Medical Child Abuse: A Guide for Child Protection Workers

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Abstract

Medical child abuse (MCA) is a complex entity that can take years to accurately diagnose and report to Child Protective Services (CPS). In cases of suspected MCA, CPS is faced with parents who appear to be caring advocates for their child, children who appear to have complex medical issues, fragmentation of medical care among multiple providers and hospitals, and a dearth of standardized protocols for safeguarding children. The purpose of this report is to provide a single, accessible resource on the management of MCA for CPS investigators and child welfare workers. Its intended use is for situations in which there is a referral to CPS made by a medical provider for a concern of MCA.

Keywords: *medical child abuse, Munchausen syndrome by proxy, factitious disorder imposed on another, child abuse, child maltreatment*

Background

History and Definitions

Medical child abuse (MCA) is defined as "unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker" (Flaherty et al., 2013). First described by Henry Kempe in "Uncommon Manifestations of Battered-Child Syndrome" (Kempe, 1975), the condition of a child suffering medical harm at the instigation of a caregiver has gone by many names: Munchausen syndrome by proxy, factitious disorder imposed on another (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, 2022), pediatric condition falsification, child abuse in a medical setting, fabricated or induced illness, caregiver-fabricated illness in a child (Flaherty et al., 2013), and MCA. There are nuanced differences between these various definitions that primarily depend on whether the focus is on the child as a victim, the caregiver's motivation, or both.

MCA was so named with the intention of placing focus on the *harm to the child* rather than the psychopathology or motivation of the caregiver. Whether the harm is the result of intentional manipulation by the caregiver, desire for secondary gain, untreated anxiety, or another cause, the definition of MCA applies when the child is suffering medical harm or potential harm at the instigation of a caregiver. Of course, caregiver psychopathology and motivation must be addressed if the long-term goal is rehabilitation with family preservation, but the first priority should always be safeguarding children from further harm.

Patterns

MCA involves exaggeration, fabrication, falsification, misrepresentation, or induction of illness in a child by a caregiver. In all its forms, MCA leads physicians and other healthcare providers to perform unnecessary medical investigations and interventions that threaten or

cause harm to a child. In essence, physicians become the instrument through which caregivers harm the child. MCA is differentiated from malpractice, in which a medical provider orders excessive, inappropriate, and harmful interventions in response to a *reliable* history from the caregiver (Roesler, 2010). In MCA, the history from the caregiver is *unreliable*, and the physician's response to the unreliable history is what leads to harm. As described in the *APSAC Practice Guidelines*, "highly competent clinicians can be misled into providing unnecessary or harmful care to the child" (APSAC, 2017).

Many victims of MCA do have underlying medical disease(s), and it can be challenging to recognize MCA in children who start out with legitimate medical signs, symptoms, or diagnoses (Rosenberg, 1987). Nevertheless, MCA commonly involves several distinctive patterns of manipulation of the healthcare system by a caregiver (Flaherty & Macmillan, 2013), including fragmenting care among many medical institutions and providers, and exaggerating or misrepresenting the results of prior medical evaluations. As noted in the *APSAC Practice Guidelines*, "some abusers seek out clinicians who provide nonstandard or substandard care to further their goals" (APSAC, 2017). There is often an *overutilization* of *inappropriate* care paired with *underutilization* of *appropriate* care. The underutilized care often consists of mental health services and primary care (Jenny & Metz, 2020; Johnson et al., 2022). A case of MCA may involve all of these patterns or a subset. It may develop insidiously or abruptly (as is the case with suffocation or poisoning, i.e., direct induction of harm).

In addition to medical harm, victims of MCA are at risk of great psychological harm by being manipulated to adopt the sick role and experiencing social isolation as they are often removed from school and extracurricular activities because they are "too ill." The children often have visual indicators of their falsified illness (e.g., intravenous lines, feeding tubes, glasses, wheelchair, walker). The caregivers are sometimes very active on social media, seeking sympathy and sometimes funding pertaining to their child's illness (Brown et al., 2014). Caregivers sometimes directly harm their child to "prove" the falsified illness. MCA can be fatal; the risk of mortality is 6%–9% (Jenny & Metz, 2020).

Medicolegal Context

To some CPS and child welfare workers, MCA will be a new concept. Although the harms of physical abuse or sexual abuse are relatively self-evident, it may not be immediately apparent to CPS and child welfare workers how excessive medical care can cause harm. While MCA research is in its relative infancy compared with some other forms of maltreatment, Figure 1 demonstrates the exponential increase in peer-reviewed publications relating to MCA over the past 50 years. To date, there are nearly 17,000 peer-reviewed publications on MCA. The breadth of existing research on MCA may help reinforce the validity of such concerns brought to CPS by a medical provider.

Figure 1. Peer-Reviewed Publications on Medical Child Abuse.

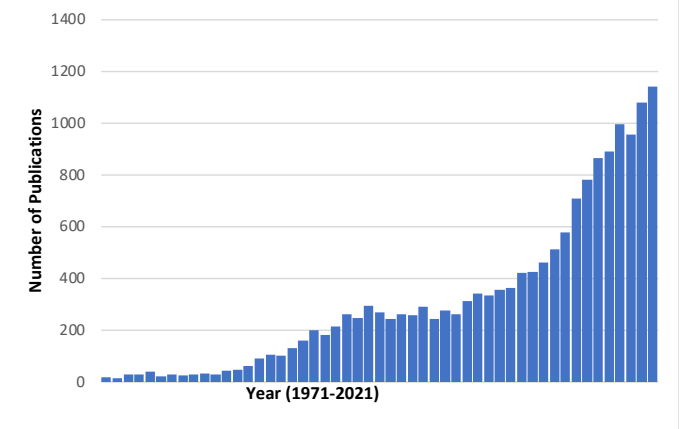

Figure 1 was derived from PubMed (September 22, 2022), the medical literature search engine of the National Institutes of Health. Each bar represents the number of articles published per year (i.e., not cumulative) relating to the following search terms: medical child abuse OR caregiver-fabricated illness in a child OR pediatric condition falsification OR child abuse in a medical setting OR factitious disorder by proxy OR Munchausen syndrome by proxy OR factitious disorder imposed on another

Despite the growing awareness about MCA among the medical community, it makes up less than 6% of reports to CPS (*Child Maltreatment*, 2020). Pathways to manage MCA in CPS, child welfare, law enforcement, and legal prosecution are sparse, and those available tend to be extensive, sometimes inaccessible, or state-specific (*Arizona Department of Child Safety. Investigating Involving Medical Child Abuse*, 2021; *Michigan Governer's Task Force on Child Abuse and Neglect. Medical Child Abuse: A Collaborative Approach to Identification, Investigation, Assessment, and Intervention*, 2013). Most CPS investigators and child welfare workers are not trained in case management of MCA. Faced with parents who appear to be caring advocates for their child, children who appear to have complex medical issues, and fragmentation of care among multiple hospitals and providers with varied medical opinions, CPS case workers and legal partners are often left with little direction for how to investigate and intervene to safeguard these children.

Aim

The purpose of this report is to provide a single, accessible resource on the investigation and management of MCA for CPS investigators and child welfare workers. Its intended use is for situations in which there is a referral to CPS made by a medical provider (rather than a community or family member) for a concern of MCA. **This resource draws upon relevant articles from the APSAC Advisor Special Issue: Munchausen by Proxy, and in particular, the practice guidelines on Munchausen by Proxy by the APSAC Taskforce.** It will highlight the important take-home points from these and other articles on CPS management of MCA, will place the recommendations in medicolegal context, and will give concrete examples of how to work with the medical providers and law enforcement throughout the investigation.

This resource will not focus on how a medical provider makes a diagnosis of MCA. For this, we refer readers to more comprehensive resources such as the 2017 *APSAC Practice Guidelines* and the *American Academy of Pediatrics Clinical Report* (Flaherty & Macmillan, 2013). This article will also not focus on the law enforcement investigation, for which we refer readers to the article by Michael Weber in the 2018 *APSAC Advisor* special report.

CPS investigators and child welfare workers may share this resource with their colleagues in the medical field, law enforcement, and legal settings to promote a shared paradigm for case management.

Practical Application

Prior to the CPS Report

One of the most important things to know about MCA is that by the time a medical provider calls a referral to CPS, the pattern of care may be well-established and the threat of harm to the child quite prolonged, severe, and/or imminent. Because of the nature of MCA—the fragmentation of care, the misrepresentation by caregivers, and the manipulation of medical providers as the instrument of abuse—it can take years for medical providers to recognize the concern and gain consensus in the decision to make a report (Sheridan, 2003). Medical providers sometimes become quite enmeshed with the caregiver's false narrative and may have difficulty recognizing or accepting their role in the child's harm.

Unlike, for instance, a patterned bruise or a disclosure of sexual abuse, the threshold for mandated reporting of MCA is less straightforward. The determination that MCA is occurring often involves the engagement of the hospital's social work team, child protection team, medical provider meetings, record reviews, and innumerable attempts to converse with the caregiver and redirect the harmful pattern of care. When these efforts at clear communication and care redirection in the clinical setting are ineffective, or when a life-threatening event is imminent, a report should be escalated to CPS (Flaherty & Macmillan, 2013).

When the CPS Intake Comes In

1. **Screening.** For cases of suspected MCA, the screening decision should lead to an investigative pathway rather than an alternative response. Voluntary services are not appropriate for these cases, given the high level of deception and evasiveness inherent to the condition.

2. **Organizational Infrastructure.** If possible, it can be helpful to create a state-wide protocol for child protection workers and law enforcement responding to intakes for concern of MCA (*Arizona Department of Child Safety. Investigating Involving Medical Child Abuse*, 2021; *Michigan Governer's Task Force on Child Abuse and Neglect. Medical Child Abuse: A Collaborative Approach to Identification, Investigation, Assessment, and Intervention*, 2013). It can also be helpful to assign one CPS investigator in each jurisdiction to receive additional training on this topic and be the primary investigator assigned to such cases.

3. **Early cross-reporting.** We recommend early cross-reporting to law enforcement, as these investigations can be complex and laborious. Working as a team from the beginning may help ensure that consistent communication between agencies is maintained as the case unfolds.

4. **Contact with the referring provider.** After reviewing the intake, and before contacting the family, the assigned CPS case worker should contact the medical provider(s) who made the report to better understand the concern(s) that prompted the report. This may be done in coordination with law enforcement if an investigator is assigned.

   The first question to be asked is whether there is concern for imminent risk to the child—i.e., whether the child is at risk of death or serious decompensation if intervention does not occur immediately. If this is the case, immediate protective custody should be sought with the assistance of law enforcement, and direct admission to the hospital may be indicated (APSAC, 2017). The reporting medical provider should be engaged in the decision about whether hospitalization is indicated, or if the child is medically safe to enter a foster home.

   If the risk is not imminent, then the conversation with the reporting medical provider should focus on concrete and tangible examples of risk and harm. Ideally, a comprehensive medical timeline called a chronology will be constructed by a medical provider trained in assessing MCA (Flaherty & Macmillan, 2013). This may occur before or after the CPS intake is made. When it is not feasible to obtain such a chronology within the timeline needed for an investigative response, then the CPS investigator can work with the medical provider who made the report to clarify *specific* examples of risk and harm. The medical provider(s) who made the report should be asked to summarize the medical history and concerns for overmedicalization in written form in language that can be understood by non-medical audiences including investigators, attorneys, and judges. We have provided a letter template that may be shared with the reporting medical provider to help create this written summary (see Appendix).

5. **Initial investigation.** Early in the investigation—ideally before the instigating caregiver is notified of the report—CPS should collaborate with law enforcement to review all social media accounts owned by the caregiver. This is to look for examples of misrepresentation or secondary gain based on the presentation of the child as ill. CPS should request all medical records for the child and share these with law enforcement and with a physician skilled in reviewing such medical records. Law enforcement should obtain search warrants for the instigating caregiver's phone and Internet search history, should review electronic communications in which the instigating caregiver has discussed the child's health, and should conduct an early scene investigation (APSAC, 2017).

Trial Separation

Once imminent harm has been addressed and the earliest pieces of the investigation are underway, CPS is faced with determining a safety plan. Because of the complexity of these cases, the preponderance of perpetrators that are the child's primary caregiver (Sheridan, 2003), the physical and psychological threat to the child (McGuire & Feldman, 1989), and the inability to gain an objective assessment of the child while they remain in the care of the instigating caregiver, a trial separation is often indicated. Often, the true medical needs of a child with underlying illness cannot be evaluated unless they are separated from the instigating caregiver. As described in the *APSAC Practice Guidelines* (APSAC, 2017), "If the child's condition or functioning improves when sufficiently protected from the influence of the suspected abuser […], many courts will use the concept of *res ipsa loquitur*, [or] "the thing speaks for itself" (p. 15).

If the risk of harm to the child is assessed as low, the driving factor of the instigating caregiver's behavior is anticipated to be anxiety (as opposed to secondary gain or factitious disorder imposed on another), and there is a second protective caregiver in the household who understands the concern for MCA and can take charge of the child's healthcare during the investigation, a trial separation may not be needed. If all three of these criteria are not met, however, a trial separation may be the only way to obtain an unbiased, objective assessment of the child's true medical needs.

1. **Options for establishing safety through a trial separation.** In some cases, a child may initially require hospitalization for evaluation and stabilization during which the instigating caregiver is prohibited from being at the bedside or communicating with the patient (APSAC, 2017). For children who are hospitalized, careful planning with the referring medical provider and inpatient medical team should be sought ahead of time to establish goals of the admission, a plan for weaning each medication and device, and discharge criteria.

   Otherwise, there are a few options for how to initiate a trial separation in the home setting: (1) the instigating caregiver can move out of the home, (2) the child can be placed in kinship care with a friend or family member, or (3) the child can be placed with an unrelated foster caregiver. We recommend approaching these three options based on level of risk to the child and the degree to which family and friends of the instigating caregiver understand the concern for MCA and are willing to act protectively.

   A friend or family member who downplays the concern for MCA may not appropriately safeguard the child to allow for an unbiased investigation. In cases of MCA, the denial of the instigating caregiver and their immediate social connections toward the possibility that abuse is occurring can be quite persistent. It is important to place the child in an environment where a completely unbiased assessment of their behaviors and medical needs can be attained. A guide for assessing the protectiveness of alternative caregivers is available in the APSAC special report on Munchausen syndrome by proxy (Giardino & Greeley, 2018; Sanders & Ayoub, 2018). This article recommends asking prospective alternative caregivers about the following:

   - **Belief:** The alternative caregiver's ability to believe and accept the allegations
   - **Protectiveness:** The alternative caregiver's ability to provide appropriate protection for the child
   - **Impact of Allegations:** The impact that the allegations have had on the alternative caregiver
   - **Communication:** The alternative caregiver's plans for communication with the instigating caregiver
   - **Parenting Issues:** How home and caregiving duties are typically designated between the caregivers (if the prospective caregiver is a

spouse or co-parent)

- **Legal and Mental Health Issues:** Any outstanding legal matters or mental health or substance use concerns in the family
- **Knowledge and Needs:** The alternative caregiver's understanding of the child's health and any questions they may have

If the child's condition appears to be medically complex, a medical foster home may be appropriate until unnecessary devices and medications are able to be weaned. If court proceedings are needed to obtain custody and carry out the trial separation, a summary letter from the medical provider describing concrete examples of risk and harm should be included (see Appendix).

2. **Safety planning for the instigating caregiver.** The 2017 *APSAC Practice Guidelines* note that safety planning for the instigating caregiver is recommended, particularly relating to suicidal ideation around emotionally-fraught circumstances, such as removal of the child.
3. **Interviewing the instigating caregiver.** Once immediate safety has been established for the child, CPS can work with law enforcement to interview the instigating caregiver. Any medical claims or diagnoses reported by the caregiver should be compared with the medical records, and any claims the instigating caregiver makes about their own health or educational background (such as specific medical training) should be verified (APSAC, 2017).
4. **Establishing a medical home and de-escalating medical care.** A key component of the trial separation is establishing a medical home with a primary care provider who will play an active role in care coordination, de-escalation of care, and boundary-setting with the instigating caregiver. Hospitals providing care should establish means to route all recommendations and referrals through this primary care provider. The goal of the trial is to collect objective, reliable observations of the child that may facilitate medical improvements, including those related to nutrition, mental health, development, and weaning of unnecessary therapies, medications, and devices. Items are typically weaned one at a time to evaluate the child's need for each individual medication and device.

   To facilitate an unbiased assessment of the child's medical needs, the instigating caregiver should be restricted from communication with the child's health care team and from attending medical appointments with the child. The decision about whether or not the medical record should be blocked from the instigating caregiver (i.e., whether the caregiver should maintain access to an online patient portal) should depend on whether their access puts the child at risk of further harm.
5. **Guidance for foster caregivers.** Foster caregivers should be trained regarding how to assess the child's behaviors and respond appropriately. For example, if a certain type of movement, behavior, or apparent need for mobility device by the child was rewarded by the instigating caregiver with affection, the new caregiver should be advised to give the child a great deal of positive attention and affection regardless of the presence of such behaviors or needs. Spells or behavioral episodes that are determined to not be dangerous are often best responded to with "benign neglect," meaning to not give specific attention to the behavior. The caregiver should also be aware that certain behaviors may be a response to the stress of separation and change in the child's daily routine and environment. The new caregiver should be encouraged to respond to all such behaviors by reminding the child that they are safe and loved.

   Whenever there is question about the true nature of the child's behavior or symptoms, sources of potential bias in the child's environment should

be considered. For example, if the child is in the physical custody of a caregiver who does not believe the concerns for MCA are legitimate, transitioning the child to an unrelated foster caregiver or arranging for a direct admission to the hospital may allow for a more unbiased assessment of the child.

6. **Additional sources of information.** Information from outside observers, such as school or daycare, should also be sought to gain an accurate assessment of the child's medical needs. Since the instigating caregivers often isolate and "homeschool" the child, the observations of other family members or acquaintances of the family may be sought as well (again, keeping in mind that the deception inherent to MCA may leave many friends and family of instigating caregiver in denial of the possibility of MCA).

7. **Length of trial separation.** The trial separation should be long enough to capture any symptoms commonly reported by the instigating caregiver. For example, if the caregiver reports several seizures per month, the separation should be at least one month. The separation will often require much more time—on the order of months to years—to achieve all rehabilitative steps needed for safe reunification.

Visitation

If visitation with the instigating caregiver is planned, supervision by an unbiased person who understands the concern for MCA is important. The CPS investigator or child welfare worker is often suitable for this role. The *APSAC Practice Guidelines* (APSAC, 2017) provide specific recommendations for visitation, including the following key components:

- The instigating caregiver should be restricted from preparing the child's food or providing them with any food, drinks, gum, candy, or mints, or anything they would put topically on their body.
- The child should be visible at all times.
- All verbal communication should be audible to the supervisor.
- Communication of all forms—verbal, nonverbal, and written—between the instigating caregiver and child should be monitored. Communication should be restricted from any mention of symptoms or medical needs. This should apply to both in-person as well as remote (i.e., phone or video chat) interactions between the caregiver and child.

Intervention and Service Provision

The context of maltreatment and family dysfunction that leads to MCA is arguably more complex than other forms of maltreatment. It often involves unrecognized caregiver mental illness (Bass & Jones, 2011; Sheridan, 2003) and a lack of insight into the harm being imposed. Prior literature has suggested that most instigating caregivers are females and have some degree of psychopathology, particularly cluster B personality disorders such as borderline, histrionic, sociopathic, or mixed personality disorder (APSAC, 2017; Yates & Bass, 2017). Anxiety, substance use disorders, somatoform disorders, and delusional disorders are also prevalent in these cases. A case series by Bass and Jones found high rates of somatoform disorders (57%), factitious disorders (64%), non-epileptic spells (32%), and pathological lying (pseudologia fantastica (61%) among instigating caregivers (Bass & Jones, 2011). Another case series by Bools, Neale, and Meadow in 1994 found that 72% of instigating caregivers had histories of somatic symptoms disorder or factitious disorder imposed on self, 21% had substance misuse, 55% had histories of self-destructive behaviors, and 89% had personality disorders (Bools et al., 1994). The instigating caregiver's tendency to fabricate illness in the child may be experienced as an overwhelming compulsion, comparable to an addiction to the attention, affection, and sympathy derived from having an ill child (APSAC, 2017). This requires intensive work to resolve.

When an anxiety disorder is at the root of the behavior, it is often the anxiety-avoidance cycle that prompts excessive, unnecessary medical interventions. For example, a caregiver may have anxiety about what they are observing in their child, seek medical care to reduce that anxiety (i.e., "avoiding" the anxious feeling of uncertainty), and experience relief when medical tests, interventions, or referrals are undertaken. Over time, this can solidify into a habit where the anxiety-avoidance cycle is reinforced by the response of the medical system to an anxious caregiver.

While the reasoning behind why the caregiver is instigating medical harm is irrelevant to the *diagnosis* of MCA, it will be of particular relevance to the CPS investigator or child welfare worker faced with making determinations about service provision and possible reunification. We recommend the following considerations in terms of service provision and intervention:

1. **Comprehensive mental health evaluation of instigating caregiver.** One priority of service provision should be a mental health evaluation for the instigating caregiver by a mental health professional experienced in assessing conditions such as Munchausen syndrome by proxy, factitious disorder imposed on another, and MCA. Because expertise in this area is relatively rare, a mental health professional who is skilled in evaluating personality disorders and is open to learning more about the psychopathologic origins of MCA while maintaining open communication with CPS (to ensure child safety) is sufficient.

   In addition to diagnosing and treating any unmet mental health needs, the provider should assess the caregiver's parenting skills, coping skills, any learning or cognitive disabilities, and the quality of the social support structure around the caregiver. Instigating caregivers are often skilled in co-opting evaluators. To limit this, the mental health evaluator should be provided with objective evidence of harm to the child. It is important to remember that the evaluation is done to assess pathways and barriers to potential reunification, and not to prove or disprove that MCA has occurred. A normal psychologic or psychiatric evaluation does not mean MCA has not occurred.

2. **Protocol for treatment of instigating caregivers.** The "ACCEPTS" model is one published protocol that provides guidance on the treatment of caregivers who have instigated MCA (Bursch, 2018; Sanders & Bursch, 2020). This protocol may be shared with the mental health provider consulting on the case. The key components of the ACCEPTS model as described by Drs. Sanders and Bursch are as follows:

- **AC: Acknowledgement.** It is important that the instigating caregiver is able to acknowledge and take responsibility for their behaviors that placed the child at risk and/or caused harm.
- **C: Coping.** It is important that the instigating caregiver has developed and can implement skills to cope with their own stress and emotional needs.
- **E: Empathy.** It is important that the instigating caregiver demonstrates ability to empathize with the child, including an appropriate cognitive and emotional response to the past harm caused through MCA.
- **P: Parenting.** It is important that the instigating caregiver demonstrates effective parenting skills, including the ability to put the needs of the child before their own needs.
- **T: Taking charge.** It is important that the instigating caregiver take charge of their own recovery and stability, including proactive plans for how to prevent relapses.
- **S: Support.** It is important that a structure is built around the instigating caregiver for ongoing support and monitoring of potential relapses into MCA.

3. **Multi-disciplinary team collaboration.** Given the context of deception inherent to MCA, it is difficult for any individual managing a case or mental health provider evaluating the caregiver to remain objective and avoid becoming misled by the caregiver's false narrative. Continuing to work as part of a multi-disciplinary team and always returning to the objective medical data to answer questions about the child's illnesses (or lack thereof) is critical for these cases.

   As formal intervention occurs through the child protection system, the case may be transferred to a child welfare worker, who was not a part of the initial investigative team. It is imperative that ongoing communication occur between the medical provider(s) and the child welfare worker to ensure they understand the risk of harm, and to reduce triangulation between the family and the systems involved. In addition, the mental health provider evaluating the instigating caregiver should provide guidance to the CPS investigator or child welfare worker regarding which services may be most appropriate for rehabilitation, and the anticipated likelihood (or lack thereof) of successful reunification.

Considerations for Reunification

MCA has a high rate of relapse after reunification. This is particularly true in cases driven by factitious disorder imposed on another (Bursch, 2018) as opposed to caregiver anxiety. Reunification, if sought, should proceed slowly and carefully (Flaherty et al., 2013). Child welfare workers should expect involvement with the family to last months to years to facilitate interventions that may create a safe environment for the child. Perpetrators' insight into their tendency to fabricate often comes slowly, and they must learn to recognize and avoid their impulses to harm the child via fabrications. This means identification of the psychopathology or motivation at the core of the behavior, and the development of alternative coping skills is imperative. Many perpetrators will never improve sufficiently to be safe around the child.

1. **Re-initiation of the instigating caregiver's involvement in the child's healthcare.** If reunification is planned, the instigating caregiver's participation in the child's healthcare should be re-initiated slowly and with careful monitoring. An unbiased third party (often the CPS investigator or child welfare worker)

should attend appointments with the child and caregiver and take notes. Medical records from these visits should be obtained and placed in the child's case file. Close attention should be paid to whether exaggeration or fabrication of the child's symptoms is occurring, and whether the caregiver is asking for specific medical tests or referrals not otherwise suggested by the medical provider. These are indicators that the caregiver has not fully rehabilitated to the point that they can safely participate in the child's healthcare.

Medical care should be sought from a single primary care provider who is aware of the concern for MCA and the risk of overmedicalization. The provider should be able to set boundaries and decline a caregiver's requests for unnecessary interventions. All subspecialty referrals should be placed by this provider, who should be in close communication with subspecialists both before and after subspecialty visits to ensure recommendations are made based on objective findings rather than subjective history.

2. **Ongoing multi-disciplinary team collaboration.** It will be helpful throughout the case for a protective multi-disciplinary team to meet routinely including CPS, law enforcement, the child's primary care provider, the instigating caregiver's therapist, foster caregivers, and visitation supervisors. This will allow for open communication about the barriers to, and prospects for, reunification.

   As the instigating caregiver progresses through the "ACCEPTS" model, and if deemed appropriate by the protective multi-disciplinary team, it may be helpful for the instigating caregiver to have a conversation with the child about their behaviors that led to harm for the child (APSAC, 2017). The instigating caregiver should reassure the child that they are loved regardless of their health or ill status.

3. **Building a safety net.** If reunification is to occur, a protective community including the patient's primary care provider, family members, and friends should be built who all understand the risk of harm from MCA. This protective community should be educated about the motivation behind the instigating caregiver's overmedicalization of the child, and alternative coping skills that have been developed to prevent recurrence. This community should also be advised to remain alert for any signs that the instigating caregiver's description of the child's symptoms is exaggerated, fabricated, or falsified, and to re-engage CPS if there is concern for recurrence of medical harm via MCA. They should be provided with the number for CPS intake and the names of the previous CPS investigator and child welfare worker, both of whom should be consulted in the screening process and should have priority assignment if the intake screens in.

Conclusion

Medical child abuse is a complex entity that can take years to develop, years to accurately diagnose, and years to de-escalate. By the time a report reaches CPS, the pattern of healthcare manipulation and fragmentation is often so developed that de-escalation is beyond the scope and capabilities of the healthcare system, and protective intervention is required. When a CPS case worker can partner with the medical team to summarize and translate their concerns into non-medical jargon, citing concrete and tangible examples of risk and harm, a stronger case can be made for a protective response in investigative and legal settings. A trial separation from the instigating caregiver may allow for objective and reliable observations of the child's true medical needs as excessive medications and interventions are gradually weaned. Concurrently, an evaluation of the instigating caregiver for unmet mental health needs, psychopathology, and motivation behind the healthcare-seeking behavior is critical if reunification is to be considered. Reunification, when sought, should proceed slowly and carefully with monitoring of milestones indicating that the instigating caregiver may be ready to safely participate in the child's healthcare. A protective community should be established that can recognize patterns of MCA and report concerns should they arise again.

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Appendix

Date: [MM/DD/YYYY]

Re: [Patient full name], DOB: [MM/DD/YYYY]

To whom it may concern:

This is a letter summarizing concerns of medical child abuse leading to Child Protective Services intake for [Patient full name].

Medical child abuse is defined as "unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker." It is sometimes referred to as Munchausen Syndrome by Proxy, but unlike Munchausen Syndrome by Proxy, the definition of medical child abuse focuses on the *harm to the child* rather than the motivation or diagnosis of the abuser. Medical child abuse can involve exaggeration, misrepresentation, fabrication, falsification, or induction of illness in a child.

[Patient]'s Medical History

[Provide a brief summary of the patient's medical history]

Involvement of Reporting Provider

[Provide a brief description of how the reporting provider came to know the patient, and how concerns culminated in a mandated report]

[Include the following 3 sections as applicable, with a bulleted list of examples specific to the patient]

Concerning Pattern of Healthcare Seeking

Perpetrators of medical child abuse often fragment medical care between different providers and undergo frequent care transitions. There is often overutilization of inappropriate medical care, and underutilization of appropriate medical care, as observed in [Patient]'s case:

- *[Examples may include, but are not limited to: seeking care from many different hospitals and clinics, resisting the release of records from one institution to another, or seeing multiple subspecialists within the same specialty. It can be helpful to provide a complete list of all the hospitals and clinics where the patient has been seen]*

Exaggeration, Fabrication, Misrepresentation, or Induction of Illness

Medical child abuse involves exaggeration, fabrication, misrepresentation, or induction of illness. The following are examples of this in [Patient]'s case:

- *[Examples may include, but are not limited to: exaggerating symptoms, reporting symptoms that have never been observed by another person, misrepresenting the medical opinions of other doctors, reporting diagnoses that have not been confirmed, or inducing illness such as through suffocation or poisoning]*

Harm to [Patient]

The inappropriate utilization of healthcare by [suspected perpetrator] has potential for serious harm. The following are examples of harm or risk of harm in [patient]'s case:

- *[Examples may include, but are not limited to: unnecessary medical exams, labs, imaging, radiation exposure, medication side effects, procedures, surgeries, risks of anesthesia, missed school, educational neglect, unsought psychiatric or psychologic care, medical neglect, removal from social activities that are important for child's development, and being placed in the psychological sick role]*

Summary of Concerns

In summary, it is my medical opinion that [patient] is a victim of medical child abuse by [suspected perpetrator]. This type of abuse is often difficult to recognize because the perpetrator gives an impression of caring and advocating for the child. However, the pattern of overutilization of inappropriate healthcare services and underutilization of appropriate healthcare services leads to undue medical harm to the child. Medical child abuse can have long-term physical and psychological repercussions. It can lead to unnecessary surgeries and can cause death. Thank you for your close review of this case and I welcome you to contact [me/us] with any questions.

Sincerely,

[Signatures and contact information for medical provider(s) making report]