

**STATE OF MICHIGAN**

**GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT**

**Medical Child Abuse**

**A Collaborative Approach  
to Identification, Investigation,  
Assessment and Intervention**

**GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT**



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# Table of Contents

Part One – Introduction .....	1
Part Two – Identification .....	3
Part Three – Investigation .....	5
• Children’s Protective Services	
• Comprehensive Medical Assessment	
Part Four – Post-Investigative Actions.....	9
• Additional Evaluations	
Part Five – Permanency .....	12
Appendix A – The Medical Resource System.....	13
Appendix B – Clinical Evaluations Versus Forensic Evaluation .....	14
References .....	15

## MEDICAL CHILD ABUSE

### A COLLABORATIVE APPROACH TO IDENTIFICATION, INVESTIGATION, ASSESSMENT AND INTERVENTION

#### PART ONE

#### INTRODUCTION

The purpose of this publication is to present an updated multidisciplinary approach that guides various professionals through the identification, investigation and assessment of and intervention in cases involving suspected Medical Child Abuse<sup>1</sup> (MCA). This term is used to describe a form of child abuse in which a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of the child's parent or other caretaker. A parent/caretaker may exaggerate, fabricate (lie about), or cause symptoms of illness that will lead to unnecessary medical treatment of the child. Parents/caretakers may present a convincing but deceptive medical history that persuades medical professionals to provide unnecessary medical interventions. Thus, medical providers may become unwitting instruments of the abuse by performing unnecessary surgeries, diagnostic procedures and other medical treatments based upon the parent/caretaker's false or exaggerated reports. Medical Child Abuse is a diagnosis recognized and supported by the American Board of Pediatrics.

The impact of Medical Child Abuse on the child who is the victim of it may include physical and psychological harm. Children who are victims may experience the deterioration of an existing medical condition because of deliberately neglected treatment for a genuine illness or may acquire medical problems after invasive diagnostic procedures and/or surgeries. All of these children suffer harm; some may suffer significant long-term harm or permanent disability from their maltreatment; some children die.

The psychological mechanisms that cause a parent/caretaker to harm a child in this way are not a factor when making a diagnosis of Medical Child Abuse, but may need to be considered when deciding about interventions (i.e. removal of the child, termination of parental rights or reunification of the family).

Many cases of Medical Child Abuse go undetected because caregivers are skilled at deceiving the medical community. Accordingly, the coordination and collaboration of several disciplines and agencies is essential for identifying and responding to cases of suspected Medical Child Abuse. Each discipline should approach these cases from its own area of expertise with the common goal of ensuring the safety of children who are victims. This publication describes the role of each discipline and the manner in which the various professions should coordinate and interact. It is organized chronologically, using the time frame common to the detection and management of these cases.

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<sup>1</sup> Previously known as Munchausen By Proxy Abuse, Pediatric Condition Falsification and Factitious Disorder by Proxy.

Identifying and responding to this complex form of child abuse requires a carefully coordinated multidisciplinary intervention. This document is not a substitute for professionals' knowledge of Medical Child Abuse from the perspective of their disciplines. Rather, this publication is meant to serve an integrative and coordinating function to help professionals understand their roles. Coordination and collaboration by several disciplines and agencies is essential for identifying and responding to cases of suspected Medical Child Abuse with the common goal of ensuring the safety of the child victims. A list of selected references is included at the end of this document.

## **PART TWO**

### **IDENTIFICATION**

A primary medical provider is typically in the best position to initially detect and report suspected MCA. However, family members, neighbors, teachers and others may also report concerns related to abnormal/excessive medical care to Children's Protective Services (CPS). Detection is difficult and dependent on recognition of the warning signs that should trigger suspicion.

#### **WARNING SIGNS OF MEDICAL CHILD ABUSE**

The warning signs listed below are not diagnostic on their own and are not necessarily exclusive to Medical Child Abuse. However, when several warning signs exist, the primary medical provider is responsible for recognizing that the child may be at risk of harm and needs to consider the possibility of MCA. The warning signs include the following:

- There is a continuing discrepancy between the medical history of the child provided by the parent/caretaker and the medical provider's clinical assessment of the child.
- A child has one or more persistent and unexplained medical problems that do not respond to standard treatment.
- There are physical or laboratory findings which are unusual, inconsistent with history or clinically impossible.
- A highly attentive parent/caretaker is unusually reluctant to leave his/her child's side.
- A parent/caretaker appears to thrive on the attention given to the child's lack of response to medical treatment.
- A parent/caretaker appears to be abnormally calm in the face of complications in the child's medical course.
- A parent/caretaker insists that the medical provider do more invasive procedures, demands second and third opinions and gets angry when demands are not met.
- A parent/caretaker is not relieved or reassured when presented with negative test results and resists having the child discharged from the hospital.
- The parent/caretaker may work in health care or have unusually detailed medical knowledge.
- The signs and symptoms of a child's illness do not occur in the parent/caretaker's absence or are not witnessed by other individuals such as medical providers, family members, friends, teachers, etc.
- The child has extended absences from school despite reassurance that the child can return to normal activity.
- There is a family history of other children with similar unexplained illness or death of a sibling.
- A parent/caretaker gives a history of having symptoms similar to the child's illness.

When a medical provider, or other person, recognizes that the child may be a victim of Medical Child Abuse and is at risk of harm, a report should be made with CPS by calling (855) 444-3911.

If a medical provider is uncertain whether to file a report with CPS and would like to discuss concerns about a patient or family, the provider may contact the regional Michigan Department of Human Services Medical Resource System (MRS) provider. See Appendix A. The medical provider and MRS personnel can discuss the medical provider's concerns and MRS personnel can assist the medical provider in understanding Medical Child Abuse.

Reviews of medical records concerning Medical Child Abuse are not a part of the DHS Medical Resource System contract; however, MRS personnel will facilitate the review of medical records in such cases.

The review of medical records cannot occur until a report is filed with CPS and a request for review of the records is initiated. Health Insurance Portability and Accountability Act (HIPAA) regulations require CPS involvement prior to review of a child's medical records without parental consent.

Upon initiation of the review of medical records, a meeting involving the CPS reporting source (if a medical provider), the child's primary care provider, CPS, and the reviewer is strongly recommended. This meeting will serve to clearly define the concerns that generated a suspicion of Medical Child Abuse, the means by which the safety of the child will be ensured by CPS, the interventions planned by medical providers, the party providing the comprehensive record review, and a time frame for completion of the record review.

This process may occur on an outpatient basis while the child remains in custody of the caregiver if CPS and medical personnel are satisfied that the safety of the child has been properly addressed.

**Key questions to be answered by the primary medical provider:**

- Can all of the child's symptoms be accounted for by a known medical condition?
- Are there inconsistencies between the medical provider's clinical assessment of the child and the history provided by the parent/caretaker?
- Is there objective evidence (e.g., positive test results) that the child has the signs/symptoms reported by the parent/caretaker?
- Is there evidence that the child's parent/caretaker has provided false information?
- Has treatment for the child been based on objective evidence for an illness or condition or has it been based on parental report of symptoms and demands?
- Has any member of the medical staff witnessed the child's symptoms?
- Have other family members or the child's teachers verified any of the child's symptoms when asked without the parent/caretaker present?
- Has the child failed to respond to standard medical treatments?
- Does the child's parent/caretaker insist on more tests and/or treatments?
- Does the child's parent/caretaker refuse to accept assurance that the child is well?
- Does the child's parent/caretaker resist having the child discharged?

## PART THREE

### INVESTIGATION

Those involved in a Medical Child Abuse investigation should be aware that there is often a lack of consensus among medical providers regarding the diagnosis of Medical Child Abuse. This should *not* be grounds for closing an investigation without further assessment. In many cases, parents who engage in this form of abuse are effective at rallying allies or locating one or more providers who are vulnerable to their deceptions rather than accepting the possibility of Medical Child Abuse.

#### A. CHILDREN'S PROTECTIVE SERVICES (CPS)

The CPS investigation begins at assignment of the complaint received. CPS must first determine the child's immediate safety in accordance with CPS policy and procedure. In some cases, CPS may delay notifying the person responsible for the child's health or welfare of the allegations of Medical Child Abuse, if that notification would compromise the safety of the child or the child's siblings, or the integrity of the investigation.<sup>2</sup> When necessary, the order in which investigative steps occur can be varied to accommodate the specific needs of the case. Within this framework, investigators can select approaches that match their needs, the safety of the children and the specifics of individual cases. The steps in the investigation will typically include the following:

1. Consulting with a Child Protection Team.<sup>3</sup>

This consultation should be a team meeting to plan for and determine:

  - The immediate safety of the child.
  - The possible involvement of additional team members and law enforcement.<sup>4</sup>
  - The extent of medical review needed.
  - The need for a planned hospitalization.
2. Obtaining medical and other records regarding the child and the family.
  - Provide records to medical record reviewer.
3. Completing a medical record review.
4. Completing CPS investigative requirements.
  - Interview children.
  - Interview parents.
  - Visit the scene/home.
  - Make collateral contacts.
    - o Teacher/school.
    - o Day care providers.
    - o Other medical or mental health providers.
5. Determining CPS case disposition.
  - Preponderance of evidence (greater than 50 percent).

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<sup>2</sup> See MCL 722.628(8)

<sup>3</sup> A medically directed multi disciplinary team (involving DHS, law enforcement, a prosecuting attorney, and community professionals) that evaluates suspected child abuse and neglect.

<sup>4</sup> See MCL 722.623 and 722.628

- Type of abuse or neglect.
  - Risk level (low/moderate/high/intensive).
  - Need for legal involvement.
6. Providing for services when abuse or neglect is confirmed.
- Psychological evaluations.
  - Therapeutic services.
  - Substance abuse evaluations/services.
  - Developmental assessments.
  - Other services as determined.

When CPS receives a complaint from a medical professional, an additional medical record review may not be necessary. Using the evidence provided by the medical staff and other evidence obtained throughout the investigation, CPS may have a preponderance of evidence to open a case and service the family.

If the reporting source is not a medical professional, CPS can provide medical records to its own local medical professionals to assist with the dispositional findings.

On rare occasions, CPS may seek out a Comprehensive Medical Assessment by using a medical provider experienced in assessing Medical Child Abuse.

Ongoing consultation between CPS and the providers of the Medical Resource System should continue throughout the investigation.

## **B. COMPREHENSIVE MEDICAL ASSESSMENT:**

### 1. Obtaining Medical Records During the Investigation

CPS may request medical and mental health records without asking parents to sign releases. Michigan law allows the Department of Human Services (DHS), in the course of an investigation into suspected child abuse or neglect, to obtain medical records and mental health records without a court order when such records are pertinent to an investigation of child abuse or neglect.<sup>5</sup> If records are not released, despite this statutory authority, it may be necessary to seek a court order to obtain them. In order for DHS to seek a court order, it must file a child protection petition with the family court.

Information from medical and mental health records is frequently necessary to complete a CPS investigation, to provide information to the court or to develop a more comprehensive services plan in a CPS case. The Child Protection Law, the Public Health Code (1978 PA 368, MCL.333.2640 & 333.16281) and the Mental Health Code (1974 PA 258, MCL 330.1748a) provide the legal authority and obligation for these providers to share their records with CPS, even without the client's consent. If records requested verbally are not forthcoming from providers, CPS is to make the request in writing, using the Children's Protective Services Request for Medical Information form (DHS-1163-M) or Children's Protective Services Request for Mental Health Information form (DHS-1163-P). If the written request is still denied by the provider, the local office is to send a copy of the denied request to the CPS program office in Lansing. The CPS Program Office will then contact the Department of Community Health for assistance in obtaining the needed records. In an emergency, the local office CPS unit must

<sup>5</sup> See Public Health Code, MCL 333.16281(1) and MCL 330.1748a(1)

seek the assistance of the local prosecuting attorney and family division of circuit court to obtain records which are needed to protect the child or complete an investigation.<sup>6</sup>

When a court order must be requested to obtain medical records, the CPS worker should discuss the case with the DHS attorney and the critical members of the medical team. Ideally the DHS attorney meets with the Child Protection Team and, based on the medical information, provides legal guidance as to whether the evidence is sufficient to file a petition and obtain a court order for the remaining medical records, when needed.

Upon the filing of a petition, the court has the authority to order an evaluation of a child by appropriate medical and psychological experts and the release of medical records to CPS.

## 2. Medical Record Review

A medical provider experienced in assessing Medical Child Abuse should be utilized to complete a comprehensive medical review. The review should include the medical records from all medical providers, hospitals, clinics, and laboratories that provided medical treatment to the child. Insurance companies may be contacted to obtain a complete list of all health care providers and a list of medications prescribed.

The following are essential elements of the medical review:

- The medical record reviewer should develop a timeline of the child's medical care.
- The reviewer should document whether members of the medical staff have witnessed the signs/symptoms reported by the suspected parent/caretaker.
- The goal of the medical review is to determine if a medical condition actually exists or if the reported symptoms are exaggerated, fabricated or induced. The treating medical provider(s) should be contacted for clarification of symptoms and treatment decisions. It should be noted that having a medical condition does not rule out Medical Child Abuse.

Ongoing consultation with the Child Protection Team and the Medical Resource System providers should continue throughout the investigation, regardless of who reviewed the medical records.

## 3. Additional Assessment Strategies.

In coordination with the Child Protection Team, the investigation may include the following:

- Planned Hospitalization:** Hospital admission allows medical professionals to closely observe and monitor the child's symptoms in the hospital, to assess interactions between the child and the parent/caretaker, and sometimes to limit or restrict the parent/caretaker's contact with the child. The parent/caretaker should not be made aware of the suspicion of Medical Child Abuse.
- Covert Video Surveillance:** Such surveillance allows the hospital to monitor parent-child interactions without the parent's knowledge and may be helpful in confirming the diagnosis. The absence of video evidence does not rule out Medical Child Abuse.

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<sup>6</sup> PSM 713-6

Covert video surveillance is a delicate area legally and should be approached with caution. Hospitals are encouraged to develop their own protocols about surveillance in close consultation with their legal counsel. DHS may seek the guidance of the county prosecutor or attorney general regarding admissibility in court.

- c. **Temporary Separation:** Either through parental consent or a court order, the child is separated from the suspected offending parent/caretaker while signs/symptoms are monitored. The parent/caretaker should not have contact with the child during this time. A diagnostic separation allows for an objective evaluation of the child's medical status, provides an opportunity to obtain a report of the child's symptoms while away from the suspected parent, and protects the child from possible further abuse. Unless a parent agrees to hospitalization or diagnostic separation, a court order is necessary.

If contact is mandated by the court, it should be limited and supervised closely by DHS. In carefully controlled circumstances, care of the child by a relative may be appropriate when the family member will limit the suspected offending parent/caretaker's access to the child in accordance with court orders. When this cannot be assured, the child should be placed in non-relative foster care.

## **PART FOUR**

### **POST-INVESTIGATIVE ACTIONS**

Following a CPS finding of Medical Child Abuse, DHS workers will continue to ensure coordination among the involved professionals while decisions are made regarding court involvement, provision of services and permanence in accordance with DHS policies. Generally, the DHS worker should ensure the child's current medical providers are aware of and understand the diagnosis of Medical Child Abuse, while making determinations on other issues raised during the case.

As noted on pages 2 and 5, the safety of the child has priority in investigations of Medical Child Abuse and in decisions about providing services in such cases, just as in all other types of abuse and neglect cases. Decisions about safety will also guide DHS in determining the appropriate involvement of the courts in each case.

Possible recommendations in response to decisions about safety and the involvement of a court include but are not limited to:

- A petition for temporary wardship (no request for removal).
- A petition for temporary wardship (request for removal of a parent/caretaker).
- A petition for temporary wardship (request for removal of the child).
- A petition for termination (request for removal of the child).

In some circumstances, DHS will recommend termination of parental rights or some other permanent alternative home for the child at the first dispositional hearing. This will occur when the parental offenses are so egregious and the resources of the perpetrator and extended family so limited that an attempt at treatment is not warranted.

Following determinations about safety and the involvement of a court, DHS should consult with mental health professionals to determine appropriate services for each family member, as well as to evaluate whether interventions should be permanent. One possibility is the formulation of a community protection plan that includes people beyond the nuclear family in order to moderate any risks to the child during reunification. For instance, while the child remains a ward of the court, the power to make medical care decisions could remain with someone other than an offending parent. Extended family members, such as a non-offending parent, grandparents, aunts, or uncles, could be engaged to help protect the child from further harm. Therapy could continue for a period of time, as could supervision by DHS.

Both clinical and forensic psychological evaluations of the perpetrator and victim of MCA will be central to decisions about their treatment. As described in Appendix B, these are distinctly different types of evaluations which provide complementary information from different perspectives. The psychological examination of the perpetrator, a large part of which will be forensic, is not done to confirm a diagnosis of MCA. That diagnosis is a medical judgment which is made by the physician conducting the review of medical records and which serves to place the treatment of the child within a category of child abuse that is defined by Children's Protective Services. The psychological examination of the perpetrator is done after a finding of MCA to evaluate the issues in previous conduct that bear on the perpetrator's need for therapy and supervision. The psychological examination of the victim, which will typically be more clinical in nature, is likewise directed toward determinations of the immediate and ongoing needs of the victim.

## **Psychological Evaluations of Perpetrators of Medical Child Abuse**

The forensic psychological examination of perpetrators of Medical Child Abuse is done to identify critical treatment issues and appropriate interventions. The psychological evaluation needs to occur early in the case to promote the effective utilization and coordination of services. Forensic methodology is necessary in these cases because of the seriousness of the complaint, because all parties' rights must be protected, and because of the potential for involvement of a court.

The evaluator conducting a psychological evaluation with forensic methodology will meet the following criteria:

- Be appointed by a court, when applicable.
- Have no prior involvement with the family (i.e., as a therapist, past evaluator, friend, etc.).
- Have an objective and neutral stance in the case.

The psychologist will use standard forensic procedures, including the following:

- Clinical observation of psychological and mental status.
- Psychological testing.
- Utilization of multiple sources of data.
- Close scrutiny of collected data.
- Development and testing of hypotheses.
- Review of pertinent documents.
- In-depth interviews.
- Collateral contacts.

The psychological evaluation using forensic methodology has the following uses in cases of Medical Child Abuse.

- To rule out cognitive impairment.
- To assess for mental illness, such as psychosis or affective disorder, as well as any personality disorders.
- To analyze pertinent intrapersonal, interpersonal and family dynamics.
- To analyze parenting skills.
- To assess the perpetrator's willingness to accept the diagnosis of MCA.
- To identify avenues to barriers to reunification of the family.
- To identify and recommend appropriate interventions and a safety plan.

The report of the evaluator who does the psychological evaluation of the perpetrator of MCA should be comprehensive, with the likelihood that expert testimony may be required from the evaluator. The report needs to follow a standard format for forensic reports and address the following issues:

- The perpetrator's current cognitive and personality functioning and the presence of any psychopathology or personality disorder.

- The perpetrator's perception and awareness of the child's illness and willingness to accept other explanations.
- The perpetrator's understanding of the impact of his or her behavior on the child and family and the perpetrator's degree of empathy.
- The intrapersonal, interpersonal and family issues that might be playing a role.
- An analysis of parenting skills.
- An analysis of the potential for reunification, including the perpetrator's amenability to treatment.
- Recommendations for treatment and a plan for safety.

The evaluator performing the psychological evaluation should gather a comprehensive psychosocial history of the perpetrator that includes a summary of the perpetrator's perceptions of the victim's functioning and medical issues. Psychological testing and an examination of mental status will rule out intellectual disability and severe mental illness, as well as assess for personality disorders. In addition, an assessment of parenting skills and of the potential for other types of abuse is helpful. However, caution must be used in drawing conclusions from test results, since perpetrators of MCA commonly do not have severe mental illness and there is no specific profile of perpetrator that can be identified by a test.

### **Psychological Evaluations for Medical Child Abuse Victims**

A clinical/developmental assessment of children who are victims of MCA may be necessary when a child exhibits cognitive or emotional difficulties. These evaluations should be conducted by an appropriate licensed professional who is familiar with the impact of abuse on child development. When possible, these evaluation should also utilize forensic methodology. Case records related to the abuse should be provided to the evaluator.

## **PART FIVE**

### **PERMANENCY**

#### **Permanency**

Reunification should be a thoughtful process rather than a single act or event, and it should only be considered following successful and well-monitored parental treatment. A decision about reunification should start with the DHS Reunification Assessment, which has three steps:

1. An assessment of compliance with the parenting time plan.
2. An assessment of primary barriers to reunification and risk reduction.
3. A determination about the child's safety.

The issue of reunification is usually raised within one year of placement and following successful treatment. The determination of reunification versus termination of parental rights should be based on successful completion of the treatment plan.

Termination should be strongly considered in cases of Medical Child Abuse when:

- The abuse had a high potential for death.
- Caretakers do not accept the diagnosis of Medical Child Abuse.
- Caretakers lack insight into how their pathological health-seeking impacted the child
- There is continued fabrication and distortion of the child's medical condition.
- The extended family does not acknowledge Medical Child Abuse and supports the identified parent's pathological behavior.
- There is lack of follow-through on recommended services.

## APPENDIX A

### **Medical Resource System (MRS)**

DHS maintains a contract with various medical providers through the Medical Resource System (MRS). This contract provides services such as a 24-hour, seven-day/week statewide hotline for physicians and workers seeking medical consultation on cases involving child abuse and neglect and for physician training. For further information, contact the CPS program office.

The telephone number for MRS in southern and eastern Michigan counties is (734) 763-0215. These counties include: Bay, Branch, Calhoun, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Saginaw, Sanilac, Shiawassee, Tuscola, Washtenaw, and Wayne.

For western and northern Michigan counties (counties not listed above), the number is (616) 391-1242.

These numbers may also be found on the DHS website at:

[www.mfia.state.mi.us/olmweb/ex/PSM/713-4.pdf](http://www.mfia.state.mi.us/olmweb/ex/PSM/713-4.pdf)

## APPENDIX B

### Clinical Evaluation vs. Forensic Evaluation

	<b>Roles</b>	<b>Clinical Psychologist</b>	<b>Forensic Psychologist</b>
1	Who is being served?	Individual patient	Court (or attorney)
2	Purpose	Diagnosis and treatment	Assisting the court in addressing the psycho-legal issue
3	Nature of standard	Medical, psychiatric and psychological	Psycho-legal issue
4	Areas of competency	Clinical assessment, diagnosis and treatment	Forensic methodology and assessment
5	Notification of purpose	Less formal notification	Formal, explicit notification, usually written
6	Privilege that governs disclosure	Patient signs release of information	Court (or attorney)
7	Relationship	Accepting, helping and supportive	Objective and neutral stance
8	Data source	Self-report	Multiple data sources, including collaterals
9	Scrutiny applied	Assumed reliable, much less collateral data	Nothing assumed as reliable, challenges perceptions and uses hypothesis testing
10	Adversarial	Helping and supportive relationship	Frequently adversarial
11	Written report	Reports are shorter and focus on diagnostic and treatment issues	Lengthy and detailed, addressing the psycho-legal issue
12	Court testimony	Not expected	Expected and assumed

Adapted from S. Greenberg and D. Shuman (1997). *Irreconcilable conflict between therapeutic and forensic roles. Professional Psychology: Research and Practice, 28, 50-57.*

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