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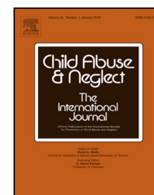

Research article

Child advocacy center multidisciplinary team decision and its association to child protective services outcomes[☆]

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ABSTRACT

Limited studies exist evaluating the multidisciplinary team (MDT) decision-making process and its outcomes. This study evaluates the MDT determination of the likelihood of child sexual abuse (CSA) and its association to the outcome of the child protective services (CPS) disposition. A retrospective cohort study of CSA patients was conducted. The MDT utilized an a priori Likert rating scale to determine the likelihood of abuse. Subjects were dichotomized into high versus low/intermediate likelihood of CSA as determined by the MDT. Clinical and demographic characteristics were compared based upon MDT and CPS decisions. Fourteen hundred twenty-two patients were identified. A high likelihood for abuse was determined in 997 cases (70%). CPS substantiated or indicated the allegation of CSA in 789 cases (79%, Kappa 0.54). Any CSA disclosure, particularly moderate risk disclosure (AOR 59.3, 95% CI 26.50–132.80) or increasing total number of CSA disclosures (AOR 1.3, 95% CI 1.11–1.57), was independently associated with a high likelihood for abuse determination. Specific clinical features associated with discordant cases in which MDT determined high likelihood for abuse and CPS did not substantiate or indicate CSA included being white or providing a low risk CSA disclosure or other non-CSA disclosure. MDT determination regarding likelihood of abuse demonstrated moderate agreement to CPS disposition outcome. CSA disclosure is predictive of the MDT determination for high likelihood of CSA. Agreement between MDT determination and CPS protection decisions appear to be driven by the type of disclosures, highlighting the importance of the forensic interview in ensuring appropriate child protection plans.

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Introduction

An estimated 3.4 million referrals of possible child abuse or neglect, involving alleged maltreatment of approximately 6.3 million children, were made to child protective services (CPS) agencies across the United States in 2012. CPS agencies responded in the form of an investigation or alternative response to just over 60% of these referrals. An estimated 686,000

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children were determined by CPS to be a victim of abuse and neglect nationwide. Of those determined to have been abused, 9.3% were sexually abused (US Department of Health and Human Services, 2012).

As a matter of standard of practice, an allegation of child sexual abuse (CSA) initiates a law enforcement and/or a CPS investigation. Historically, CSA investigations had been perceived to cause additional distress to child victims and their caregivers due to redundancies in the investigative process resulting in multiple interviews (Cross, Jones, Walsh, Simone, & Kolko, 2007; Henry, 1997; Jackson, 2004; Whitcomb, Goodman, Runyan, & Hoak, 1994; Yeaman, 1986). Child advocacy centers (CACs) were initially developed in response to this criticism to reduce harm and discomfort by limiting redundant interviewing and improving prosecution outcomes with a coordinated investigative and therapeutic response to child abuse (Faller & Palusci, 2007).

Although the CAC model has been regarded as best practice in CSA investigations, outcome studies evaluating the effectiveness of the multidisciplinary team (MDT) in determining abuse is sparse (Jones, Cross, Walsh, & Simone, 2005). When taking into account implementation of the CAC model by incorporating the MDT and increasing training, improved outcomes would be anticipated, not only with respect to investigation, but also in increased interagency communication.

In 2007, a series of three articles as well as invited commentary were published in this journal, addressing the hypothesis that CACs lead to positive case outcomes (Cross, Jones, Walsh, Simone, & Kolko, 2007; Faller & Palusci, 2007; Jones, Cross, Walsh, & Simone, 2007; Walsh, Cross, Jones, Simone, & Kolko, 2007). Improved outcomes with the CAC model as compared to non-CAC investigation included increased number of CSA victims having a medical examination, increased forensic interviews occurring in a child friendly setting with improved coordination between multiple agencies, and better caregiver and child victim satisfaction with the evaluation process. These studies are touted as an initial first step in the much needed evaluation of CACs; however, the MDT decision-making process of CSA evaluations and relevant outcomes including CPS decisions were not evaluated (Faller & Palusci, 2007).

The purpose of this study was to evaluate the association of a CAC MDT determination of the likelihood of CSA to CPS dispositions. We hypothesized: (1) there would be high concordance between the MDT and CPS determinations and (2) specific demographic and clinical factors would be predictive of decision-making discordance between the CAC MDT and CPS determinations.

Methods

Study Setting and Population

The MDT in a CAC at a large Midwestern U.S. children's hospital consisting of a forensic interviewer, mental health advocate and a medical provider (physician or nurse practitioner) was the study setting. The role of the forensic interviewer was to perform non-leading interviews of children regarding child maltreatment and family violence for the purpose of medical diagnosis and treatment. The mental health advocate's role was to gather pertinent psychosocial information about the family and to provide recommendations regarding mental health services. The medical provider conducted a comprehensive history and physical examination of the patient, completed any necessary testing for sexually transmitted infections, and completed evidence collection in acute sexual assault cases as needed. Although not always present, due to the co-location of the local CPS agency and law enforcement within the CAC, most cases serviced by these agencies also had representatives present during the evaluation to provide background, case-specific information, observe the forensic interview, and gather results from the medical examination.

Patients were referred for CSA evaluations through several access points including CPS agencies, law enforcement agencies, emergency departments, primary care offices, schools, or parent request. Both acute and non-acute cases of alleged CSA were evaluated. Since 2005, each case evaluated for CSA by a MDT was rated by the MDT at the conclusion of the forensic interview and medical examination (Fig. 1). Although representatives from CPS agencies and/or law enforcement may have been present at the conclusion of the evaluation, the final determination for the rating of each case was driven by the forensic interviewer, mental health advocate and medical provider. A five point Likert rating scale to determine the likelihood of abuse was completed by MDT consensus. Although there are no known validated scales to assess likelihood of abuse, this scale was previously vetted by content experts within the various disciplines to establish content validity. For the purpose of this study, the likelihood of abuse was stratified into either high likelihood (score of 4 or 5) or low/indeterminate likelihood of CSA (score of 1, 2, or 3). All information available at the conclusion of the MDT evaluation was taken into consideration such as the patient's disclosures during the forensic interview, findings during the medical examination or known presence of an STI previously diagnosed by another provider prior to presentation at the CAC. Although the rating was assigned at the end of each case, it should be noted that in cases where an STI was diagnosed after the conclusion of the CAC appointment but as a result of testing performed as part of the CAC evaluation, this rating may have been changed to a score of 5 based on the criteria for likelihood of abuse. This only occurred if the presence of the STI was diagnostic of sexual abuse as determined by the medical provider such as the presence of an STI in a prepubertal child where vertical transmission was excluded (Adams et al., 2007). The rating otherwise was never changed once assigned.

Typically, children aged 3–18 years presenting to the CAC with a concern for CSA underwent a forensic interview by a trained social worker. In those close to but not quite 3 years, an interview was completed only if they were determined by the MDT to be developmentally capable of doing so. In addition, those 18 years or older with cognitive delays were also eligible for a CAC evaluation. Patients with only disclosures of sexualized behaviors between children under the age of 10 years were

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