others involved in protecting children can obtain immediate access to specialized staff at MCRC. The purpose of the service is to extend the specialty expertise at MCRC into other communities to assist in diagnosis, investigation and child protection services.

MCRC's Toll-free Professional Consultation Line
1-800-422-0879

Training

Training services

Professional educational programs are available for physicians, attorneys, law enforcement personnel, child protection personnel and mental health personnel. All staff members are available to speak about the center and their areas of expertise at workshops, conferences or small group meetings. Internships and fellowships are offered in pediatrics and psychology, focusing on child abuse and interaction with other professionals.

Specialized training in child abuse services

This training is designed for small groups of professionals who are interested in developing or expanding their knowledge and skills in medical evaluations, interviewing children, psychological assessment and treating abused children. Professionals participate in on-site teaching at MCRC with Carolyn Levitt, M.D., and other staff.

Expert testimony

Physicians and child psychologists are available to make court appearances as an expert witness regarding a specific evaluation or general professional testimony on medical, forensic or psychological aspects of child abuse.

Research services

A computerized data system assists in easily retrieving and analyzing data. MCRC staff members also are initiating studies in their specific areas of expertise. Data and research findings will be shared with community professionals and used collaboratively with other centers.

For reporting

As a professional, if you have reason to believe that abuse or neglect has occurred, a report must be made to your local child protection and/or law enforcement agencies.

1,000 : 92

"Financial Impact of DRG's on Abused Children" by B.M. Perry, J. Thomas, C. Rogers, and B. Jones, from *Restructuring Health Policy: An International Challenge* (1986) edited by John M. Virgo. Permission to reprint granted by the Atlantic Economic Society, Southern Illinois University at Edwardsville, Box 1101, Edwardsville, Illinois 6206-1102.

Chapter Nineteen

Financial Impact of DRG's on Abused Children

BRUCE M. PERRY,
JOYCE THOMAS,
CARL ROGERS,
BARBARA JONES

Introduction

Two-year-old Jennifer died. An autopsy revealed rib fractures, retineal hemorrhages, bulging fontanelle, and multiple tears of the liver, pancreas, and mesentery. This child was diagnosed as having "battered child syndrome." Prior to her death, she was hospitalized in the intensive care unit for 20 days; she was later transferred to an intermediate care unit for 15 days; she spent her final 60 days in a long-term care facility. The estimated cost for her hospital care exceeds $80,000. Other cases have resulted in bills over double that amount.

Fortunately most cases of child abuse do not end so tragically (although about 2,000 American children die each year as a result of maltreatment) [HHS, 1981]. Unfortunately, however, the hospital care required by abused, neglected, and sexually victimized children is frequently extensive—and expensive.

The subject of child maltreatment is emotionally charged, calling up feelings of outrage, revulsion, and disbelief toward perpetrators and warmth, nurturance, and protection toward victims. Increasingly, over recent years, societies around the world have mandated and codified the care of maltreated children. In the United States, increasing concern about child abuse has resulted in extensive new federal, state, and local legislation, rapidly expanding service delivery systems, and intensive research and advocacy efforts. These initiatives carry far-reaching implications—and heavy costs—not only for health care systems, but for mental health social service, educational, law enforcement, and judicial systems as well.

At the present time, it is virtually impossible to assess the full national economic impact of child abuse, neglect, and sexual victimization. Specific data are lacking. These problems weave throughout the social fabric, touching on institutions as diverse as the day care industry and the prison system, often unseen—even denied—but always costly. The economic implications of this problem cannot be ignored.

Recognizing that no one can adequately measure the human costs of child abuse, the purpose of this paper is to provide greater understanding of its impact from a hospital management and economic perspective. Even within this narrow focus, one is faced with a decidedly inadequate

data base. For example, national data concerning the role of hospitals in reporting child abuse and neglect are limited and often contradictory, and there is virtually no national data regarding hospitalization rates as a function of child maltreatment. Similarly, there is little site-specific information on the costs of medical services provided in these cases by health care centers.

Child Abuse Defined

The definition of child abuse, as legislated in the U.S. Child Abuse Prevention and Treatment Act (PL. 93-247), is "the physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of 18 years . . . by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby."

As can be inferred from this broad definition, making a diagnosis of child maltreatment is seldom easy. Such diagnoses take time, training, and experience--all high-priced "commodities." However, every state and territory in the country has enacted legislation making it mandatory for all health professionals to identify and report child abuse.

Types of maltreatment routinely seen in hospitals include physical abuse, medical neglect, nonorganic failure-to-thrive, "immediate danger" neglect, and sexual victimization. In each case, the clinician must make painstaking differentiations between non-accidental trauma and that which is accidentally incurred or results from infectious, neoplastic, congenital, or acquired metabolic disease. In cases of medical neglect, the clinician must determine if a child's poor health status is associated with parental ignorance, parental lack of concern about the child's needs, or parental inability to provide for those needs.

Child Abuse in the United States

The true incidence of child abuse in the U.S. is not known. Even with mandatory reporting requirements, it is generally acknowledged that identified cases make up only the tip of the iceberg. It has been estimated that 1 percent of all U.S. children under age 18 are abused or neglected annually [HHS, 1981]. The National Committee for the Prevention of Child Abuse estimated in 1983 that there are between two and four million cases of child maltreatment each year. It is estimated that each year there are at least 200,000 cases of physical abuse, 800,000 cases of neglect, 60,000 cases of sexual abuse, and an undetermined number of cases of emotional abuse and neglect. The National Association of Children's Hospitals and Related Institutions [1985] reports that 40 of its members have child abuse clinics or other special services. Over 150 specialized hospital-based services or programs have been developed in recent years [Clearinghouse of Child Abuse and Neglect Information, 1983].

By any yardstick, child abuse is clearly a massive problem, and as experience shows, it comes with a massive price tag.

Child Protection at Children's Hospital National Medical Center

Hospitals have been called gatekeepers for the identification of child abuse and neglect [Hampton and Newberger, 1983]. Increasingly, hospitals are compelled to accept the reality that, although child abuse requires intervention by a great many societal systems, the role of health care facilities is pivotal in that they often serve as the initial point of entry and decision making for victims and their families. Through the delivery of comprehensive, specialized services, hospitals also have a significant influence on case outcomes. This is particularly true for families at the lower end of the socio-economic scale who tend to use hospitals as their primary source of health care.

Children's Hospital National Medical Center (CHNMC) is a 268-bed, university-affiliated, private, not-for-profit hospital. CHNMC is by far the largest provider of pediatric care in the Washington, D.C. metropolitan area.

Community philanthropy has played a major role in providing money to meet the budget for current operations. The hospital receives no direct governmental support for operations. Some governmental grant funds are secured through competitive applications.

The hospital serves the District of Columbia, Southern Maryland, and Northern Virginia. Sixty-five percent of all admissions of District children are made at CHNMC. Outpatient caseloads are skewed even more heavily toward District residents, who tend to be from the lower end of the socio-economic scale. This results in significant financial burdens, since CHNMC cares for all children regardless of their ability to pay.

The hospital was among the early advocates for maltreated children, as well as a pioneer in the development of case management techniques. Since 1974, when the hospital established a specialized, multidisciplinary child abuse treatment unit, there has been a steady increase in demand for services and consultation. The hospital has a staff in a single unit specializing in physical and sexual abuse. This unit, the Division of Child Protection, is currently struggling to maintain its fiscal balance with a precarious combination of Medicaid and other third party reimbursements, local government contracts, hospital support, and a variety of relatively small contributions from private agencies and citizens.

The success of the division's treatment approach in halting the abusive cycle has been well demonstrated. Recidivism (i.e., repeated incidents of abuse of a child) occurs in less than 8 percent of the cases. This is a striking finding in view of reports in the research literature indicating that recidivism occurs in about 50 percent of cases in which no comprehensive intervention is made [White, 1977].

The Division's Caseload

Children seen by the division range in age from infancy through 18 years. Most reside in the District of Columbia, and at least 60 percent are from low income families. The average age of physically abused and ne-

glected children is about four years, while the average age of victims of sexual abuse is eight to nine years. At any given time, the caseload has over 200 families receiving ongoing services.

Children required hospitalization in 11 percent of the division's cases. Less than 2 percent of all sexual abuse intakes require hospitalization, while 25 percent of the physical abuse and neglect cases must be admitted, with most of these being physical abuse cases. Of the 85 children hospitalized in 1984, 29 percent required care in the burns/intermediate care unit; 24 percent were admitted to the orthopedics unit; and 14 percent were admitted to Intensive Care, with the remaining 33 percent cared for by other specialty and general medical units. Lengths of hospitalization ranged from one to 60 days.

The Costs of Medical Care

The economic aspects of hospital-based child abuse programs are difficult to examine on a national basis due to the paucity of available information. Given the many variables that infuse cases of abuse and neglect, it is even difficult to develop an economic profile for a children's program. For purposes of this paper, two different approaches to calculating costs are utilized. First, the medical care costs per patient are examined. Second, the costs of maintaining a specialized treatment and intervention program, such as the Division of Child Protection, within a hospital environment are studied.

Treatment costs, of course, depend on treatment needs, and these vary widely in cases of child abuse and neglect. However, using random samples of cases drawn from different treatment categories, total billable services provided to clients by both division staff and other hospital providers are computed. These figures reflect only the initial visits for outpatients and the initial hospitalizations for inpatients; follow-up services related to the initial trauma have not been included. Since subsequent services can be both extensive and costly, the following estimates should be considered very conservative.

For physical abuse and neglect cases managed on an outpatient basis, average initial charges were $227 per child. The average cost for initial outpatient services in sexual abuse cases was $257. Based on these averages, the total cost for initial outpatient medical care for division cases in 1984 was about $178,600.

Similarly, the average cost per child for inpatient services was $28,228. (For ICU cases, the average was $50,816; for children hospitalized in the burn unit, it was $23,525.) Therefore, total cost for initial inpatient services for division clients in 1984 was about $2,400,000.

Applying this experience to the limited national data available, the magnitude of the country's health care bill for caring for abused and neglected children begins to become clear. Based on the 1981 national study of the Incidence and Severity of Child Abuse and Neglect, it has been estimated that hospitals identified about 17,000 cases between May [illegible] and April 1980 [Hampton and Newberger, 1985]. Assuming that only 11 percent of these cases required hospitalization (CHNMC's current experience), this would mean that over 8,400 children are hospitalized annually for abuse and neglect. Using CHNMC's average cost of hospitalization ($28,000) the total national bill for these children's care would be approximately $240 million. Initial outpatient services for the remaining 68,500 cases (assuming an average cost of $250 each) would be in the neighborhood of $17 million.

These are very conservative estimates. They reflect only reported cases identified by hospitals, which make up only a small proportion of total cases. They include no follow-up care costs, nor do they take into consideration the expenses generated by children who leave the hospital only to go to long-term care facilities. Another view of the size of the problem can be seen by looking at the likely amount of service being provided by the 5,006 U.S. hospitals that give pediatric emergency care. If one assumes that, on an average, each hospital sees about 100 cases of child maltreatment per year and the hospitalization rates and cost figures are comparable to those of CHNMC, then the immediate medical care costs would be almost $1.7 billion.

In fact, basing projections on CHNMC's average costs may lead to significantly underestimated totals. There is evidence to suggest that hospitals with specialized service units find it necessary to admit a smaller proportion of abused and neglected children, and those children who are hospitalized tend to have shorter stays. At Boston's Children's Hospital Medical Center, hospitalization rates for physically abused children exceeded 50 percent, with an average length of stay of 29 days before a special program was established. Afterwards, rates of hospitalization dropped to less than 33 percent, and the average length of stay dropped to 17 days [Newberger, *et al*, 1973].

At CHNMC, hospitalization rates in cases of physical abuse and neglect is about 25 percent, and the average length of stay is slightly under 18 days.

Although the foregoing suggests that specialized, comprehensive intervention programs may actually lead to reduced direct health care costs, such programs are not inexpensive in their own right. The total Fiscal Year 1985 budget for the division is $927,579. Such programs are labor intensive, with direct personnel costs, excluding purchase services, accounting for 74 percent ($688,976) of the total operating budget.

The Costs of Comprehensive Service Programs

Fifteen years ago, specialized, hospital-based intervention and treatment programs were virtually unknown. Today, they embody the state of the art for caring for abused, neglected, and sexually victimized children, and, as is the case with any breakthrough in the health care field, their

numbers are growing. To add another dimension to the national cost picture, it may be helpful to consider what the country's bill would be if all children's hospitals or all hospitals providing pediatric emergency care had specialized programs.

As was noted earlier, the division's annual operating budget totals slightly over $927,000. If such fully-articulated programs were initiated in all 126 U.S. children's hospitals, the total bill would be over $115 million. Even if one considers that CHNMC is one of the larger children's hospitals and that many of the others could probably operate adequate programs for half the cost, the total would still be about $58 million. Using the earlier conservative estimates of hospital medical care costs, it is estimated the U.S. is spending a minimum of $133 million—and probably closer to $500 million—each year for hospital-based care of abused, neglected, and sexually victimized children. And that is only for a narrowly defined range of services. It excludes the costs of all long-term care and all remedial care, not to mention the enormous expenses incurred by the law enforcement, judicial, and social service systems.

Paying the Bill

Clearly, the costs for giving abused children the care that society mandates and that ethics demand are high. Unless viable ways are found to underwrite these costs, in whole or in part, the drain on hospital resources will become increasingly untenable.

Little information is available concerning how specialized programs are supported in other hospital settings across the country. Certainly, third party reimbursement and self-pay mechanisms are used universally to help cover the costs of medical treatment of abused children, just as they are for other patients. Beyond that, other similar programs rely on local government contracts, federal grants and contracts, private philanthropy, and direct hospital subsidies.

Fees for service, whether reimbursed through third parties or self-pay, less than one-quarter of the overall budget. (Full reimbursement of all billable services would raise the percentage to almost one-third.) However, the fee for service system is based on a medical model which is inadequate to address the full range of services needed by abused and neglected children. These include such activities as case coordination and case liaison (routinely, as many as eight different outside agencies may be involved with a case from the very beginning).

Based on a study completed by the CHNMC Division of Child Protection in 1982, it has been estimated that, for every hour of direct client mental health service, over one hour is spent in coordination and liaison activities. Similarly, the costs of preparing a child for court, providing court accompaniment, or providing material testimony in judicial proceedings are not routinely reimbursable. Other associated (and unreimbursed) costs relate to collecting and maintaining the chain of evidence (e.g., photographs of injuries, preparation of reports, and so forth) and to maintenance of trauma indices and other records.

Other built-in limitations of the fee-for-service system in these cases include the fact that most private insurers will only reimburse mental health services at the rate of 50 percent of charges. The remainder becomes a self-pay item for the patient or is treated as forgiven debt. Further, the introduction of "caps" on reimbursable length of stay by Medicaid in many states can result in extensive inpatient costs that are not covered by any third party. State and local agencies also practice another "cost-saving" mechanism at the expense of hospitals: Usually, when a child is placed in protective custody, his or her health care costs become the state's responsibility. The child is usually enrolled in Medicaid to cover these costs but, in many instances, enrollment is delayed until the child is ready for discharge, leaving behind large inpatient bills and no source of reimbursement.

Impending changes in the mode of hospital reimbursement under Medicaid and other third-party insurers, primarily the implementation of Diagnosis Related Groups (DRG's), will only exacerbate the fiscal problems of abuse and neglect programs. Under the DRG's, in most instances, a diagnosis of child abuse will be secondary to the child's primary, presenting medical problem. Therefore, child abuse services will not be directly reimbursable. Further, only recently have efforts begun to consider the unique needs of pediatric patients in computing the average costs of treatment for DRG's. The unique situation of specialized child abuse programs has yet to be addressed. At present, the costs of such programs are not even indirectly covered in the primary DRG reimbursement rates.

One particularly distressing outcome of this situation is that hospitals in areas most in need of specialized service programs (urban inner-cities and other poverty areas) will be least likely to be able to afford them. The payor-mix for these hospitals is highly skewed toward public insurance, primarily Medicaid, so the impact of the DRG's will be more immediate and profound. The payor-mix also makes it more difficult for these hospitals to recoup lost revenues through increased self-pay charges. In short, it appears that DRG's will present a strong disincentive to hospitals to offer specialized child abuse services.

Problems with the fee-for-service system itself are matched by problems inherent to the population being served. First, families near or below the poverty level are disproportionately represented in the identified abuse and neglect population. This is primarily a function of four factors: (1) the precipitating role of economic and other life stresses in the occurrence of abuse; (2) the tendency of middle and upper-class families to use private pediatricians who, as a group, make relatively few reports of abuse; (3) the tendency of poverty-level families to rely on hospitals as their primary source of health care; and (4) the relatively high level of involvement these families have with other official systems. These families are substantially

less able to pay for services than the hospital population as a whole.

A second problem is that many of the families encountered in child protective work are unlikely to comply with the basic assumption of the fee-for-service system, i.e., that people will pay rather than be refused service now or in the future. To use an obvious example from the child protection caseload, medically neglectful parents are unlikely to be motivated to pay for services that they did not want or intend to get for their child in the first place.

Another source of revenue is local government contracts. These funds help underwrite the team's consultation and liaison functions, provide full reimbursement for court-ordered psychological and psychiatric evaluations, and help cover the costs of specialized training for law enforcement and social services personnel, and similar activities.

Federal grants, as a source of income, are limited and rarely available for continuing clinical services, targeting basic or applied research, demonstration programs, or training efforts. Even when grant funds can be used to cover some aspects of general operating costs, they usually require substantial additional staff effort on some new endeavor. Still, the usefulness of these funds should not be underestimated. All of CHNMC's initial specialized child protection services were federally funded demonstration projects.

Private philanthropy through foundation grants, private donations, and other fund-raising activities, can fund substantial percentages of a program. Sixty-five percent of CHNMC's program is covered by these sources. That leaves about 35 percent of its operating expenses that must be subsidized by the hospital. Comparable budget breakdowns for other programs across the country are not available, but anecdotal information indicates that most programs are even more dependent on their host hospitals.

Looking to the future, it appears that supplemental revenues for specialized child abuse and neglect programs may become available from two relatively new initiatives: Victims Compensation Programs and state-based Children's Trust Funds. So far, 40 states have some form of compensation program to help cover the medical and mental health care expenses of crime victims. Unfortunately, 31 of these states specifically exclude victims of intra-family crime. Most state programs require a minimum loss of $100 and establish a maximum recovery limit (as low as $1,500) [National Organization of Victim Assistance, 1984].

The U.S. 98th Congress enacted the Victims of Crime Act of 1984, which authorizes grants to states to support direct victim compensation, as well as treatment programs serving victims, with specific emphasis on services in cases of sexual assault and child abuse. It is too early to gauge how much these efforts may benefit hospital-based special service programs, but the possibility is there.

Children's Trust Funds may bring relief from another direction. Currently, 14 states have established such funds, which are intended to support the primary prevention of child abuse and neglect. About half of these states raise funds through a voluntary checkoff on the state income tax return. The others attach a surcharge to marriage licenses, birth certificates, and divorce filings. The size of the funds vary from state to state, but most raise between $100,000 and $250,000 per year [National Center on Child Abuse and Neglect, DHHS, 1984].

In 1984, Congress enacted a challenge grant program to spur more states to develop Children's Trust Funds. States may now receive matching funds for up to 25 percent of the money they raise or 50 cents per child resident, whichever is less. While it is doubtful that these funds will ever become a major source of support for medical care or specialized hospital services, they may well offer supplemental support for some program components, such as parent and public education, that are now provided without reimbursement.

Summary

In summary, comprehensive hospital-based services and programs serving abused, neglected, and sexually victimized children are expensive to operate and, if offered in all appropriate health care facilities, could cost somewhere between $2.25 and $4.5 billion per year on a national basis. Neither existing reimbursement mechanisms nor alternative sources of funding are likely to offset more than about two-thirds of these costs.

Current trends suggest that these programs may, in the near future, become less self-sufficient, primarily due to changes in reimbursement systems. Given these rather dismal facts, it may be legitimately asked whether hospitals should continue to maintain or to develop such specialty programs. The moral and ethical, not the economic, answer to this question is clearly yes. Specialized multidisciplinary teams have clearly been demonstrated to improve diagnosis and medical decision making, to reduce the likelihood of subsequent trauma, and to increase the likelihood of optimal recovery of child victims.

An alternative question may very well be: Are not these programs more cost-effective? There are additional and strong fiscal factors which may cause institutions to decide that they can ill afford not to develop and maintain such programs. Specifically, despite their costs, such programs may be cost effective both on a societal and an institutional basis due to their contributions to cost containment. Further, as the frequency of malpractice litigation in this area continues to rise, the role of specialized programs will become more crucial in avoiding circumstances which lead to legal actions.

Cost containment has been, and continues to be, a source of major concern for hospitals in general and children's hospitals in particular. From a national health care policy perspective, it should be noted that specialized hospital-based intervention and treatment programs help con-

tain costs by improving the early identification and diagnosis of cases, by reducing inpatient care days, and by improving discharge planning. With the cost of hospitalization in an intensive care unit approaching $1,000 per day, early identification and intervention through outpatient care can substantially reduce the overall costs.

For example, if a specialized program reduces hospitalizations by a mere 4 percent per year of total intakes, the savings more than offset program costs. Similarly, when one considers that the cost of long-term care averages $200 per day, a program that reduces the likelihood of serious abuse leading to a need for long-term care by a mere three children per year (assuming an average care length of five years) more than pays for itself. It has been estimated that the total care costs for a seriously emotionally disturbed child will exceed $600,000 in current dollars over the child's life span [Greenspan, 1984]. If the presence of a specialized intervention program reduces the likelihood of need for such care for only two children per year, the program can be shown to be cost effective from a national health care perspective.

These arguments focus on the national perspective, however, the presence of such programs may very well be cost-efficient at the industrial level. Both CHNMC's experience and that of Boston Children's Hospital suggests that such programs can reduce hospital stays by an average of 10 days. For CHNMC, this equates to annual savings of approximately $255,000 just based on average occupancy charges. With the onset of DRG's as the major mechanism of reimbursement, such savings will become increasingly important.

Moreover, inappropriate hospitalizations and, particularly, admissions for purely social reasons can be drastically reduced. A drop of over 16 percent in hospitalization rates of children for abuse or neglect following establishment of a specialized program has been reported [Newberger, *et al*, 1973]. Anecdotal information from selected other settings without specialized programs suggests that perhaps 50 percent of their admissions are for purely social reasons. Using the Newberger figure as the base, CHNMC would have hospitalized a minimum of 14 additional children in 1984 if a specialized program did not exist. This would have cost somewhere between $50,000 and $300,000 (depending on length of stay and services provided). Because purely social admissions are not routinely reimbursable, these savings can have a significant impact on overall hospital fiscal operations.

A final direct cost savings results from improved discharge planning through closer and better coordination with public protective services and court agencies. Experience suggests inability to identify and arrange appropriate care or custody placements for children who are ready for discharge or transfer can lead to additional hospitalization costs as high as $40,000 per case.

Indirect cost savings for the institution accrue primarily as the result of improved speed of service delivery and substitution of [illegible] time in many aspects of case management with the time of other, less expensive professionals. Although difficult to estimate, savings in this area can be as much as $60,000 per year.

In addition to the cost-containment benefits of hospital-based specialty programs, such programs may also play an important role in reducing the civil liability of hospitals for malpractice. Increased litigation, primarily focusing on failure to diagnose, report, or treat child abuse, is a reality. With awards and settlements reaching $600,000, inappropriate management of cases can lead to substantial financial hardship for hospitals serving children [*Time*, 1972].

Conclusion

Maltreatment of children constitutes a major problem with important ramifications particularly for hospitals. Increasingly, society both expects and demands that hospitals provide optimal quality care to these children and their families. Yet, as has been seen few sources of funding for such care exist. Current trends suggest that the gap between resources to support hospital-based services and the need for such services will continue to widen over the next decade unless remedial steps are taken. Increasing numbers of cases are being identified, including more relatively severe cases. At the same time, there is diminishing support for services through reimbursement mechanisms. This situation places hospitals that care for abused children in an increasingly precarious position.

A major obstacle to constructive, rational policymaking and planning is the lack of accurate information about the problem itself and about its impact on health care providers. The national data on the incidence of gonorrhea are better than on child maltreatment. Research must focus on the fiscal as well as the human costs of the child abuse problem and must explore the efficacy of alternative intervention models and methods of addressing the service needs of this population within the health care system as a whole.

Although development of a substantially improved knowledge base is essential, immediate action is needed now. Reimbursement mechanisms, such as DRG's, must be modified to ensure recognition of the special needs of abuse victims and support for specialized services and programs which ultimately reduce the total costs of care.

Public policy should also support the regionalization of health care for this population. That is to say, appropriate hospitals in a given geographic area should be identified as specialized treatment centers, with surrounding hospitals and health care facilities serving as sources of referrals and transfer cases. The costs of care should be shared among all institutions: protective service agencies, the police, and the courts.

Similarly, the development of more formal collaborative partnerships between hospitals and public protective service agencies can lead to sub-

stantially reduced costs through decreased hospitalizations for nonmedical reasons and improved discharge planning. Such collaborative partnerships should be both promoted and fiscally supported at the local level.

Other, more inventive changes could also improve the overall picture. As a matter of public policy, parents adjudicated as abusive or neglectful could be required, as part of the overall court action, to pay, within their financial means, for their children's health and mental health care.

The total health care costs for abused, neglected, and sexually victimized children in the United States, considering both short- and long-term care, undoubtedly are in the billions. One can only speculate about what the total national costs of this problem are, given the extensive involvement of so many other social systems and the likely long-term emotional and behavioral consequences of abuse. Health care providers, and hospitals in particular, should continue to play a pivotal role in addressing this problem.

References

Clearinghouse on Child Abuse and Neglect Information, *National Child Abuse and Neglect Programs List*, Arlington, VA, 1983.

Department of Health and Human Services (HHS), *National Incidence and Severity of Child Abuse and Neglect*, Publ. No. (OHDS) 81-30325, 1981.

E. H. White and Company, *Final Report: Formative Evaluation of 12 NCCAN Treatment Demonstration Centers*, II, National Center on Child Abuse and Neglect, San Francisco, CA, 1977.

S. Greenspan, *Children, Youth, and Families: 1983—A Year-End Report on the Activities of the Select Committee on Children, Youth, and Families*, U.S. House of Representatives, Washington, DC: GPO, 1984, pp. 20-1.

R. Hampton and E. Newberger, "Child Abuse Incidence and Reporting by Hospitals: Significance of Severity, Class, and Race," *American Journal of Public Health*, 75, No. 1, January 1985, pp. 56-60.

———, *Hospitals as Gatekeepers: Recognition and Reporting in the National Incidence Study of Child Abuse and Neglect*, National Center on Child Abuse and Neglect Grant 90CA841, 1983.

National Association of Children's Hospitals and Related Institutions (NACHRI), Personal Communication, January 1985.

National Center of Child Abuse and Neglect, *Children's Trust Funds*, HHS, Washington, DC, 1984.

National Organization for Victim Assistance, *Victim Rights and Services: A Legislative Directory*, Washington, DC, 1984.

E. Newberger, J. Hagenbuch, N. Ebeling, E. Colligan, J. Sheehan, and S. McVeigh, "Reducing the Literal and Human Costs of Child Abuse: Impact of New Hospital Management System," *Pediatrics*, 51, No. 5, 1973, pp. 840-48.

Time, November 20, 1972, p. 74.

Part Two

Quantitative Methods for Marketing and Corporate Strategic Planning

BIBLIOGRAPHY: HOSPITAL BASED RESPONSES TO CHILD ABUSE AND NEGLECT

American Academy of Pediatrics Committee on Hospital Care. (1987) "Medical necessity for the hospitalization of the abused and neglected child." Pediatrics. Vol 79 (2), p.300.

Bross, D.C., Krugman, R.D., Lenherr, M.R., Rosenberg, D.A., and Schmitt, B.D. (1988) The New Child Protection Team Handbook. New York: Garland Publishing.

Child Abuse Protection Center. (1979) Child Abuse and Neglect Protocol for Hospital Child Protection Teams. 1979.

Cultural issues and concerns. (1987) ICW Network. September-October, 2, (2), 1-2.

Gill, F.T. (1989) "Caring for abused children in the emergency department." Holistic Nurse Practitioner. Vol 4 (1), pp.37-43.

Green, Arthur H. (1983) "Hospital based intervention in child abuse." Resident and Staff Physician. Vol 29 (2), pp. 76-80

Hampton, R.L., & Newberger, E.H. (1988) Child abuse incidence and reporting by hospitals: Significance of severity, class and race. In G.T. Hotaling, D. Finkelhor, J.T. Kirkpatrick & M.A. Strauss (Eds.). Coping with family violence: Research and policy perspectives. Sage Publications, Newbury Park, California.

Kaufman, K.L., Johnson, C.F. & Cohn D. Hospital approaches to the prevention of child abuse. In D. Willis, E.W. Holden & M. Rosenberg (Eds.). Child abuse prevention. in press, John Wiley & Sons, New York.

G. Morrow. (1988) Residency training in management of child abuse. Pediatrics, 82 (3), 513-514.

Multidisciplinary and interdisciplinary teams: A bibliography. April, 1992. Clearinghouse on Child Abuse and Neglect Information, Clearinghouse on Family Violence Information.

National Center on Child Abuse and Neglect User Manual Series. (1980) Guidelines for the Hospital and Clinic. DHEW publication No. (OHDS) 80-30167, 1980.

New York State DH/DSS. Sexual abuse and maltreatment of children: Identification and management in hospitals and clinics. Official guidelines of the State of New York Department of Health and Department of Social Services.

New York State DH/DSS. Suspected child abuse and neglect: Identification and management in hospitals and clinics. Official guidelines of the State of New York Department of Health and Department of Social Services.

Perry, B.M., Thomas J., Rogers C. & B. Jones. (1986) Financial impact of DRG's on abused children. In J.M. Virgo (Ed.), Restructuring health policy: An international challenge. International Health, Economics and Management Institute, Edwarsville, Illinois.

Taylor, D.K. & G. Beauchamp. (1988) Hospital-based primary prevention strategy in child abuse: A multi-level needs assessment. Child Abuse and Neglect, 12, (3), 343-354.

White, K.M., Snyder, J., Bourne, R. & Newberger, E.H. (1984) Hospital Training on Family Violence. Boston, Massachusetts: Children's Hospital.

Woolf, A., Taylor, L., Andolsek, K., Dubowitz, H., De-Vos E., & Newberger E. (1988) What residents know about child abuse: Implications of a survey of knowledge and attitudes. American Journal of Dis. Childhood, 142 (6), 668-672.