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# THE URGENT NEED IN ILLINOIS FOR UNIT-BASED MULTIDISCIPLINARY TEAMS TO INVESTIGATE CHILD ABUSE

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Recommendations to the Illinois General Assembly per Public Act 099-0023

By The Illinois Children's Justice Task Force

February 2016



***Illinois  
Children's Justice  
Task Force***

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## ACRONYMS

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The following is a list of the acronyms which appear throughout the report.

**AAP:** American Academy of Pediatrics

**CAC:** Children's Advocacy Center

**CACI:** Children's Advocacy Centers of Illinois

**ChicagoCAC:** Chicago Children's Advocacy Center

**CAP:** Child Abuse Pediatrician

**CAPTA:** Child Abuse Prevention and Treatment Act

**CHA:** Children's Hospital Association

**CPI:** Child Protection Investigator

**CPT:** Child Protection Team

**CQI:** Continuous Quality Improvement

**DCFS:** Department of Children and Family Services

**FI:** Forensic Interview

**LE:** Law Enforcement

**MCOE:** Medical Center of Excellence

**MDT:** Multidisciplinary Team

**MOU:** Memorandum of Understanding

**MPEEC:** Multidisciplinary Pediatric Education and Evaluation Consortium

**OIG:** Office of the Inspector General (at DCFS)

**PedCAN:** Pediatric Child Abuse and Neglect

**RFP:** Request for Proposal



## ACKNOWLEDGEMENTS

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The Illinois Children's Justice Task Force was organized in 1989 in accordance with the guidelines in the federal Child Abuse Prevention Treatment Act (CAPTA), and in 1999 it became one of four of the Illinois' Citizen Review Panels. This Task Force is a multidisciplinary, legislatively-mandated advisory group that is charged with making recommendations to the Illinois Department of Children and Family Services (DCFS), directed at improving investigative, administrative, and judicial handling of child abuse cases, in a manner that limits additional trauma to the child victim. Increased focus is placed on cases of child sexual abuse and exploitation, child fatalities in cases where abuse or neglect is suspected, and cases involving a combination of jurisdictions.

The members of the Illinois Children's Justice Task Force represent legislatively-mandated categories and include child protection investigators, law enforcement professionals, medical and mental health service providers, criminal and civil court judges, prosecution and defense attorneys, educators, individuals knowledgeable about children with disabilities, child advocates, parent advocates, child abuse survivors, dually-involved children, and children who are homeless. The Task Force members are appointed by the Director of DCFS to staggered four-year terms. The Chair, Vice-Chair and Secretary are elected to their respective offices by the Task Force members.

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As the Chair of the Illinois Children's Justice Task Force, I would like to acknowledge the generosity of the many stakeholders who made this report possible, including all the Task Force members and the small workgroup created to work on these recommendations. The small workgroup, which I chaired with Dr. Jill Glick, dedicated many hours of their time to researching, writing, meeting, and debating how best to tackle this problem. What you will find in this report is the collective wisdom and combined decades of experience of professionals across the state who have intimate knowledge and expertise working in child abuse investigations.

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Finally, I would like to thank Senator Julie Morrison, without whom this report would not have been written, and the Department of Children and Family Services for their commitment to the Illinois Children's Justice Task Force and their willingness to commit resources to ensure these recommendations were completed.

A handwritten signature in black ink, appearing to read 'Char Rivette', with a stylized, cursive script.

Char Rivette, MSW, LCSW

## EXECUTIVE SUMMARY

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It is well known within the professional community intervening with child abuse that a collaborative response between child protection services, law enforcement, child maltreatment medical experts, courts, and children's advocacy centers is necessary to protect children from further harm. Unfortunately, formalized collaboration is not a standardized response in all areas of the state, resulting in inefficient and sometimes incorrect decisions. There are multiple examples of multidisciplinary teams led by children's advocacy centers within the state, but the level of collaboration and access to expertise varies greatly from county to county. To date there is no statewide formalized system to ensure that all the necessary experts are well-trained, accountable to their tasks as a unit, and accessible to all children regardless of geographical area. Allegations of severe child abuse, including severe injury, sexual abuse, and neglect involving medical concerns, are very difficult to determine and require a multidisciplinary, highly-skilled response to ensure that mistakes are not made, children are not further traumatized by the process, perpetrators are identified, and children with accidental injuries are recognized and such cases are expediently investigated and closed.

Illinois can do better. The multidisciplinary team model, well supported as a best-practice model, is lacking a statewide mandate to require their activation to investigate the targeted child abuse allegations discussed in these recommendations. This is exacerbated by a lack of accountability at a centralized level to ensure that the multidisciplinary teams that do exist respond in an efficient and effective manner. In addition, the current system is lacking in standardized training and expertise, and it is lacking in universal access to medical expertise and children's advocacy centers, resulting in decisions being made without access to accurate information, and an increased risk of trauma to the child and family. In particular, there is a crisis-level lack of medical pediatric maltreatment expertise within the state.

The State of Illinois has many collaborative partners in place from which to build a comprehensive and effective system to correct the problems that currently exist. Illinois has a strong network of children's advocacy centers that has been evolving and growing over the last thirty years. Children's advocacy centers have existing protocols with DCFS and law enforcement, with various levels of partnerships throughout the state. Our state has a few regional medically-directed child abuse hospital-based programs in Chicago, Peoria, Springfield, Anna, and Rockford, but not enough to ensure necessary access for all children reported for serious child abuse. Illinois has a new director of DCFS interested in reform, and a group of legislators that includes Senator Julie Morrison (who called for this report and recommendations), who are ready to make changes to improve.

We, the members of the Illinois Children's Justice Task Force, are grateful for this opportunity and respectfully request that the Illinois General Assembly and the Governor of the State of Illinois give due consideration to the findings and recommendations set forth in this report, and take all action necessary to implement the model of a unit-based multidisciplinary team investigation of child abuse statewide. Our members are ready to assist in an implementation plan, the realization of which would be life-changing to children for generations to come and would make Illinois a model that could be followed by other states also struggling with similar issues.

In this report, you will find our thorough review of the problem and our proposal for the creation of unit-based multidisciplinary teams throughout Illinois. Our recommendations are detailed at the end,

along with an implementation plan over the next several years. In summary, our overarching recommendations, supported by this document, are as follows:

1. Create mandatory regional unit-based multidisciplinary teams to investigate severe child abuse cases, including physical abuse and neglect of children younger than 3 years old, neglect related to medical concerns for children younger than 18 years old, and sexual abuse for children younger than 18 years old. The teams will consist of trained and dedicated investigators from law enforcement and child protection services, pediatric child abuse and neglect medical centers of excellence, children's advocacy centers, and state's attorneys.
2. Create a meta-organizational Commission, with a paid Commissioner, reporting directly to the Governor. This Commission will ensure implementation, accountability, and quality of the unit-based multidisciplinary teams across the state and will consist of representatives across the state in each multidisciplinary area.
3. Create a statewide network of pediatric child abuse and neglect medical centers of excellence and develop telemedicine for low-density areas where immediate access is not possible, to ensure access to medical review, intervention, and oversight in severe child abuse investigations. DCFS shall create an internal leadership position with pediatric child abuse and neglect forensic medical expertise and oversee this network.
4. Enact legislation to mandate and protect communication conducted between multidisciplinary team members for the purposes of investigation to increase collaboration, accuracy in decision-making, and efficiency.
5. Enact legislation to protect the mental health information for child victims that may be ascertained while screening and providing trauma-related support services during the investigative process.

## INTRODUCTION

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Public Act 099-023 charged the Illinois Children's Justice Task Force, an Illinois Citizen Review Panel, with exploration, research, and recommendations regarding a multidisciplinary team approach for the investigation of reports of abuse or neglect of children under the age of 18 years.<sup>1</sup> The charge to the Task Force was prompted in part by concerns about child abuse death cases in Illinois, especially multiple cases in which children were previously known to DCFS within a year prior to their death (Arnold & Fusco, 2013; Arnold, Schlikerman, & Fusco, 2015). This report is the Task Force's response.

Additionally, the Illinois Children's Justice Task Force is required to conduct a three-year statewide needs assessment on child abuse and neglect. The assessment, conducted by C+R Research in Chicago on behalf of the Task Force, asked participants about areas in child abuse and neglect which could be improved. The 554 participants surveyed included a wide range of professionals including social workers, counselors, support specialists, specialty advocates, physicians, law enforcement, judicial professionals, lawyers, and therapists. Of the 50 potential areas of child abuse and neglect, the analysis yielded 10 top priority areas for system improvement, six of which relate directly to issues addressed by unit-based MDTs recommended in this report<sup>2</sup>:

- Require the use of specially-trained DCFS investigators and law enforcement to work collaboratively to investigate child sexual abuse
- Ensure all children alleged to have been sexually abused have access to a specialized child sexual abuse physical evaluation
- Redesign the investigative system to require immediate scene investigation during the initial 24-hour mandate period in response to serious physical abuse allegations
- Ensure there is state-based funding of children's advocacy centers so that all areas of the state have access to the centers' services
- Require specialization of investigators in DCFS, law enforcement, state's attorneys, and judges who work on child abuse cases
- Require the use of a children's advocacy center multidisciplinary approach for the handling of child sexual abuse cases

The decisions that professionals make about whether child abuse occurs are life-changing for children and families. Through an intensive, deliberative process of review and discussion, including this systematic needs assessment, Task Force members representing all disciplines and various parts of the state<sup>3</sup> have identified significant weaknesses and concerns in investigative practices related to a lack of statewide access to essential forensic expertise and collaborative investigations. In addition, where multidisciplinary investigation processes are in place in Illinois, multiple systemic factors often impair their ability to function efficiently and effectively.

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<sup>1</sup> See Appendix A for the legislative text.

<sup>2</sup> See Appendix B for an illustration of the statewide needs assessment results.

<sup>3</sup> See Acknowledgements for the list of Task Force members and participants in the MDT subcommittee.

To address these concerns, we articulate a vision for dramatically improving the quality, timeliness, and accuracy of investigative decision-making through the **statewide implementation of regional unit-based multidisciplinary teams (MDTs)**. These teams will be comprised of expert professionals from DCFS, law enforcement (LE), medical child protection teams, children's advocacy centers (CACs), and prosecution. This is a shared vision, in which the responsibility for protecting children does not fall on DCFS alone. Teams will be trained to function as collaborative units that are focused on tailoring investigations to the needs of each child and family, rather than on meeting the bureaucratic requirements of each agency or organization. A Commission with meta-organizational authority will report directly to the Governor and oversee cross-organizational, statewide, and continuous quality improvement efforts and ensure that partner organizations support the integrity of MDT units and investigative processes.

The envisioned model offers Illinois the opportunity to move beyond other states that are making significant efforts to improve multidisciplinary investigative responses and the infrastructure necessary to support effective implementation of these responses. Rather than statewide reform efforts to focus on either sexual abuse (e.g., Pennsylvania; see Wolfe, Heckler, & Jackson, 2015) or medical responses to maltreatment (e.g., Texas; see The Texas Department of State Health Services, 2009 & 2012), the Illinois MDT model would address serious physical harm, abuse and neglect allegations for children under 3 years old, and sexual abuse and medically-related neglect allegations for children under 18 years old.<sup>4</sup> Professionals

### **A unit-based MDT could well have helped Amierah**

According to the WBEZ/*Chicago Sun-Times*, 19-month-old Amierah Roberson was beaten to death by her mother's boyfriend a month after a daycare worker reported to DCFS that Amierah had bruises and scratches and while the investigation was active (Arnold, Schlikerman, & Fusco, 2015). This case exemplifies the need for medical child abuse expertise to be fully integrated into the investigative process. While we do not have detailed information about this case, we note the following:

Bruises on toddlers are frequently reported to DCFS and many toddlers bruise as a result of their normal developmental inclinations to explore. Discerning which bruises are due to child abuse and which are due to an accident requires immediate examination of the child by a child abuse pediatrician (CAP) to assess the bruises and order necessary medical tests, as bruises can be signs of other injuries. This must be immediate, as bruises heal quickly. See Sugar, Taylor, & Feldman (1999) and Pierce, Smith, & Kaczor (2009) for research findings on bruising in children.

In a unit-based MDT, the CAP would be notified immediately of such a report and quickly able to start an evaluation. The forensic medical evaluation and conclusions would draw from cutting-edge scientific research on the differences between accidental and non-accidental bruising and analysis of the congruence between the caregiver's explanation of the injuries and the type and location of the injuries. To answer this question, the CAP, DCFS investigator, and law enforcement professional, trained in medical child abuse, would collaboratively conduct interviews with caregivers and a scene investigation to provide detailed information about the proposed explanation(s) of the injuries, as well as current and historical data on maltreatment, risk factors, and safety issues. The unit would review the case as soon as all necessary information was obtained and conduct an interdisciplinary meeting with participation from the medical center of excellence, CAC, DCFS, law enforcement, and prosecution. The quality of the evidence available and the ability to analyze that evidence would be dramatically enhanced by this collaboration.

A quick, coordinated, expert response available through a unit-based MDT could well have given Amierah another chance at life.

<sup>4</sup> See Table I in Appendix I for the allegations included within each category. DCFS uses the term "Lack of Health Care" for allegations which are referred to in this report as medically-related or medically-involved neglect.



would be trained and supported as a group. Additionally, they would be provided with dedicated resources and authority to function as a multidisciplinary unit, rather than as a collection of professionals attempting to manage important but often competing priorities. Effective unit-based communication and accountability will also be promoted through formalized institutional agreements and procedures, and through developing stronger and formalized collaborative relationships among the professionals who work together every day to protect children and support families.

The potential benefits of expanding and improving multidisciplinary investigations of child maltreatment are palpable and multifaceted:

- With the best available forensic evidence and sharing of pertinent information, professionals can make more accurate decisions that could enable them to better protect children after maltreatment has occurred or rule out abuse when appropriate and avoid the trauma of false accusations and unnecessarily placing children in foster care;
- CAC involvement will ensure that more children and non-offending caregivers will receive advocacy and support during the highly stressful investigative process;
- Increased CAC presence in Illinois will mean that more children will be able to talk about alleged maltreatment with trained forensic interviewers (who use a child-friendly, developmentally-appropriate approach) rather than enduring the pain of having to tell their stories to multiple people who may not be sufficiently trained. The interview will be digitally visually recorded to provide more accuracy and accountability in the investigative process;<sup>5</sup>
- Expansion of medical child protection teams and expertise will improve the detection and diagnosis of abuse and neglect by medical professionals. Just as importantly, medical child abuse experts will be able to more accurately rule out maltreatment, ensuring families are not separated unnecessarily or that those separations are as short as possible. If an injury is investigated and found to be caused by an accident upon admission, the need for a DCFS investigation would be eliminated, which spares families pain and stigma;<sup>6</sup>
- Following DCFS investigative findings, the increased quality of evidence and accuracy of decisions produced by unit-based MDTs will likely lead to more successfully maintaining an indicated finding after an appeal, and possibly a decline in the number of administrative appeals requested, and therefore the associated costs of time and effort.

Given that the request to the Task Force was prompted in part by concerns about death cases in which DCFS had prior involvement, the case example of Amierah is an illustration of how MDTs provide emergency expert responses that may have protected a child from harm in a specific death case.

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<sup>5</sup> See the section on Children's Advocacy Centers for more information about forensic interviews.

<sup>6</sup> For example, a study by the child abuse team at the University of Cincinnati found that 7 percent of cases referred to the team did not need to be reported to child welfare authorities (Wallace, Makoroff, Malott, & Shapiro, 2007).

## What is a Unit-Based Multidisciplinary Team?

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The term **multidisciplinary team (MDT)** is used frequently in medicine, human services, and business to refer to a group of expert professionals from different disciplines or orientations who work together to solve problems and make decisions and recommendations.<sup>7</sup> In this report, we focus on the use of MDTs to investigate allegations of child abuse or neglect. We specify the need for **unit-based MDTs** (comprised of expert professionals from CACs, medical child protection teams, DCFS child protection investigators (CPIs), LE, and prosecution) in order to emphasize that the team should be trained together and work as a collaborative unit, rather than as a collection of professionals from different organizations with different (though often overlapping) priorities, and separate organizational lines of authority. We believe that the unit-based approach will ensure that team members respond more efficiently and collaboratively to the needs of each case, resulting in more accurate and timely findings.

Our recommendations build on the strengths and infrastructure of two types of existing MDTs in parts of Illinois that are involved in the process of investigating child maltreatment:

- In 92 of 102 counties in Illinois, accredited CACs convene, coordinate, and participate in MDTs including DCFS and LE representatives, as well as medical, mental health, and advocacy professionals, via written protocols to investigate allegations of child sexual abuse and certain physical abuse cases and to provide advocacy and support services for child victims and non-offending parents.<sup>8</sup>
- There are 14 active, full-time certified child abuse pediatricians<sup>9</sup> (CAPs) in Illinois and five medically-directed child protection teams<sup>10</sup> that contract with DCFS to provide medical expertise in investigating sexual abuse, physical abuse, and medically-related neglect. Significantly, when an injured child arrives at their hospitals, the teams are capable of ascertaining accidental injury accurately, and this may result in avoiding a DCFS call altogether, reducing stress on the family and resources of the state.

In addition, there are innovative cross-organizational projects that have goals that are congruent with MDTs and that pull together professionals to collaborate and communicate more effectively around child abuse and neglect cases, including the Illinois Southern Region Child Death Review Team and the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC). Further, the error reduction training for DCFS investigators, developed by the Office of the Inspector General (OIG) at DCFS, has contributed to the ability of CPIs to support and work more collaboratively with physicians (Rzepnicki et al., 2011). The OIG (2015) made recommendations to improving the functions of child protection

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<sup>7</sup> Appendix C provides a similar and more detailed definition of an MDT based on the National Children's Alliance accreditation standards for Children's Advocacy Centers.

<sup>8</sup> Appendix D has the legislative text of the Illinois Children's Advocacy Center Act stipulating the creation and accreditation of CACs.

<sup>9</sup> See Appendix E for a list of CAPs in Illinois.

<sup>10</sup> See the Pediatric Child Abuse and Neglect Medical Centers of Excellence section for the list of teams.

investigations, CACs, and DCFS coordination with LE that are relevant to unit-based MDTs and the Task Force's overall efforts to improve child maltreatment investigations.<sup>11</sup>

Despite the presence of CAC-facilitated MDTs, medically-directed MDTs in Illinois, and such complementary efforts to support MDTs, Task Force members strongly believe that MDT investigations need to be both expanded and improved in order to address gaps in access to expertise and to increase the efficiency and effectiveness of existing MDTs.

### Child Maltreatment in Illinois: Priorities for Unit-Based MDT Investigations

Although we do not know the actual incidence of abuse or neglect because it often goes undetected or unreported, what we do know illustrates that child maltreatment remains a significant public health problem in Illinois. In fiscal year 2014 (FY14: June 1, 2013 to July 31, 2014), there were 109,783 reports to the DCFS Hotline that were accepted for an investigation, and 24,627 (22%) of these reports were indicated for abuse or neglect (i.e., substantiated). Of the FY14 reports, there were 211 child death reports, 105 (50%) of which were indicated. Of the indicated child deaths, about two-thirds were due to abuse and the rest to neglect.

While access to unit-based MDTs would be useful in many cases, the Task Force is recommending that Illinois prioritize serious cases of child maltreatment in which there are more specialized needs for medical child abuse expertise and forensic interviewing, and in cases in which law enforcement and DCFS are both involved. These would include child maltreatment allegations of serious physical injury to children under 3 years old, and neglect cases in which there is a medical concern for children under 18 years old (allegations of medical neglect, neglect of a disabled infant, nonorganic failure to thrive, and/or malnutrition), and child sexual abuse for children under 18 years old.<sup>12</sup> The Task Force also recommends that all reports involving alleged child victims with diagnosed developmental disabilities should be referred for MDT investigations (no data are available on this group of children) and that other reports can be referred by DCFS when a multidisciplinary response is needed.

The need for a unit-based MDT in response to each of the three targeted types of allegations is summarized below:

- 1) *Physical harm/injury of children under the age of 3 years*: Unit-based MDTs address the primary need in these cases for medical expertise to ascertain the manner of injury, as well as the need of timely and accurate forensic information from DCFS and LE for the child abuse pediatrician (CAP) to make his or her diagnoses. Additionally, since these children are typically not verbal, forensic interviews of older siblings can be advantageous in determining the truth of allegations. These are very difficult cases to investigate and, as is emphasized below, young children who are physically abused are at relatively high risk of severe injury or death.

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<sup>11</sup> We do not mean to imply that there are no other important MDTs in Illinois. See the Pediatric Child Abuse and Neglect Medical Centers of Excellence section for examples of other medically-directed MDTs. Appendix F, Appendix G, and Appendix H contain additional information about MPEEC, the Child Death Review Team, and the OIG recommendations, respectively.

<sup>12</sup> See Table I in Appendix I for the list of specific DCFS allegations and Appendix J for additional data on these cases. These four allegations in which there is a medical concern are categorized as "Lack of Health Care" in DCFS reports.

- 2) Neglect involving medical concerns for children under the age of 18 years: Unit-based MDTs are needed due to the degree of difficulty in ascertaining the root cause of the condition of the child. The expertise of a CAP in directing the collection of evidence by skilled investigators from DCFS and LE is essential to making an accurate diagnosis and appropriate recommendations for medical treatment and other clinical and supportive services.
- 3) Sexual abuse and exploitation for children under the age of 18 years: In these cases, children require a forensic interview from a CAC, along with the potential for gathering medical evidence, and the collaborative collection of forensic evidence by DCFS and LE. Given that sexual abuse is most likely perpetrated by a household or family member and that there are typically no witnesses, these cases are often difficult to investigate. Also, given the trauma of sexual abuse, victims are in need of the support and resources offered by CACs.

The table below shows that there were more than 13,000 maltreatment reports statewide that involved these three types of allegations in FY14, which were approximately 12% of all maltreatment reports. About 25-30% of these reports were ultimately indicated. It is important to highlight that these types of reports occur throughout the state, with approximately one-third coming from Cook County and the remainder from other areas of Illinois.<sup>13</sup>

**Table 1: Illinois DCFS child maltreatment statistics for FY14**

<b>Types of Allegations Targeted for MDT Response</b>	<b>N</b>
Physical harms (children < 3 years)	1,600
Neglect cases involving medical concerns (children < 18 years)	3,984
Sexual abuse (children < 18 years)	7,569
Human Trafficking (including commercial sexual exploitation; children < 18 years)	135
<b>Total<sup>14</sup></b>	<b>13,288</b>

*Note: We are targeting only a subset of human trafficking allegations that involve commercial sexual exploitation.*

Several areas of research on child deaths and serious injuries inform our broad recommendation to create unit-based MDTs, as well as our specific recommendations to target young children in cases involving serious physical harm, and all children with medically-involved forms of neglect. Young children are at the greatest risk of maltreatment-related deaths, especially infants under the age of 1; they make up almost half (46.5%) of all reported child maltreatment fatalities in 2013 (Child Welfare Information Gateway, 2015). Analysis conducted for the Task Force showed that 70% of abusive head trauma allegations in Illinois involved children under the age of 1 year.<sup>15</sup>

<sup>13</sup> Further, while Cook County accounts for a large number of cases, the rates of maltreatment reports per 1,000 children in Cook County are lower than the population rates for most other Illinois counties. This is true for both sexual abuse and the medically-related neglect of young children; see Appendix K and Appendix L.

<sup>14</sup> The physical harms figures are counts of child reports that include target allegations. Some children may be counted more than once. Data sources for physical harms are provided by Dr. Tamara Fuller, UIUC Children and Family Research Center. The figures for lack of health care and sexual abuse allegations are drawn from the DCFS Annual Statistics Report for FY14. These figures can include duplicate counts of children when there different reports and/or multiple perpetrators.

<sup>15</sup> See Appendix M for supplemental analyses of abusive head trauma allegations.

One important decision made by the Task Force is to include among the target allegations reports of cuts, welts, and bruises (DCFS abuse allegation 11) of children under 3 years of age. While the physical harm to the child is not as serious as some other allegations (e.g., those involving head trauma), this alleged maltreatment of young children should be elevated to a “major” level of concern similar to a skeletal or burn injury due to child safety concerns and the need for immediate medical evaluation. We found that there were 1,020 of these child abuse reports in FY14. Studies illustrate the importance of seeing these as red flags for later abuse and the need for a developmentally-informed understanding of how these injuries occur to make accurate medical diagnoses. In a study of 200 infants (less than 12 months old) who were definitely abused, there was documented evidence of previous (usefully termed *sentinel*) injuries for over one-quarter of the infants. Over three-fourths of these prior injuries involved bruising, and almost all occurred when the child was less than 7 months old (Sheets et al, 2013). Research on bruising (Sugar, Taylor, & Feldman, 1999) known to child abuse experts now shows that infants who do not “cruise” (i.e., slide or crawl along on the floor, hold on to things for support) rarely have accidental bruises. That is, bruising of non-cruising infants, in the absence of medical explanations, is usually due to physical abuse and neglect. Due to the high-risk nature of bruises in young children and the fact that bruises can fade quickly, an expert medical evaluation must be conducted quickly and in close collaboration with LE and DCFS investigators.

Once infants become mobile (i.e., start to cruise, then crawl, then walk), medical diagnosis of child maltreatment is even more difficult. Toddlers, in particular, frequently bruise as a result of normal developmental tendencies to actively explore their environment. Proper medical diagnosis of maltreatment in these cases for cruising infants and mobile toddlers is informed by research on the locations and frequency of bruising in accidental versus non-accidental injuries (Sugar et al, 1999), but it also requires an assessment of viability and credibility of the caregiver’s explanation of the injury. The latter assessment is drawn from interviews, scene investigations and reenactments, and risk assessments by LE and DCFS investigators, which are ideally directed by the CAP.

Especially in targeting physical abuse of young children, unit-based MDTs can potentially reduce the likelihood of maltreatment cases seen by professionals for prior concerns. In Illinois, WBEZ and *Chicago Sun-Times* reported that for 27% of child deaths in FY13 due to abuse or neglect, DCFS had been involved with the child prior to the death (Arnold & Fusco, 2013). In an important study of over half a million children age 0 to 5 years in California, about one-third of intentional child fatalities (i.e., deaths due to abuse) for children were previously known to the child protection system (Putnam-Hornstein, 2011). Children who had a report of maltreatment were 5.9 times more likely than unreported children to have an intentional fatality before the age of 5 (Putnam-Hornstein, 2011). Further, children who had a prior report of physical abuse were five times more likely than children with a prior neglect report to experience a fatal injury (Putnam-Hornstein, Cleves, Licht, & Needell, 2013).

Prior involvement with children who are killed or physically harmed is not restricted to a child protection professional. Researchers have found evidence of medical visits prior to abusive injuries in which the child’s presenting problems raise concerns about previous maltreatment. Among a sample of children with abusive fractures, over 20.9% had at least one previous visit with a physician in which abuse was missed (Ravichandiran et al, 2010). In an in-depth hospital-based study of a small sample of abusive head trauma cases, 30% had prior injuries and 65% had a history of prior medical evaluations for problems that were possibly related to abuse (Ricci et al, 2003). In a larger study of 173 abusive head trauma cases, the diagnosis of abuse was initially missed in 31% of cases. Of the children with missed abuse diagnoses, 27.8% were reinjured after the missed diagnosis, and 40.7% had medical complications

related to the missed diagnosis (Jenny et al, 1999). The diagnoses of abuse were missed generally due to lack of expertise on the part of the medical providers, as well as lack of a unit-based MDT response.

The need for unit-based MDT investigations of child sexual abuse investigations is rooted in concerns about systemic problems and investigative practices that predate and prompted the expansion of CACs in Illinois and nationally. The first CAC was developed in 1985 in Huntsville, Alabama, because, “The social service and the criminal justice systems, at the time, were not working together in an effective manner that children could trust, adding to the children's emotional distress, and creating a segmented, repetitious, and often frightening experience for the child victims” (National Children’s Advocacy Center). Specific concerns included: a) the frequent re-traumatizing of child sexual abuse victims by making them tell their story to multiple professionals; b) multiple interviews with various professionals creating possible conflicting evidence due to the developmental stages of children; c) questions among some professionals and researchers that interviewing techniques (e.g., leading questions) might encourage children to make inaccurate statements (American Prosecutor Research Institute, 1993; Pence & Wilson, 1994; Saywitz & Goodman, 1996) and/or produce evidence of maltreatment that was not usable in court; and d) chain of custody issues. In response, CACs are able to conduct and digitally visually record interviews by a single expert forensic interviewer who is trained in nationally-recognized models, is skilled at engaging children, understands the developmental level of children, and avoids leading questions. The interviews are observed by the investigatory team members who can recommend that the interviewer ask specific questions. The forensic interview is a necessary and critical piece without which it would be extremely difficult to move forward to make protective decisions and prosecute cases. These cases are very difficult to prove due to the nature of the abuse; there is rarely physical evidence and the dynamics of the abuse are secrecy and shame. Research indicates that only 20-40% of sexual abuse is reported to authorities and the incident rate is high (1 in 20) (Finkelhor, Ormrod, Turner, & Hamby, 2012).

## VISION FOR STATEWIDE UNIT-BASED MULTIDISCIPLINARY TEAMS

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The Illinois Children’s Justice Task Force was legislatively charged, through Public Act 099-0023, with improving the quality and accuracy of decision-making of child maltreatment investigations, and increasing child safety while reducing trauma to child victims and families. This will be accomplished through the creation of unit-based MDTs that consist of specialized staff to collaboratively investigate reports of child maltreatment accepted by the Statewide Central Register and/or referred by LE. Core unit-based MDT partners include DCFS, LE, medical child maltreatment centers, CACs, and prosecution. To more fully articulate our vision, we highlight the guiding principles and strategies of this vision, and then describe important roles, strengths, and challenges of each MDT partner.

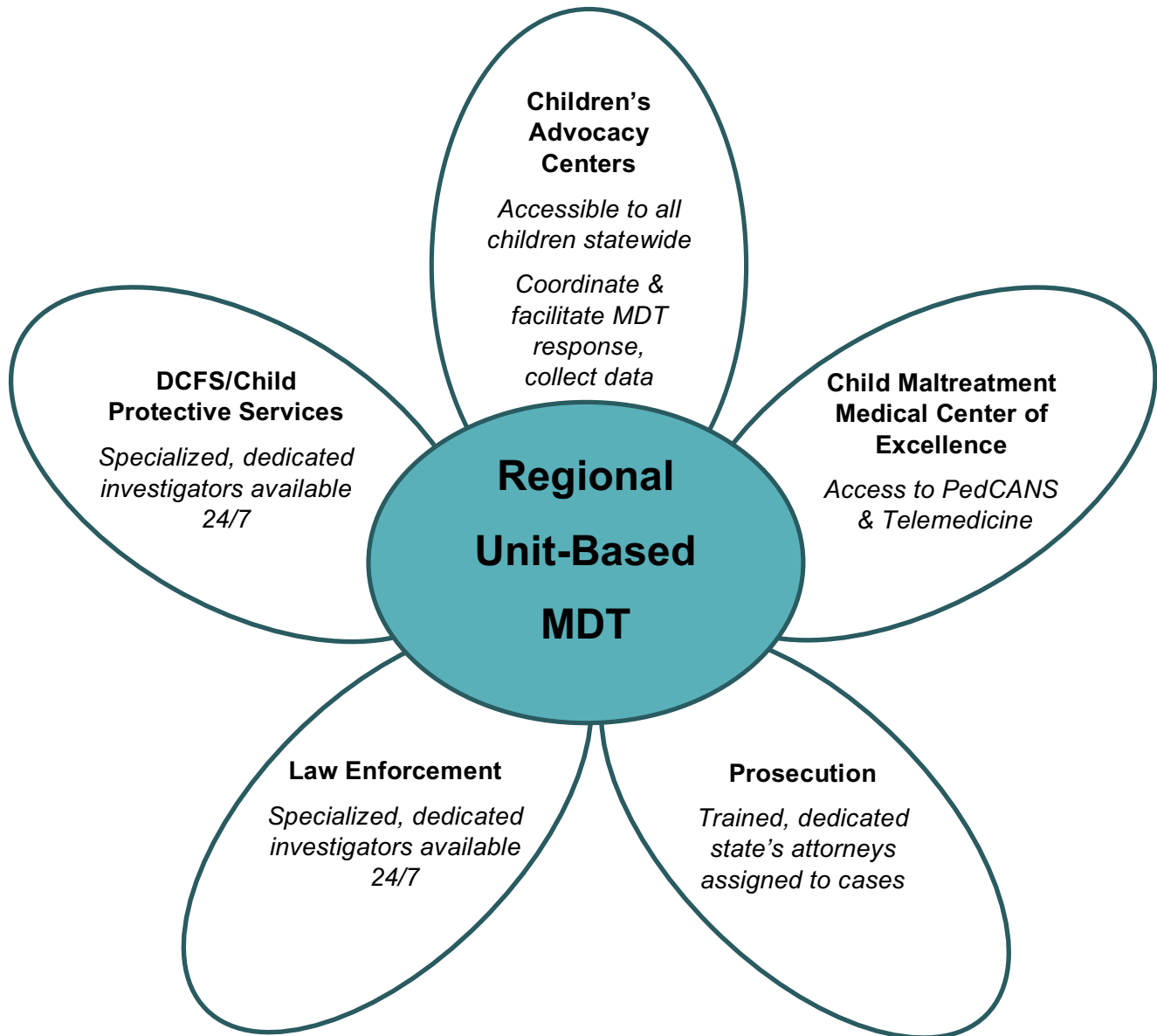
### AN ILLUSTRATION

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The following is a graphic defining the roles of the multiple members of a regional unit-based MDT and how they will work together.

## Statewide Commission

Commissioner reports to Governor, oversees implementation of unit-based MDTs, collects statewide data, ensures accountability & quality. Commission includes leaders from each discipline. Develops Medical Centers of Excellence Network and Pediatric Child Abuse & Neglect (PedCAN) sites.



Develop Network of PedCANS, including Medical Centers of Excellence  
Ensure Statewide Coverage of Children's Advocacy Centers  
Implement Unit-Based Ongoing Education and Quality Improvement Processes  
Enact Legislative Changes to Improve Collaboration and Communication

## GUIDING PRINCIPLES AND STRATEGIES

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Planning and implementing unit-based MDTs for investigating child maltreatment in Illinois should be guided by the following interconnected principles and strategies:

- Unit-based approach to training, reviewing, and summarizing cases. MDT members must be trained as a unit, both initially and on an ongoing basis. This is essential so that members will build trusting, collaborative relationships and have a shared understanding of the most current scientific research and investigative best practices related to the targeted allegations of maltreatment. Just as importantly, members will develop an understanding of the unique roles and challenges of each partner and how they can communicate most effectively and efficiently during the process. For every case, decisions and reports will be discussed and reviewed by the team. Periodic meetings of the unit will be essential to addressing case level questions.
- Motivated expert professionals must have significant time allocated to MDT units. At a minimum, the MDT units will include dedicated professionals who demonstrate a strong commitment to the collaborative process and the well-being of children. Expertise within each profession will require either a certification process (e.g., child abuse pediatrics) and/or completion of specific training related to the unique role of each MDT professional.
- Prioritize cases most in need of multidisciplinary investigations. The MDTs will target reports that include allegations of child sexual abuse for children under 18 years of age, physical harm allegations due to abuse or neglect of children under 3 years of age, and medically-related neglect allegations for children under 18 years of age (see Table I in Appendix I for specific DCFS allegations covered within these categories). As noted earlier, the target allegations are highly likely to require a multidisciplinary response that extends beyond the role of the DCFS CPI. In addition, reports involving children with cognitive delays should be referred for MDTs due to the need for expert forensic interviewers to communicate effectively with these children. At the discretion of DCFS and/or LE and based on an assessment of need, other cases can also be referred to MDT units. Depending on evaluations of the effectiveness of unit-based MDTs and the availability of resources, it may at some time in the future be possible and advisable to expand the types of allegations included.
- Individualize responses to the needs of the child and case. The multidisciplinary investigative response should be tailored to the needs of the case and the child, based on the immediate safety needs of the child, as well as the needs and urgency of forensic evidence. Case coordination by the CAC will be central in ensuring that the unit is activated and all members of the MDT are intervening in the manner appropriate to the case.

For example, when a child presents with allegations related to serious physical harm or neglect due to lack of medical care, the forensic evaluation by the medical child protection team is of primary consideration. The direction of the CAP on how to move forward effectively will be the primary focus. The medical child protection team would take the lead on these cases, driving the direction for evidence collection and follow-up needed by the investigative staff. It is imperative that LE and DCFS have immediate and ongoing contact with medical experts to guide and augment the real-time investigation. The CAP and LE need ongoing communication to



collaboratively determine the manner of injury based on all the known information, including scene investigation, interviewing witnesses, and the medical history obtained by the pediatric child abuse and neglect medical center of excellence (PedCAN MCOE). Without this, the PedCAN MCOE will not be able to accurately diagnose child abuse, and LE and DCFS will not be able to accurately determine the timeframe of the injury and the perpetrator of the injury.

In child sexual abuse investigations, the need for urgency to protect the child and collect forensic evidence is based upon the immediate safety of the child, access of the alleged perpetrator to the child or other potential victims, the likelihood of the perpetrator fleeing, and the timeframe between the most recent abusive event and the report. The evidence-gathering and decision-making process is based on the forensic interview, which should be scheduled as soon as possible after the report, and should be observed by LE, DCFS and prosecution, and digitally visually recorded. This provides the basis for subsequent interviews with the alleged perpetrator(s) and witnesses by LE and DCFS (including scene investigations, timelines, and risk and safety assessments). The CAP collects forensic medical evidence when present and conducts a medical history. He or she plays a collaborative role in investigative assessment and decision-making.

- *Respond quickly and complete investigations in a timely manner.* Delays in starting key investigative tasks (e.g., forensic interviews of child victims, medical evaluations, witness interviews, scene investigations) often diminish the quality of evidence by allowing for the possibility that adults will attempt to coerce children or other adults to deny maltreatment, or that adults will collude to develop agreed upon explanations of injuries or actions that are less incriminating than what really happened. Children who had the courage to report sexual abuse may become frightened and refuse to participate. Alleged perpetrators may flee. The length of DCFS investigations is also important. Both the length of the investigation and the time and effort required of DCFS CPIs is sometimes exacerbated by the failure of some professionals (such as LE, mental health providers, and health care providers) to share information or findings that are pertinent to completing the investigation. Unlike DCFS, which has specific timelines to complete investigations, LE has no such timeframes and thus can suspend cases indefinitely. Additionally, slow medical lab report results, uncooperative parents, and a lack of available forensic experts (CACs and medical experts) can delay investigations. Perhaps more importantly, failure to complete investigations in a timely manner puts greater strain on children and families. Lengthy investigations are especially problematic in cases that are ultimately unfounded (i.e., not substantiated) after the child was placed temporarily or an adult caregiver was removed from the home pending the outcome of the investigation. In order to maximize responsiveness and minimize delays, each MDT unit needs to have ready access to expert partners from medicine, LE, DCFS, and the CAC.
- *MDT reports related to allegations of physical harm due to abuse or neglect for children under 3 years and medically-involved neglect for children under 18 years will synthesize case-level findings and evidence.* For these cases, CAPs and their medical teams will produce reports that summarize the presenting concerns and allegations, the available evidence, medical conclusions that are supported by specific evidence, and recommendations. These summary reports are provided by existing hospital-based child protection teams and are useful in clearing some caregivers of maltreatment with a greater degree of certainty and in providing high-quality

evidence that can be used in sustaining findings of maltreatment in administrative appeals, civil child abuse or neglect prosecutions, or criminal prosecutions. In child sexual abuse cases, digitally recorded/videotaped interviews at CACs now provide the high-quality evidence that is needed for case decision-making.

- *Real time coordinating and monitoring of partner activity and communication at the case level.* The collaborative process of investigation will include case-level coordination and monitoring of partner activities to ensure that all partners are responding promptly and communicating with other MDT members as needed. This will require that CAC case coordinators have the ability to track the timing of key events in the investigation and the authority to ensure timely and meaningful responses.
- *Continuous quality improvement and accountability.* Meaningful changes in practice and improvements in outcomes will require continuous quality improvement (CQI), quality assurance, and evaluation processes and strategies that operate at the MDT unit, regional, and statewide levels. The primary functions of CQI are to assess changes and progress over time, and to provide feedback about challenges and promising strategies that can be used to inform efforts to improve the quality and outcomes of MDTs. Specific activities include but are not limited to ongoing case reviews, tracking of activities and MDT members, and assessment or evaluation of: a) implementation activities (e.g., planning, specialized training, unit-based training); b) proximal service quality outcomes (e.g., support provided to children and non-offending caregivers, levels of collaboration/coordination, access to MDT expertise, timeliness of responses, and quality of evidence available to make decisions); and c) case-level outcomes.

Appendix N presents a model of CQI to increase the quality, timeliness, and accuracy of child protection decisions. It also illustrates the types of activities, service quality outcomes, and child and case-level outcomes that can be examined from the implementation of unit-based MDTs. Desired child and case-level outcomes that might be examined include:

- Reduced trauma for children during and after investigations, including reductions in subsequent maltreatment of children
- Reduced overturned appeals for cases that are indicated
- Increased rates of prosecution, resulting potentially from better evidence or increased engagement of prosecutors in taking cases to trial when DCFS indicates
- Increased ability to rule out abuse with greater certainty and/or more quickly reunify families
- Reduced child deaths in cases with prior involvement with DCFS

The CAC coordinator will play a key role in providing information about unit-level activities, including information drawn from partners. The ultimate structure of regional- and state-level quality improvement efforts should be determined by the meta-organizational Commission (see below), but will ideally include the involvement of quality improvement staff from CACs, DCFS, pediatric MCOEs, and if a viable partner can be found, LE. Organizational partners will likely need to refine their existing databases to collect specific data on MDT cases. Detailed data-sharing agreements will be necessary in order to track case-level activities and unit-based MDT

outcomes across disciplines. An illustration of the importance and utility of linking databases across organizations for evaluation and quality improvement is provided in Appendix O.

- Statewide access to MDTs. For the target maltreatment allegations, all children and families in Illinois will have access to unit-based MDT investigations and the professional expertise they will provide. The Task Force realizes that this is a significant challenge, but it is well worth the sustained commitment and effort to achieve it. Given the shortage of board-certified CAPs, it will be essential to develop an infrastructure to support the use of telemedicine to provide medical expertise in areas of Illinois where it is not a reality. It will also be necessary for accredited CACs to be expanded in order to have full coverage in all counties of Illinois.
- Statewide principles and indicators along with regional flexibility in implementation. Given the variation in available resources and the considerable differences in areas of Illinois, it will be important to emphasize that the MDT principles and ideals noted here are relevant to all children and families in Illinois. At the same time, it is essential to allow flexibility and promote creativity in adapting unit-based MDTs and utilizing existing resources to meet local and regional needs.
- A meta-organizational authority is needed to successfully plan and implement unit-based MDTs. External pressures and cost constraints within organizations are persistent and powerful dynamics that perpetuate service silos and often inhibit effective collaboration across organizations at the case-level and at regional and state system levels. We believe that a meta-organizational authority reporting to the Governor<sup>16</sup> is needed in order ensure that the expectations of each partner (e.g., allocation of resources, specialized certification and training) and the collaborative activities of unit-based MDTs are effectively implemented. We recommend that this authority consist of a full-time Commissioner and a Commission consisting primarily of partner representatives (see details in Recommendations). Essential collaborative activities involving all partners include, but are not limited to: adequate allocation of dedicated and trained staff to MDT; unit-based training; timely completion of case-level investigative activities; active communication with the MDT throughout investigations, case review processes, CQI and evaluation activities; and sharing data. Formalized written agreements (e.g., protocols and memorandums of understanding) among partners will also be needed to clarify organizational commitments, expectations, and needs.

## UNIT-BASED MDT PARTNERS: ROLES, STRENGTHS, AND CHALLENGES

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All unit-based MDTs will be comprised of institutions and explicitly dedicated experts from law enforcement, DCFS child protection services, medical child protection teams, children's advocacy centers, and prosecution. Below we briefly describe the important roles of each partner, institutional strengths, and profession specific challenges they face in maximizing their effectiveness in the MDT units.

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<sup>16</sup> The Commission must also have built-in processes to ensure political independence; see the Recommendations.

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## LAW ENFORCEMENT

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Law enforcement (LE) professionals play crucial roles in responding quickly and around the clock to crises, conducting interviews that promptly and systematically gather information about the incident and various explanations of the incident or injuries, and participating in forensic interviews<sup>17</sup> at CACs. They gather and preserve evidence for use in both child protection decision-making and criminal prosecutions. LE are essential participants in investigating cases involving sexual abuse and serious physical harms and may also be involved in other types of child maltreatment cases. Their key tasks include: interviewing alleged perpetrators and witnesses; doing background checks; conducting scene investigations and gathering physical evidence (including reenactment of the incident); constructing detailed timelines from the perspectives of multiple witnesses; and ensuring acquisition of documents.

In the unit-based MDT, they would do so in collaboration with DCFS investigators, PedCAN MCOEs, and CACs. Delays by LE and DCFS in conducting separate interviews with key people will often undermine the quality of evidence by increasing the likelihood that adults will: a) coach children on what to say (or not say) to investigators, or b) communicate with each other to try to come up with consistent explanations of a child's injuries or statements. Of particular importance is the role of LE in physical abuse cases in which the CAP is the key driver of the direction of the case. It is imperative that LE (and DCFS) have immediate and ongoing contact with medical expertise to guide and augment the real-time investigation. The CAP and LE need ongoing communication to collaboratively determine the manner of injury based on all the known information, including scene investigation, interviewing witnesses, and the medical history obtained by the PedCAN MCOE. Without this, the PedCAN MCOE will not be able to accurately diagnose whether or not child abuse occurred, and LE and DCFS will not be able to accurately determine the timeframe of the injury and the perpetrator of the injury (if caused by abuse).

All MDT units will include dedicated LE professionals from all shifts in order to provide around the clock response. In addition, a designated supervisor or administrator with expertise and authority will also be a member of the MDT in order to provide timely consultation and ensure that LE professionals respond to case circumstances and communicate with MDT partners in a timely manner. The number of LE professionals assigned to this team is contingent upon the number of reports of child maltreatment within local and regional jurisdictions. Because LE is generally organized at the local (i.e., city or county) level, each regional unit will develop and implement plans about how best to create an investigative unit in collaboration with the various jurisdictional local LE agencies in order to ensure immediate and high-quality MDT investigations throughout the region. Availability of LE to be a full participant in the MDT unit is essential to determine whether maltreatment occurred and whether it meets the requirements of a criminal act, and identify the perpetrator(s) and other potential victims when applicable.

A prompt and thorough scene investigation is critical to the success of any investigation. Optimally, law enforcement personnel have been specially trained on how to photograph, document, recover, and preserve evidence from a scene involving alleged child abuse. For example, photographing the area involves covering 360 degrees, doing close-ups, and creating an "ID card" which identifies the location, case number, date, and other essential information. Expert LE professionals are also trained to photograph first, then properly recover and inventory property using gloves, and they observe a chain of

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<sup>17</sup> See section on children's advocacy centers below for case examples and additional information about forensic interviews.

custody for physical evidence. Unlike DCFS investigators, LE has the ability to send electronic devices, weapons, drugs, biological samples, and other evidence to the crime lab for analysis. As required by the case, LE can take water and surface temperatures and measurements of rooms and the distance between fixed items. This information will be shared with all MDT members.

When a scene investigation is not done promptly or thoroughly by personnel trained to do so and having the equipment to do so, key evidence may be missed. As most of the incidents being investigated occur in a residence, it is important that access be obtained by consent, search warrant, or because of exigent circumstances or well-being check. Any delay in conducting a thorough scene investigation may result in a potential crime scene becoming compromised or the destruction of evidence. Further, in today's society, most individuals use technology such as texting or social media to communicate with others. This makes it imperative that LE act quickly to identify devices, accounts and phone numbers of suspected perpetrators and victims, and then preserve any communications made on such numbers or accounts. This process may be accomplished by obtaining consents or the issuance of search warrants as soon as possible.

Fundamental challenges of effectively engaging law enforcement in MDT investigative units statewide include:

- *Lack of a centralized LE authority.* There is no statewide authority over local LE jurisdiction, which inhibits the ability of MDTs to develop formalized inter-organizational protocols regionally and statewide, and to monitor and ensure participation of LE in MDTs.
- *Large number of independent LE jurisdictions.* According to US Bureau of Justice statistics and Task Force members, there are 877 LE jurisdictions in Illinois, including, for example, over 100 in Cook County and at least 12 in McLean County (Reeves, 2011). The sheer number of jurisdictions poses considerable challenges related to planning and implementing unit-based MDTs.
- *Lack of personnel and competing priorities.* Due to budget constraints and the prevalence of other crime-related problems, many LE jurisdictions lack the resources and staff to provide specialized, trained LE professionals to respond to child maltreatment cases. In a large majority of jurisdictions, some LE professionals are not assigned specifically to child maltreatment cases. The result is that CACs, medical providers, and DCFS investigators often work with different officers on each case.
- *Lack of expertise.* Few LE officers have the necessary training or experience to investigate serious forms of child maltreatment and conduct thorough scene investigations and interviews. In addition, detectives vary considerably in their ability to describe the available evidence and clearly articulate the evidence supporting their conclusions. When maltreatment has occurred, poor quality reports make upholding administrative appeals and successful civil or criminal prosecution much more difficult.
- *Delays in sharing reports and concluding investigations.* LE can hamper the timeliness of DCFS decision-making when they delay providing existing reports to DCFS (see details in the section on DCFS below). Additionally, since there are no expectations regarding the timeframe of completing an investigation, cases can remain open (pending) for an unspecified amount of time, whereas DCFS has 60 days to complete their investigation.

- *Lack of urgency.* Frequently, likely due to competing priorities, LE does not respond immediately to reports of child maltreatment. Unlike DCFS, which has a mandate to respond within 24 hours, LE may delay its investigation. This can result in delays of conducting scene investigations, communicating key information to CAPs, and scheduling forensic interviews.

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## DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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Professionals from DCFS will play several important roles in the MDT process. All MDT units will include selected and dedicated DCFS child protection investigators (CPIs). CPIs will complete additional specialized training on investigating all allegations targeted for MDT units. The number of child protection investigators assigned to an MDT team is contingent upon the number of targeted reports of child maltreatment. The teams will need sufficient staff in order to respond immediately to these reports of child maltreatment with 24/7 coverage. In addition to CPIs, a designated supervisor or administrator with expertise and authority will also be a member of the MDT in order to: a) provide timely consultation on reporting and investigative rules and procedures; and b) ensure that investigators respond to case circumstances and communicate with MDT partners in a timely manner.

DCFS CPIs and supervisors have the delegated authority to gather all information needed to investigate allegations of child abuse and neglect. They make life-changing decisions about whether to indicate (i.e., substantiate) these allegations and, along with the court, whether to remove children from the home. Like LE, their full participation in timely and thorough initial interviews, scene investigations, and communication with all members of the MDT is essential to making informed and accurate decisions.

In addition, expert CPIs are able to make a set of unique contributions, including:

- Conducting an immediate safety check and initiating a safety plan if necessary while the MDT unit conducts its investigation. This may include taking protective custody.
- Assessing and addressing the needs and safety of all children in the family, not just the originally identified victim, which sometimes can result in identifying multiple witnesses and additional victims of maltreatment.
- Providing the unit with a fuller assessment of family history and dynamics that can inform decisions about how to proceed in the investigative process, including detailed information about prior maltreatment, key risk factors (e.g., domestic violence, mental health issues, substance abuse, housing instability), participation in recommended/needed services, and patterns and changes in who is caring for children and household composition.
- Obtaining, based on their delegated authority, medical and mental health records pertinent to the investigation.
- Conducting multiple interviews over time with the same caregiver to gather additional information and assess the consistency over time of explanations of injuries and timelines (i.e., what happened in the 48-72 hours before an incident).
- Conducting interviews with siblings and collaterals to gather multiple perspectives on broader risk issues and to attempt to corroborate, and also to identify potential other victims that may need a forensic interview or medical evaluation.
- Obtaining statements or confessions from some perpetrators who feel more comfortable with DCFS than with LE.

- Communicating effectively with all members of the MDT over the course of the investigation in ways that enhance the quality of evidence available for making critical decisions.
- Ultimately determining whether to indicate a report, place a child in substitute care, or refer for intact family services.
- Assessing the need for and providing access to necessary services.

Furthermore, DCFS offers considerable institutional strengths that can benefit the implementation of MDT units, which include:

- The leadership of DCFS Operations has made a commitment to improving investigative procedures and the quality of investigative practice including key areas relevant to MDTs, such as conducting scene investigations, developing timelines, working with CAPs, utilizing CACs, supervision, and written documentation of evidence and findings.
- Regional and statewide Quality Improvement staff that could potentially collaborate with and support MDT CQI efforts.
- A regional and subregional administrative structure that will be useful in planning and implementing for various purposes, such as formalizing protocols, defining catchment areas and MDT units, and coordinating CQI efforts.
- Training curriculum developed by leading CAPs on medical information relevant to child abuse that is integrated into core training for all CPIs.
- Child sexual abuse reports that are accepted for investigation by the DCFS Hotline are automatically referred to CACs for investigations.
- Active partnerships with CACs throughout the state in handling child sexual abuse and severe child abuse MDT investigations. In Chicago, DCFS has a specialized unit working at the co-located ChicagoCAC facility along with LE, prosecution, and a medical clinic staffed by Stroger Hospital CAPs. In addition, priority one teams exist in some parts of the state, and although they are not fully resourced, they represent a building block of the unit-based model.
- Working with CACs to create a memorandum of understanding (MOU) allowing for more access to hotline information and other pertinent data to improve the current CAC-MDT response to child sexual abuse and severe child abuse allegations.
- Existing partnerships with medical child abuse centers noted above and innovative partnership with MPEEC.<sup>18</sup>

Despite these considerable strengths, from the perspective of planning and implementing unit-based MDTs for the purpose of investigating targeted maltreatment allegations, there are important concerns about DCFS investigative practice and systems, including:

- DCFS no longer has fully-staffed, dedicated teams that focus on the most serious allegations of physical harm and in most instances of sexual abuse. In at least two counties in Illinois (Winnebago and McLean), some partners are co-located in the CAC; only at the ChicagoCAC are all MDT partners available on site. Thus, investigators often have minimal experience and/or skill at investigating some of the serious allegations targeted by the Task Force or in collaborating with other partners in these cases.

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<sup>18</sup> See Appendix F for additional information about MPEEC.

- There is sometimes an overemphasis in practice on compliance with specific procedural objectives and statutes (e.g., meeting time frames for initiating and completing investigations, and documenting that certain tasks were done) and less emphasis on the quality of investigations related to both evidence-gathering and documentation. CPIs are required to complete investigations within 60 days, even though delays are often out of their control.<sup>19</sup>
- The current repetitive and voluminous electronic case record structure used by DCFS investigators inadvertently exacerbates the focus on procedural compliance and discourages a clear written synthesis of investigative findings and the evidence that supports the findings. The printed records are often confusing and challenging to use for the purposes of clinical case reviews or as evidence in administrative appeals, civil child abuse and neglect prosecution, and criminal prosecution.
- Despite the use of medical child abuse experts in developing and sometimes delivering core training on medical dimensions of investigations, DCFS investigators do not have internal child abuse pediatric oversight of the use of medical child abuse experts in child abuse investigations.
- Reports that come in after 5:00 p.m. on weekdays, on weekends, and on holidays, receive a response by a “mandate worker” who initiates the investigation but then hands the case off to a CPI who will be the primary DCFS investigator. This handoff process is inconsistent with the vision of unit-based MDTs because of the critical need for a collaborative, expert investigative response at the very beginning of the investigation in the targeted cases; any handoff can potentially inhibit effective communication with the MDT.
- There is currently no effective mechanism for CACs and MCOEs to receive direct and timely access to all necessary information regarding DCFS Hotline reports, in order to ensure that all appropriate cases are identified and referred to them for investigative services.
- Differences in investigative and adjudication timelines used by DCFS and LE can also inhibit effective exchange of case information. Put simply, DCFS has shorter and more proscribed time frames than LE.<sup>20</sup> Thus, DCFS investigators need to gather all evidence (including LE interviews) within the 60 days they have to complete investigations, while LE has no limitations to its time frame to build its case. LE officers are sometimes concerned about providing information to DCFS that, if shared, might contaminate their subsequent interviews. In turn, DCFS often needs critical information from LE to complete its investigation, and this lack of sharing impacts their ability to make a final decision, especially within the 60-day time frame for DCFS.

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<sup>19</sup> Various factors can delay investigations, including: inability to locate/interview witnesses; inability to access the scene to do a scene investigation; need to get a search warrant (to search a home, cell phone, car, computer, etc.); biology, DNA, and other physical evidence work-ups can take months; additional medical testing, especially ruling out genetic or other medical causes for injuries, often requires obtaining and reviewing birth records, prior medical records, siblings’ or parents’ medical records; the medical examiner’s/coroner’s autopsy report can take months; and the wait time for the outcome of the criminal investigation, which has no mandated timeline.

<sup>20</sup> DCFS has 60 days to investigate a hotline call, although this can be extended under various circumstances with supervisor approval (per DCFS Procedures, etc.) There is no statute of limitation on filing a Child Abuse or Neglect/Child Protection Petition, per se; however, a Petition must be filed, and both Adjudication and Disposition completed before a minor’s 18th birthday. The police generally have unlimited time to investigate a crime. There are general statutes of limitations on filing charges (3 years for a felony and 18 months for a misdemeanor), and there are also extended statutes of limitations on various crimes such as murder, theft not discovered immediately, and sex offenses against a minor.



There is sometimes a lack of continued communication and follow-through on cases that are currently handled by both LE and DCFS. An example of this silo of investigation would include the circumstance where DCFS has closed its case with an unfounded disposition; it is very unlikely that DCFS would ever become aware of or re-open its previous finding if LE obtains additional information in the case. This additional information obtained by LE, well after DCFS has closed its case, could result in DCFS re-opening their case and indicating it (i.e. substantiating it) based on this new information. Examples of new information include additional witnesses coming forward, a confession, or the obtaining of forensic evidence such as DNA. Similarly, a case that is indicated by DCFS but not charged criminally may result in additional information being discovered that LE has no knowledge of because they have closed or suspended their case.

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## PEDIATRIC CHILD ABUSE AND NEGLECT MEDICAL CENTERS OF EXCELLENCE

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The concept of a medical center of excellence is drawn from the Children's Hospital Association (CHA), which includes three standards of care: basic level, advanced level, and center of excellence. A center of excellence is distinguished from the other levels by additional education and research capabilities.<sup>21</sup> These national standards have not been applied to Illinois due to some of the challenges that are addressed below. In this report, it is hoped that all three tiers of care will be developed in Illinois in order to facilitate statewide coverage. All of these medical settings will be called pediatric child abuse and neglect (PedCAN) sites, and a small number will be medical centers of excellence (MCOEs).

As of 2006, child abuse pediatrics became a boarded medical subspecialty, similar to cardiology or pulmonary medicine. This subspecialty was developed in recognition of the need for scientific and evidenced-based practices to assist and collaborate with LE and DCFS to ensure precision and efficiency towards completing an investigation while minimizing the hardships on the family and child. Currently, there are over 300 child abuse pediatricians (CAPs) nationwide, most practicing in the acute care hospital setting where their expertise is crucial to ensure best practices in the evaluation and treatment of the most serious child maltreatment cases. Nationally, CAPs have been instrumental in developing standards of care for the response of children's hospitals to child maltreatment, resulting in established best practices for staffing, services, prevention, community outreach, and medical research and education.

MCOEs in child abuse require a CAP in order to ensure proper diagnosing of child abuse. The medical community currently recognizes CAPs as the medical experts in the evaluation and treatment of children who are victims of suspected maltreatment. The need for child abuse medical expertise from CAPs could drive demand for their expertise from the medical community, which could lead to the development of collaborative partnerships in Illinois. Access to this medical expertise is essential to all cases targeted for a unit-based MDT investigation, including serious physical harms cases for children under 3 years of age, medically-involved neglect for children under 18 years old, and sexual abuse for children under 18 years old.

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<sup>21</sup> See Appendix P for more information about the different CHA standards of care.

The CAP is uniquely qualified among MDT unit members and among other physicians to diagnose and investigate certain types of maltreatment because of multiple aspects of the CAP's required training and expertise, including:

- Knowledge of the most up-to-date scientific research on what distinguishes accidental from non-accidental injuries, especially with regard to head trauma, fractures, and bruising.
- Awareness of the importance of concurrent or previous injuries in determining the cause of injuries and when additional diagnostic tests (e.g., skeletal surveys, blood tests) are needed to provide additional evidence.
- Accurate understanding of when lack of adequate care or feeding of a child constitutes a form of neglect, including cases in which children are malnourished, failing to gain weight (which needs determination on whether this is due to neglect or specific medical problems), or when parents are not providing needed health care to a child (i.e., medical neglect).
- Knowledge of the specific physical symptoms and injuries associated with sexual abuse.
- Ability to conduct medical evaluations, which are important in child sexual abuse because they can potentially reveal evidence regardless of disclosure, such as sexually transmitted infections, pregnancies, and other conditions in children that support a finding that a child was sexually abused. Additionally, statements made in the course of treatment to a medical provider can come into evidence even if a child doesn't disclose during an interview.
- Ability to direct and collaborate with investigators and LE to obtain and evaluate specific forensic evidence relevant to decision-making, including what to address in scene investigations and reenactments of the incident, timelines prior to the onset of symptoms, and caregiver explanations of injuries and symptoms.
- Knowledge of the forensic interviewing process at CACs and how that can be used to effectively gather evidence (see section on children's advocacy centers below for case examples and additional information about forensic interviews).

#### **CAP expertise distinguishes accidental injuries from abusive injuries**

A 10 month old presented for a follow-up neurology consultation after being a victim of abusive head trauma. The neurologist was told the child had subdural hematomas (SDHs) and retinal hemorrhages (RHs) after a fall; the treating hospital determined that these were due to abusive head trauma and the child was removed from his parents. The neurologist asked the CAP to review the case as the child's current symptoms were mild. The CAP did so, and found that the treating hospital, which is a pediatric hospital lacking a CAP team, noted that this child had SDHs and RHs. Upon obtaining the primary records, the CAP was able to conclude that both the SDH and RH were not consistent with those seen in abusive head trauma, but were in fact compatible with minor trauma. The CAP drafted a detailed report summarizing the evidence and conclusions, and the child was returned home.

A 7 month old Spanish speaking child sustained a tibial fracture that was highly suspicious for abuse. Two community doctors concluded that the injury was due to abuse and reported the case to DCFS. A second opinion with a child abuse pediatrician, working in coordination with trained DCFS and law enforcement, reviewed the case. The CAP was able to distinguish the manner of the injury to rule out maltreatment. The parents gave intricate historic details, and DCFS and law enforcement were able to corroborate the parents' histories with neighbors. Due to the medical expertise and corroboration of the history provided, the CAP along with DCFS and LE were able to unfound the case and return the child home.

In most cases, determining if a child's injuries are due to abuse, neglect, accident, or natural disease is a very complicated process dependent on a medically-directed MDT team consisting of LE, DCFS, trained medical social workers, CACs, case managers, and subspecialists from emergency medicine, intensive care, trauma, orthopedics, burn and plastic surgery, neurosurgery, ophthalmology, and neuroradiology. All of these professionals need to engage in an intensive, real-time collaboration with effective communication to conclude if the evidence gathered for a child indicates maltreatment.

CAPs have been instrumental in medically-directed interdisciplinary teams in Illinois. Most CAPs sit on citizen and advisory committees to improve the current system of investigations, care of foster children, and development of services towards maltreatment prevention. The following are some of the programs in which CAPs have worked in collaboration with multiple partners to address child maltreatment:

- *Chicago Centers of Excellence*: Anne and Robert H. Lurie Children's Hospital of Chicago, John H. Stroger, Jr. Hospital of Cook County, and Comer Children's Hospital are all centers of excellence in the city of Chicago, each of which is affiliated with an academic teaching hospital. Centers of excellence consist of larger interdisciplinary teams which offer diagnostic and treatment services that require consultation with subspecialists. They provide regional and national leadership in child maltreatment and advocate for prevention services.
- *The Pediatric Resource Center at the University of Illinois College of Medicine at Peoria; the Medical Evaluation Response Initiative Team (MERIT) at the University of Illinois College of Medicine at Rockford*: Both of these programs are child advocacy community-based programs. They have an affiliation with a CAC, which performs intake and facilitates communication between LE, DCFS and community members. Both programs have CAPs who are academically-affiliated and have teaching positions at the University of Illinois. Some of the services provided include case coordination, crisis intervention, counseling, assistance to DCFS legal staff in preparing medical aspect of cases for hearings, education for health care providers, and education and training to non-health care providers (including DCFS training on medical aspects of child abuse). Both receive funding from DCFS and are the referral centers for numerous counties/catchment areas. Their target population includes any child 18 years and younger who is under DCFS or law enforcement investigation for an allegation of sexual abuse, physical abuse and/or neglect within a 15 county-wide area in the DCFS Central region; and any child 21 years and younger who is under DCFS guardianship and who is suspected or known to be sexually abused, physically abused or neglected.
- *Children's Medical and Mental Health Resource Network at the Southern Illinois University School of Medicine based in Anna*: This DCFS-funded program targets children up to the age of 17 years who are under investigation for child maltreatment within the 45 southern-most counties of Illinois, with a specific emphasis on the 34 counties of the DCFS Southern region. It provides comprehensive medical assessment, evaluation, and diagnosis to determine manner of injuries, medical advocacy (including data tracking, medical consultation, court testimony, parent education, and support for children who are alleged victims of sexual or physical abuse or at risk of harm due to exposure to drugs), training for professionals (including DCFS investigators, child advocates, health providers, and MDT members) on child abuse mandated reporting.

- *The Multidisciplinary Pediatric Education and Evaluation Program (MPEEC)*: MPEEC is a collaboration between three children's hospitals in Chicago, each with academic affiliations, pediatric trauma centers, and major teaching centers (Anne and Robert H. Lurie Children's Hospital of Chicago, John Stroger Jr. Children's Hospital, and the University of Chicago Comer Children's Hospital), Chicago Children's Advocacy Center (ChicagoCAC), DCFS, and Chicago Police Department. This hospital-based, medically-directed multidisciplinary team with 24/7 availability provides comprehensive care to children with concerns for all forms of child maltreatment. Additionally, MPEEC provides mandatory curriculum for pediatric residents as well as CAP fellowships. It requires that all children younger than 3 years reported to DCFS for serious harms must have an MPEEC CAP consultation. ChicagoCAC is the administrator over the program and is responsible for the identification, assignment, and aid in the coordination between CAPs, LE, and DCFS. Basic data is collected on number, type, and duration of cases by ChicagoCAC, which also oversees the quarterly trainings provided by MPEEC CAPs. See Appendix F for additional information about MPEEC.

Although every child reported for medically-based maltreatment allegations deserves to have access to child abuse pediatric expertise, this is not currently the reality. The medical evaluation to determine if a child's injury was caused by abuse is the primary evidence in decision making; without it, the investigation outcomes would likely be indeterminate, or incorrect. Without expert forensic medical evaluations, there is an increased likelihood that child abuse will be ruled out incorrectly, or an incorrect diagnosis of child abuse will occur. In acute cases of sexual abuse, it is critically important that a forensic medical evaluation occur within 72 hours so evidence that may exist is collected while it is still useful to the investigation. In any case, a medical evaluation is critically important in sexual abuse investigations for diagnosing and treating any health concerns (e.g., sexually transmitted diseases; genital injuries), as well as for reassuring children and non-offending caregivers when children do not have concomitant health problems. Additionally, any information gathered by the CAP in conducting the medical history can be used as corroborating evidence to support child welfare and legal decisions.

From the medical child abuse perspective, there are a wide range of challenges associated with creating PedCAN MCOEs and integrating them with unit-based MDTs in Illinois, including:

- *Lack of CAP involvement in DCFS*. Despite their expertise and the implicit authority accorded physicians, CAPs lack the authority to guide the participation of DCFS child protection investigators and law enforcement professionals and to ensure timely collaboration from these partners. There is also no established position within DCFS for a CAP to provide oversight on the review, development, and quality assurance of investigations, particularly with serious harms and difficult medically-related neglect cases.
- *Lack of a state-based system or network of MCOEs in the evaluation of child abuse and neglect*. While a few children's hospitals have made this commitment, there is no law requiring pediatric hospitals, which are Level 1 Adult and Trauma Centers, to have medically-directed interdisciplinary child protection teams.
- *Shortage of CAPs in the country*. Many factors may contribute to the limited number of CAPs, including the emotionally-demanding nature of child abuse pediatrics, the lack of the usual

positive pediatric parent-doctor relationship, the adversarial nature of court testimony, and the relatively low salary average of CAPs compared to other subspecialties.

- *Squandering resources by referring children to hospital emergency departments.* Many children are referred to emergency departments because they are open 24/7. Children with suspected child sexual abuse need to be seen emergently only if they are symptomatic or have potential forensic evidence to be collected (abuse occurred within 72 hours), and these instances are rare. In most pre-pubertal sexual abuse medical assessments, there is no need for an examination in the emergency department.
- *Issues in access to medical evaluations.* In many instances, medical evaluations are not conducted unless there is strong proven disclosure in cases of suspected child sexual abuse; however, as stated earlier, such exams can yield critical evidence for an investigation regardless of whether a child discloses maltreatment.
- *Lack of communication with other MDT members, especially DCFS and LE.* The CAP needs specific information from the scene investigation by DCFS and LE in a timely manner for the explanation of injuries. A lack of communication between CAPs and other agents involved in the MDT unit process for child maltreatment can contribute to inaccurate and lengthy decisions.
- *Inability to ensure financial sustainability of programs.* There are several financial barriers to implementing PedCAN MCOEs within a unit-based MDT in Illinois, such as:
  - The costly nature of child abuse cases; on average, child abuse victims have admissions twice as long, twice as many diagnoses, and more unpaid hospital stays while awaiting disposition.
  - There is a lack of funding and underfunding for reimbursements for time-consuming CAP services such as interdisciplinary case reviews, prior medical record reviews, forensic interviews, ongoing communications with DCFS and LE, drafting of comprehensive reports, and preparing and delivering testimony for courts.
  - There is lost revenue to the hospitals due to lack of reimbursement for social hold of patients, Medicaid, and lost wages by doctors when in court.
  - Both lack of funding and underfunding occur by the Illinois Department of Public Aid (IDPA) for CAP services. There is a no funding for pediatricians to attend necessary interdisciplinary case reviews with subspecialists, DCFS and/or LE, which could be vital in a suspected maltreatment case. For services that do receive funding, there is still a disparity between the actual charge and the amount paid by IDPA. For example, Level 5 initial patient consultation, which includes some of the services mentioned above, charges \$605; the amount paid by IDPA is \$87.10.

## ILLUSTRATIONS AND EXAMPLES

### **Undetected maltreatment in the absence of child abuse pediatric experts**

A 6-month-old child had an unexpected cardiac arrest at home and subsequently required life support. Since this was an atypical injury, a child abuse pediatrician was consulted. Upon diligent review, the CAP reviewed an x-ray obtained from a previous hospital of the victim's air located in an unusual pattern which prompted the CAP to consider that the child had internal throat trauma. When the child's airway was visualized by an ear, nose, and throat expert, they discovered a finger-length deep puncture wound in the child's throat. Based upon these specific findings, a report was made to DCFS and LE, leading ultimately to a confession obtained from a caretaker that they forcibly inflicted this injury to stop the child's crying. Thus, this forensic expertise helped detect maltreatment that would have otherwise been missed and helped remove the victim from an abusive home environment.

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A 4-month-old was seen in an emergency room for irritability and was transferred to a hospital with a child abuse protection team. Upon examination of the child, the team noticed a bruise to his chest and was then directed to obtain a skeletal survey and abdominal CT scan. The tests demonstrated liver injury as well as rib fractures; the CAP team used its expertise to conclude that this combination was clearly due to abuse. Had there been no consultation from the CAP, another doctor without this kind of training and experience might have focused on the child's fever, missing the significance of the other injuries and bruises. This case illustrates how the training and experience of CAPs are important in recognizing maltreatment that would otherwise go undetected.

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A 5-month-old who died unexpectedly was reported to DCFS by the medical examiner's (ME's) office. In a review of the victim's history, it was noted that he had had a femur fracture two months prior and that the primary physician had interviewed the mother about the fracture. She had stated that the child had fallen off the changing table; a sibling who was with the mother corroborated this story. The primary physician neither performed a skeletal survey nor conducted an evaluation to assess for possible child abuse injuries. Additionally, he did not have access to a CAP for consultation in the area. After the unexpected death, the victim was found to have not only the healing femur fracture but also four healing rib fractures and subdural hematomas on post-mortem injuries for which the mother had never sought care. The injuries were highly suspicious of being inflicted. Most primary doctors do not have the necessary training in identifying and evaluating suspected child abuse. This case highlights how a lack of medical resources and continual training in child abuse and neglect is detrimental to recognizing and stopping maltreatment before it leads to death.

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In another case, law enforcement professionals were investigating a child abuse case in which one of the siblings was killed. The ME stated that the cause of death was blunt head trauma and the manner of death was homicide. There were two caretakers of the child, and LE needed to know how old the injuries were and how the child would present if there were signs and symptoms of abusive head trauma. The ME could only state that the injuries were acute (i.e., they occurred within 24 hours) and could not state with certainty how long after an injury the child would be symptomatic. MEs, coroners, and pathologists are not trained in pediatrics or child abuse pediatrics. However, a CAP could answer these questions with a reasonable degree of medical certainty. There is no system in place for child homicides to ensure access by LE to CAPs, who could provide critical expertise in cases of child deaths related to abuse.

## ILLUSTRATIONS AND EXAMPLES

### **CAPs diagnosing maltreatment in collaboration with DCFS, LE, and CAC partners**

A 10-month-old girl died due to blunt head trauma. LE and DCFS investigated the case and found that there had been a prior report to DCFS in which the now deceased child had sustained a complex skull fracture from a fall that had been determined to be an accident. Since the child had died in a hospital staffed by a CAP, they were involved with the case. In reviewing the case, the victim's mother and two teenage sisters were considered possible perpetrators. LE failed to have this case screened into court initially, because of suggestions that the twin sisters could have been perpetrators and the case was about to be suspended. The CAP advised and arranged a victim-sensitive interview at ChicagoCAC. The twin sisters independently gave the same history of their mother's abuse of their now deceased sister, leading to the mother's subsequent arrest. The communication between and expertise of the CAP, LE, DCFS, and CAC led to the thorough investigation of the case and the possible perpetrators in order to correctly identify and apprehend the killer.

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A 7-year-old was seen by her local primary physician for acute onset of vaginal bleeding. He examined her and determined that the child had missing hymenal tissue, which was a concern for sexual abuse. He directed the mother to a gynecologist who also confirmed that the hymen did not appear normal and reported the case to DCFS. The child was removed from the home. Subsequently the gynecologist consulted a CAP because the courts requested his opinion regarding the case. The CAP examined the child and found a normal hymenal variation for the child's age. He then conducted a medical history to assess the source of the bleeding and elicited a history of a sore throat and fever. Based upon the historical information, it was determined that the child had blood in her urine from a strep infection, ruling out vaginal bleeding. The child had been removed from the mother's care for two months and then returned based upon the CAP's expertise. If this case had been referred to a CAC for an MDT response before DCFS made a recommendation based on faulty evidence, the child would have had a forensic interview. Even if the child had not disclosed, the CAC team would have advocated for the evaluation of the child by a CAP.

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A 9-month-old female toddler was reported to DCFS by a community emergency department doctor due to concerns that the history given by the parents did not explain the injury. The patient was admitted to a hospital with a CAP and a child protection services team. They were able to determine the injury was caused by an accident within 24 hours, based upon their medical expertise and ability to discern childhood injuries vs. abusive injuries. This was done by conducting medically-directed interviewing by trained medical social workers and utilizing evidence gathered by DCFS and LE. The expert medical team was able to facilitate the MDT investigative response, and DCFS and LE were able to confirm important scene and witness information that led to an expedient decision. This led to an unfounded report of child abuse. Without this expert MDT response, the investigation could have lingered for 60 days or more; the current average being 39 days in serious harms investigations.



## CHILDREN'S ADVOCACY CENTERS

Accredited children's advocacy centers (CACs) are an important member of the MDT unit and must be accessible to all victims of child maltreatment. CACs in Illinois provide critical existing capacity and infrastructure on which our recommendations will build.<sup>22</sup> They will serve multiple essential functions in the recommended unit-based MDTs, all of which are related to existing CAC accreditation standards:

- They serve as the primary case coordinator of the unit-based MDTs, bringing the assigned MDT members together, facilitating communication, and ensuring the investigative unit is working together effectively. The responsible CAC will be the hub of the MDT unit, receiving targeted reports directly from the DCFS Hotline, keeping track of the MDT activities and members, ensuring all members of the team are activated in a timely manner to each case, and that the most effective and efficient investigation occurs. The CAC will ensure the protocol is followed, and team members are meeting the needs of the individual case.
- Connected to case coordination, the CACs will be responsible for the quality assurance and quality improvement process for the MDT.
- CACs will provide forensic interviews (FIs). A forensic interview of a child is defined as a developmentally-sensitive and legally-sound method of gathering factual information regarding allegations of abuse and/or exposure to violence. This interview is conducted by a neutral professional utilizing research and practice-informed techniques as part of a larger investigative process. FIs are conducted for alleged child sexual abuse victims, other child maltreatment victims and for children that may have witnessed child maltreatment. The

### Components of a forensic interview

A 12-year-old girl alleged that she was sexually abused by her father when she was 7. Due to the delay in reporting the abuse, a forensic interview was critical to determine the facts of the alleged abuse so that both LE and DCFS could make accurate decisions to protect the child and hold her father responsible.

A forensic interview starts with rapport-building to help a child feel comfortable and trusting of the interviewer. During this time, the victim provided a lot of narrative about her life. The interviewer then began to ask open-ended questions about family and facts about the child's life, allowing the child to take the lead in telling her narrative. The victim said that when she was little, she and her mother used to live with her dad and that her mom and dad would fight a lot. The interviewer needed to ascertain the credibility of the child and therefore probed more details, asking open-ended questions and ensuring the child was not experiencing trauma within the interview. The child demonstrated an understanding of the rules and of the consequences of truths and lies, and promised to only talk about the truth. The victim disclosed that her dad would come into her bedroom at night and would lie next to her and tell her that he was going to do a back massage. He would then pull down her pants and anally penetrate her. The girl shared her room with brother at the time, and she was able to describe her bedroom, which provided a timeline of the abuse. She said that her mom had caught her crying once and she had confided in her that she was afraid of her father's back massages, but had never disclosed the abuse. She was afraid and worried about all of the drama that would start with police coming. Victim's brother was also interviewed and disclosed to hearing his sister crying and hearing his father making noises.

The victim was able to tell her story to the trained forensic interviewer while the detective, child protection services investigator and state's attorney observed through a one-way mirror. This meant she only had to tell her story once, and the specific facts brought out could be used to build the case to move forward with the investigation, showcasing the utility of a forensic interview.

<sup>22</sup> Additional information about CACs is provided in Appendix C and Appendix D.



interviews will be observed by the members of the MDT and will be digitally visually recorded. The forensic interviewers provide testimony in court (National Children's Advocacy Center, 2016).

- CACs will provide family and child advocacy for psycho-education, emotional support, mental health screening, and referrals for needed services. The CAC will ensure that they either provide evidenced-based, trauma-informed mental health services and/or ensure there is a network of providers to which they can refer victims and their families. This includes providing direct referrals to mental health professionals and other social services. Advocates can also assist the family through the legal process and assist them in advocating for their rights and needs.

Other significant advantages and assets of CACs for planning and implementing unit-based MDTs in Illinois include:

- The CAC model is over 30 years old and well-established in all 50 states and multiple other countries. The model has national accreditation standards and processes related to all of the above roles in the MDT (see Appendix C), and it is sanctioned by the Office of Juvenile Justice and Delinquency Prevention (Cross et al., 2008).
- The Illinois Children's Advocacy Center Act was enacted in 1989 and amended in 2014, providing a platform for the importance of the use of CACs and the MDT process for child abuse investigations, and it requires the implementation of an MDT protocol in counties that have a CAC.<sup>23</sup> Therefore, counties that have an existing CAC already have signed protocols in place with MDT members. These protocols and this practice will be a springboard for the creation of the MDT units. See Appendix D for the wording of this law granting statutory authority to CACs.
- The Children's Advocacy Centers of Illinois (CACI) provides statewide leadership and a coordinated vision of CACs in the state and strongly supports multidisciplinary approaches.
- Accredited CACs currently fully cover 92 of 102 Illinois counties (see Appendix Q), providing significant infrastructure and coverage across the state that will enhance the ability of unit-based MDTs to coordinate cases, conduct forensic interviews, and provide advocacy services to victims and non-offending caregivers.
- Trauma-informed environments for child victims that minimize the pain of having to tell their story to multiple interviewers provide supportive advocates and a friendly atmosphere during the investigation, provide forensic interviewers who are skilled at listening and asking appropriate investigative questions to children, and offer or link children to services that can help them heal from trauma.
- Digital visual recordings of FIs are made that can be used in court as powerful evidence supporting the prosecution. These capture the developmental level, size, appearance and demeanor, as well as communication skills of children. Given that most cases don't go to trial for months or years after the forensic interview, the ability to see the child at the age they disclosed can ensure that judges and juries have a realistic view of the child at the time of the outcry. In addition, the existence of the recorded interview can be a powerful tool to negotiate a plea, eliminating the need for a trial. Similar to the power of photographs, the recorded statement of a child victim or witness is highly valuable evidence.

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<sup>23</sup> See Appendix D for the legislative text of the act.

- CACs are required for accreditation to have MOUs with medical providers for medical evaluations, and some CACs have ready access to CAPs.
- CACs are required to have established networks with mental health providers, along with extensive knowledge of and ability to link children and families to other necessary social and medical services.
- Some CACs also coordinate and participate in investigations of types of maltreatment other than sexual abuse. For example, in FY14, 88% of all cases referred to CACs in Illinois were for sexual abuse; 10% of all cases referred were for physical abuse; and 2% of all cases referred were for other allegations. There are also cases referred for domestic violence, homicides, and parental substance abuse.
- Examples of existing innovative collaborations with medical child abuse experts are described above (MPEEC).<sup>24</sup>
- Demand for FIs has increased, and CACs have responded. Statewide, FIs of DCFS-reported child victims have increased by 18% in FY14, from 4,584 to 5,408. Similarly, referrals to FIs at the Chicago and Madison County CACs have increased by 17% and 27%, respectively, compared to the same time point in the previous year. (Children's Advocacy Centers of Illinois, 2014).

Challenges CACs face in fully realizing their multiple roles in unit-based MDTs include:

- Ten counties remain without a CAC. There is currently a lack of funding and sufficient interest in commitment to CACs in these remaining counties.
- Whereas all accredited CACs have MDT protocols in place to investigate cases referred to the CAC, not all protocols mandate that all eligible cases of sexual abuse are handled at the CAC and with the MDT. For example, in some counties, prosecutors direct the CAC to interview only children who are under 13 years of age. This is inconsistent with (325 ILCS 5/3) (from Ch. 23, par. 2053), which defined child abuse victims as children who are 17 and under. As a result, some vulnerable teenagers are excluded from having an FI at the CAC and a thorough and supportive MDT response.
- Although the CAC functions as the facilitator of the MDT, it currently has no authority to ensure the partner agencies or staff complete tasks.
- There is no existing database or access to partner databases that could be used in tracking case-level activities across partners, outcomes, and members of the MDT over time (although some projects have developed relevant capacity).
- Considerable variation in capacity and services among Illinois CACs include: a) medical evaluations are not readily available at many CACs; in FY14, only 30.3% of all children referred to CACs statewide received a medical evaluation (Children's Advocacy Centers of Illinois, 2014); b) resources available to fund services; c) the type, amount, and quality of advocacy services provided; and d) access to mental health services. In addition, many CACs throughout the state do not have access to medical child abuse pediatric expertise for either physical abuse or sexual abuse exams.
- Even when medical evaluations and FIs are available, there are often delays in services. For example, wait times from the moment of case receipt to the FI was more than 9 days longer

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<sup>24</sup> See Appendix F for additional information about MPEEC.

than the previous year, suggesting that an increase in referrals for FIs needs to be supported by the CAC's capacity to provide services quickly and efficiently.

- The regional and statewide role of CACs in CQI efforts (as opposed to case-level CQI) is to be determined. It may make sense to house CQI in CACs, but there is currently inadequate infrastructure and expertise to collect, manage, analyze, and use data for QI purposes.
- For the handoff from the DCFS hotline: a) for sexual abuse cases, this works well when sexual abuse is the first or only allegation listed but not the second; and b) there is currently no mechanism for automatically flagging the other types of target cases—allegations of physical harm, including abuse and neglect, to children under 3 years and neglect allegations under the category of lack of health care.<sup>25</sup> Most CACs do not have (and will need) a direct connection to and better understanding of medical expertise on serious physical harms and medical forms of neglect.
- Despite the increases in FIs in statewide CACs mentioned earlier, there have been no corresponding increases in funding to meet the increased demand for FIs.

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<sup>25</sup> See Appendix I for the types of allegations included in each category.

## ILLUSTRATIONS AND EXAMPLES

### **Forensic interviews in investigations of alleged child maltreatment**

A teacher made a hotline report concerning a 12-year-old student living with her step-father, who was a sex offender. When DCFS contacted the mother, they found that the girl and her mother were Spanish-speaking only. The investigator relayed that information to the CAC so that an interpreter could be provided by the CAC to assist in communication and with the interview. The mother was very supportive of her daughter but also terrified due to having no relatives and no money, and she was worried about her residency. The interviewer had difficulty establishing rapport with the child; there was very little communication and no disclosure of abuse. The forensic interviewer and the rest of the MDT, including the Spanish interpreter, met to discuss next steps to best serve the family. All team members felt that the girl and her mother needed supportive services and that there were some concerns for her safety. DCFS made a referral to the agency who provided the interpreter and they were able to have a case worker visit the home. While visiting the home, the case worker helped the girl with homework, gave referrals to the mother and child for Spanish-speaking counseling, and built rapport and trust while discussing potential safety issues. After three weeks, the child disclosed sexual abuse to the caseworker. A new report was made and the child returned to the center for a second FI, in which she disclosed repeated sexual abuse over the past two years. Her statement resulted in LE arresting the perpetrator, who confessed, was charged, and pled to 20 years. The mother and child continued services with the agency and with the original Spanish-speaking advocate. This case highlights how the family advocate was instrumental in supporting the child and her family in disclosing abuse.

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Six children were brought to the CAC for allegations of physical abuse. LE made a hotline report, took the children into custody from the hotel they were staying at with the mother's boyfriend, and arranged to meet DCFS at the CAC. The children were all interviewed and all gave accounts of physical abuse to themselves, each other, and their mother. All children were also screened for sexual abuse. During the safety portion of one of the children's interviews, she whispered that her step-father has been "doing it" to her and her sister. She went on to disclose details of multiple acts of oral sex with her step-father and witnessing acts with her older sister. The older sister denied anything inappropriate. The children were all placed with relatives and referred for mental health services. The mother and step-father were interviewed and both denied wrong doing. The first child's disclosure was strong, but there was nothing to corroborate her statement. However, the prosecutors decided to charge her case. After about three weeks, the older sister's guardian called the DCFS investigator, notifying her that the 14-year-old was pregnant. The child came back to the center and reluctantly disclosed a sexual and romantic relationship with her step-father, of which her mother was aware. She also discussed the violence in the home and fear of her step-father. DNA collection revealed that the step-father had impregnated her. This case shows that children do not always immediately disclose sexual abuse, and there are many complicating factors that lead to children having difficulties disclosing. Supportive services and multiple interviews were vital for each of these cases, which resulted in full confessions and lengthy prison sentences.

## ILLUSTRATIONS AND EXAMPLES

### Research on the effectiveness of family advocates

Non-offending parents and other caregivers play a crucial role in helping children heal from trauma during and after the investigation process (e.g., supporting mental health services for the child), even while they are often coping with the stress of the investigation and relational conflicts. Family advocates can provide support to non-offending parents, caregivers, and children, as well as link them to needed resources and ongoing mental health and medical treatment. They can provide support during court processes.

According to the National Children's Alliance, surveys about the initial visit to a CAC (usually for an investigation) of over 80,000 caregivers and follow-up surveys of over 25,000 caregivers yielded extremely positive results (National Children's Alliance, 2015). Additionally, an evaluation of CACs response to child sexual abuse by the Office of Juvenile Justice and Delinquency Prevention found that non-offending caregivers favored CACs over traditional services (Cross et al., 2008).

From in-depth interviews with a non-random sample of 10 non-offending mothers about their experiences with family advocates following sexual abuse investigations at ChicagoCAC, Budde (2011) found similarly positive results. Mothers reported that advocates were able to provide detailed information (especially about the investigative process) that helped them know what to expect. Overall, positive relationship experiences with advocates clearly helped mothers feel more comfortable and less anxious during a significant crisis. Below are some examples of what non-offending parents said about their experiences and relationships with family advocates (Budde, 2011). The following are comments about how advocates were responsive, supportive, and provided helpful information:

- *"She [the advocate] was very comforting and answered all our questions. She let us know we were going to talk to the detective and what would happen next. She said she was going to speak to me and my daughter separately and let us know what was happening, when, and why. She said she would give us counseling referrals, and she told us about our rights too."*
- *"She sat down with me and explained the entire process, and she talked with me and my sister while my son was examined by doctor. She kept checking on us, put us in the waiting area, and explained the next steps. And she let me know where my son would be waiting with the young woman who was watching him while I was interviewed. She showed me where he'd be interviewed, walked me through that process. While he was interviewed, she helped put me at ease, talked about support services, services for us through the process. When I was interviewed by the detective and assistant DA, she was there and walked me through the next steps. She got me information about a parent support group and put me in contact with that group. Afterwards, she continued to contact me, and because we went through advocacy center, put me in contact with the right persona at DCFS. She got me contact information for CPS and DCFS."*
- *"Great overall relationship! She [the advocate] showed compassion, and the compassion was very much appreciated. I didn't expect that much warmth in this experience; I was really not expecting the warmth and understanding that I received."*
- *"Everyone there was great. My daughter loved it there; she wanted to go back. She got so much attention, and they treated her so nicely. She loved it. My husband and I loved it. It was really nice. We didn't expect to be treated as well as we were. They helped us feel better about (not) blaming ourselves. It was a very positive experience there. It's a shame what brought us there, but it was a good experience at CCAC."*

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## PROSECUTION

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The role of the prosecutor is to ensure that appropriate procedures are utilized by serving as the legal advisor as a part of the MDT. Such advisory roles not only assist all of the disciplines in working together lawfully and effectively, but help guide and meet the demanding case preparation needs of prosecutions emerging from effectively-conducted investigations. Given the immediate nature of the investigatory process, sufficient staff and funding are required to provide for their legal advisory role within the MDT and to attend LE FIs. Some prosecutors have raised two concerns about attending these interviews: a) that there are not adequate resources available to make this a realistic possibility; and b) if they attend, they can potentially be called to testify. A solution to the second concern would be legislation that codifies existing Illinois case law, which essentially provides that calling a prosecutor as a witness is looked upon with disfavor, especially where there are other witnesses who could testify, or sources of the evidence. In the case of a digitally-recorded FI, those sources would include the interviewer, the recording, or the other observers. Even in the absence of digital recording, the interviewer themselves or the other observers are preferred witnesses under the law. The case law includes *People v. Nelson*, 89 Ill.App.2d 84, 233 NE2d 64 (1<sup>st</sup> Dist, 1967) and *U.S. v. Johnston*, 690 F.2d 368, 642 (7<sup>th</sup> Cir., 1982).

When it is determined that maltreatment has occurred and criminal prosecution is appropriate, the goal of other MDT partners is to provide clear, descriptive evidence to the prosecutor and conclusions about the occurrence of maltreatment that are well-supported by the evidence.

## AN ILLUSTRATION

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### In support of MDT training

Highlighting the consequences of the lack of MDT training and forensic expertise on the quality and outcomes of investigations in child sexual abuse cases, one Illinois CAC director noted:

*"MDT members who are not trained and specialized do not understand the dynamics of victims and perpetrators. They do not understand how quickly a crime scene can fall apart. Many times there is evidence that can be collected, or rooms or dressers that can be photographed, phones, computers, iPads, etc. that have evidence. These things disappear when a case doesn't come together quickly and with trained team members. Perpetrators being 'surprised' by trained law enforcement with a 'good statement' from a CAC interview often confess. It's the difference between a case being charged and pleading out so the child doesn't have to endure trial, or someone getting off for a crime against a child."*

## RECOMMENDATIONS

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In this section, we provide recommendations to guide the planning and implementing of unit-based MDTs.

### 1. Create functional unit-based MDTs across the state.

- 1.1. Within four years, Illinois should develop and implement regional unit-based MDTs to investigate reports of child abuse and neglect accepted by the DCFS Hotline that address the needs of vulnerable children in all counties.** If fully implemented, investigative MDT units will improve the quality, timeliness, and accuracy of child protection and law enforcement decisions. This will result in improvements in identifying when maltreatment has occurred and when it has not, thus increasing child safety while also helping children and families avoid the considerable stress associated with DCFS and LE involvement.
- 1.2. Additional funding will be required.** While efforts should be made to make use of existing organizational infrastructure and collaborative relationships to create the unit-based MDTs, additional funding will be required to fully implement this regional model. Examples of critical funding needs are articulated below for each partner. Illinois should provide this funding in order to improve outcomes for children and families, potentially reducing long-term costs and burdens associated with misidentified child abuse and poorly implemented investigations.
- 1.3. Illinois should target high priority cases.** Unit-based MDTs should focus on investigating child maltreatment reports for which an MDT unit response is most needed, which we define as: serious physical harm to children under the age of 3 years, allegations related to medically-involved neglect for children under the age of 18 years, sexual abuse for children under the age of 18 years, and any report involving a child with a moderate to severe cognitive disability (see Appendix I for the types of maltreatment targeted for a unit-based MDT response).
- 1.4. MDT units must include representatives from all core partners—DCFS, LE, pediatric child abuse and neglect teams, CACs, and prosecution—that will work collaboratively on target cases, participate in unit-based training, and participate in case-specific and system-level CQI processes.**
- 1.5. Unit-based trainings should be designed statewide and implemented for each regional unit** that include detailed information about: the MDT process of investigating each type of target case; the roles and responsibilities of each partner; principles and strategies for communicating and collaborating effectively at the case level and administratively; and MDT data collection and CQI strategies. Training would draw heavily from existing training resources developed by expert CAPs, PedCAN MCOEs, DCFS, CACs, and law enforcement.
- 1.6. Regional planning and area/local MDT units must meet the standards of unit-based MDTs and also have the flexibility to tailor plans at the local level to maximize efficiency and to address local needs and challenges.**
- 1.7. Staffing by each MDT partner should address the following:**
  - 1.7.1.** Specific staff should be designated to work on MDTs (i.e., dedicated staff) and must have adequate time allocated to participate in all relevant MDT processes.
  - 1.7.2.** Staff should be selected based on interest and ability to do the work rather than requirements unrelated to the quality of practice and services.
  - 1.7.3.** Staff will receive supervision within the partner organization.

- 1.7.4. The number of full-time employees allocated by each partner should take into consideration the need for 24/7 coverage by all partners, the number of cases projected to be served in the area covered by the unit (based on previous years), and the roles and workload of different partners on different types of cases (e.g., law enforcement is often not involved in medical neglect investigations; child abuse pediatricians are central to overseeing investigations of physical harms cases, while they have an important but less time-consuming involvement in most sexual abuse cases).
- 1.7.5. Sufficient staff time must be allocated for participation in required, partner-specific and unit-based MDT trainings of investigations.
- 1.8. **Illinois should create a meta-organizational Commission with a paid Commissioner that reports to the Governor.** This is essential in order to ensure that unit-based MDTs have the authority to operate as truly collaborative units. The Commission will oversee the planning and implementation of unit-based MDTs, as well as CQI and evaluation efforts.
  - 1.8.1. **The Commissioner must have the authority to address potential issues regarding a staff member from any MDT unit with that staff member's respective agency,** based on evidence of lack of capacity or willingness to carry out unit-based MDT responsibilities.
  - 1.8.2. **The Commissioner's term of office will be four years,** and will not coincide with the governor's term.
  - 1.8.3. **The Commission will be comprised of one senior decision maker from each of the following:** DCFS, CACI, a child maltreatment program directed by a CAP, LE, prosecution, and the chair of the Illinois Children's Justice Task Force. It may or may not be useful to add a small number of independent members (e.g., evaluators, advocates).
  - 1.8.4. **The Commission will develop formalized institutional relationships among all partners** that include specific commitments to: a) provide motivated and dedicated staff to participate in all MDT unit processes; and b) collaborate on quality improvement and sharing of information at the case level and for use in program evaluation.
  - 1.8.5. **The Commission will hire an independent evaluator** to work with the Commission and CQI staff to assess implementation progress and outcomes of MDT units.
  - 1.8.6. **The Children's Justice Task Force will have an ongoing role** in: a) referring three highly qualified candidates for the Commissioner position to the governor's office—ensuring the independence of the selection process; b) writing the job description; c) creating the request for proposal (RFP) for the evaluator; d) advising on CQI; e) making suggestions about potential funding; and f) reviewing and responding to quarterly reports provided by the Commission.
2. **MDT units must have the capacity to address the following case-level investigative processes:**
  - 2.1. **Initiating the unit-based MDT response:** The DCFS Hotline should automatically flag and disseminate available information on all cases targeted for an MDT unit response to the CAC. This already occurs in many parts of the state with sexual abuse reports, but not other targeted cases. The CACs will receive these reports and ensure the MDT unit response is initiated, and that the relevant parties are fully engaged and communicating. All members of the MDT shall have immediate, full access to information relevant to the investigation.
  - 2.2. **Individualizing the response to each case:** Activation of MDT unit members will be based on the individual needs of case. The CAC will be responsible for ensuring that unit-based MDT members are responding and engaging in a manner appropriate for the case. The specific needs of the case will determine the level of engagement from the different partners. For severe



injury and medically-related neglect cases, the medical team will direct the investigative process.

- 2.3. Reviewing evidence and decisions on each case, including the need to gather additional evidence to address specific questions or concerns:** A process for systematically reviewing cases within specific time frames during investigations must be developed for all cases eligible for an MDT unit response in order to inform the ongoing investigation and the ultimate decisions and recommendations. Some aspects of the case review process may vary according to the needs of different types of cases and unit-based MDT implementation in different regions.
- 2.4. Informative summary reports should be generated by the unit-based MDT in target cases (except for sexual abuse).** For cases involving physical harms of children under 3 years and medically-involved neglect for children under 18 years, the CAP, in collaboration with other MDT unit members, will produce a final report that summarizes investigation findings of each partner, the evidence used to support those findings, and recommendations in order to provide all parties and partners with a transparent and thorough articulation of the results. In sexual abuse cases, FIs are digitally visually recorded, and the evidence can be viewed directly by all parties.
- 3. MDTs should engage in CQI strategies at the case level, regionally and statewide (see Appendix N for an illustration of the MDT CQI Model), including:**
  - 3.1. Create a temporary advisory group of medical and child abuse epidemiologists and evaluators** to provide guidance on developing indicators, identifying data elements needed, managing and linking data from different databases and organizations, and assessing change over time in measures of implementation, service quality and case-level outcomes. This group should make recommendations about the short-term and long-term focuses of formal process and outcomes evaluations, as well as potential research that would augment the CQI process.
  - 3.2. Assess both the quantity and quality of critical MDT unit planning and implementation activities,** including provision of specialized training for each partner, unit-based training for the MDT, and essential infrastructure (e.g., staffing, database requirements) for unit-based MDTs and CQI efforts. Indicators of implementation quantity and quality should be developed by stakeholders and the advisory group, along with plans to collect quantitative and qualitative information (e.g., feedback from stakeholders/participants).
  - 3.3. Develop capacity for real-time case-level monitoring in each unit throughout the investigative process,** including tracking specific indicators of activity and communication, timeliness, and quality of communication.
  - 3.4. Develop and implement a plan for collecting and aggregating information from MDT units to regional and statewide levels and using this information to improve services and outcomes.** The plan should articulate the necessary infrastructure (e.g., staffing amount and skills, computing hardware and software), and approaches to data collection (including quantitative and qualitative sources of information and feedback), data management, and data analysis (e.g., examine indicators by geographic level, type of maltreatment, by DCFS subregion & region or statewide).
  - 3.5. Develop plans at statewide, regional, and local levels for disseminating and discussing key findings on unit-based MDT performance and for making recommendations to improve/increase service quality and outcomes.**

4. **Recommendations of common expectations for all core partners (DCFS, LE, PedCAN sites, CACs, prosecution) include:**
  - 4.1. Select a high-level administrator to sit on the unit-based MDT Commission.
  - 4.2. Develop and submit to the Commission for review and feedback its own plan to select and allocate staff and complete the specialized certification/training needed by staff to participate on MDT units.
  - 4.3. Participate in planning and implementing unit-based training and CQI at statewide and area levels.
  - 4.4. Participate in a collaborative process (with oversight by the Commissioner) defining and staffing area-based MDT units and defining the roles of each unit member.
  - 4.5. Ensure capacity to share and link information across the databases used by partner organizations.
5. **Recommendations specific to each partner include but are not limited to the following:**
  - 5.1. **Law enforcement (LE)**
    - 5.1.1. Identify and propose possible entities and specific LE representatives, including a representative to the Commission, to assist with statewide planning and implementation.
    - 5.1.2. Identify challenges and strategies (including non-funded and funded) for engaging local law enforcement in unit-based MDTs and providing full (24/7) coverage and dedicated staffing expertise.
    - 5.1.3. Identify LE experts to assist in reviewing, developing, and implementing training on central aspects of investigative practice (e.g., interviewing, scene investigations) for LE professionals and MDT partners.
    - 5.1.4. Identify the challenges faced by LE by collaborating with other partners, and offer possible local, regional, and statewide strategies to address these challenges.
    - 5.1.5. Select and train investigators specializing in investigating allegations of physical harms to young children, neglect involving medical concerns for children younger than 18 years old, and sexual abuse for children under 18 years.
  - 5.2. **Department of Children and Family Services (DCFS)**
    - 5.2.1. Identify and develop strategies to address challenges of hiring expert dedicated investigators to provide full (24/7) coverage for unit-based MDTs.
    - 5.2.2. Develop a process for the selection and training of child protection investigators to specialize in allegations that will be handled by unit-based MDTs.
    - 5.2.3. Select the content of the trainings and trainers to deliver them.
    - 5.2.4. Create supervisory and administrative infrastructure for unit-based MDTs.
    - 5.2.5. Propose a plan for using existing DCFS quality improvement staff and resources to support and collaborate with MDT unit CQI efforts by CACs and other partners.
    - 5.2.6. Create an internal leadership position with PedCAN forensic medical expertise to oversee PedCAN sites (see next recommendation) and provide consultation and guidance on medical forensic issues in investigations.
  - 5.3. **Pediatric Child Abuse and Neglect Medical Centers of Excellence (PedCAN MCOEs)**
    - 5.3.1. Establish a collaborative network of existing child protection services teams to inform unit-based MDT planning and implementation.
    - 5.3.2. In the short term, fund expansion of existing efforts by expert CAPs to provide real-time telemedicine and teleconsulting to medical community partners and unit-based MDTs in areas of the state that lack direct access to this medical expertise. CAPs from the three

MCOEs in Chicago (Anne and Robert H. Lurie Children's Hospital of Chicago, John H. Stroger, Jr. Hospital of Cook County, and Comer Children's Hospital) involved in the MPEEC program, the Peoria Pediatric Resource Center, and the Children's Medical and Mental Health Resource Network can provide leadership and expertise.

- 5.3.3.** Review and refine existing training content on medical aspects of investigating target allegations to be used in partner-specific and unit-based MDT training.
- 5.3.4.** Establish a subcommittee from this network of medical experts to develop a report that assesses current medical child abuse and neglect medical need, resources, and a plan for expansion. This report would include at the very least defining the state need, resources, and issues of sustainability including a financial proposal for a statewide network of Illinois PedCAN sites using the guidelines set forth by the Children's Hospital Association, formerly the National Association of Children's Hospitals and Related Information (2011).<sup>26</sup> These sites will be named Illinois PedCAN sites. Data for the subcommittee will be provided by child welfare and child death review to assess need by allegation, age and region. The subcommittee will assess current resources and propose the expansion of necessary medical expertise to ensure all unit-based MDTs have medical child abuse expertise. Review of other state models and legislation will be part of the research, and the subcommittee will be provided staff support for research and drafting of this report.
- 5.3.5.** Create a subcommittee to develop a proposal based upon the findings from 5.3.4 for expansion of the number of child abuse pediatricians and legislation to fund PedCAN MCOEs to meet the need defined by the subcommittee.
- 5.3.6.** In terms of expansion of services, the subcommittee would develop initial and long-range plans (including infrastructure and funding needs) to utilize technology, such as telemedicine and teleconsultation, and strategies to access medical records in a timely fashion through development of an electronic health portal and a medical child abuse and neglect database to store core documents, photo, imaging, and medical records.

#### **5.4. Children's Advocacy Centers (CAC)**

- 5.4.1.** Ensure that there is CAC access to all counties across the state.
- 5.4.2.** Identify unit-based training strategies designed to promote effective communication and collaboration in MDT units, as well as trainers skilled in facilitating cross-organizational and team-based collaboration.
- 5.4.3.** Facilitate the development of region and unit-specific case coordination processes.
- 5.4.4.** Develop strategies for unit-based and regional CQI efforts in collaboration with DCFS (and potentially other partners).
- 5.4.5.** Facilitate MDT leadership within the units, create protocol, and serve as a data collector and informer to the Commission regarding the functioning of the units.
- 5.4.6.** Ensure adequate resources for forensic interviewers, advocates, and a network of mental health providers, as required by accreditation standards.

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<sup>26</sup> This report outlines what a child protection team at a children's hospital should offer in terms of infrastructure, staffing, functions and systems to be considered one of three levels of service, basic, advanced or a center of excellence.

## **5.5. Prosecution**

- 5.5.1.** Recommend a representative to the Commission.
- 5.5.2.** Identify staffing gaps around the state and propose strategies to ensure that cases investigated within the MDT units have proper attention to move forward efficiently and competently.
- 5.5.3.** Identify other challenges and strategies (including funded and non-funded) for engaging local prosecutors in unit-based MDTs and providing full (24/7) coverage and dedicated staffing expertise.
- 5.5.4.** Identify one or more prosecution experts to assist in reviewing and developing training materials for training other prosecutors to participate in MDTs, and for training other MDT unit partners on the central aspects of prosecution (e.g., evidence evaluation, common defenses, responding to motions to suppress).
- 5.5.5.** Identify the challenges for the prosecution of collaborating with other partners, and offer possible local, regional and statewide strategies to address those challenges.

## **6. Implementation of unit-based MDT investigations should be phased in.**

- 6.1. The rationale for phased in implementation:** This will maximize the likelihood of success by developing realistic plans to address the challenges of implementing collaborative unit-based MDTs.
- 6.2. Phased-in implementation would include the following (roughly) sequential steps:**
  - 6.2.1.** Hire a unit-based MDT Commissioner with meta-organizational authority and establish a Commission.
  - 6.2.2.** Develop statewide training, CQI, and formal evaluation plans.
  - 6.2.3.** Choose 3-4 sites in Illinois in which to implement unit-based MDTs, with site selection criteria to include some variation in geographical location and in existing capacity to provide unit-based MDT investigations.
  - 6.2.4.** In phase one sites, develop local and regional implementation plans to be submitted to the Commission for feedback and approval.
  - 6.2.5.** In phase one sites, implement and evaluate unit-based MDTs over at least two years after the approval of regional implementation plans.
  - 6.2.6.** Discuss CQI/evaluation findings and lessons learned biannually, with recommendations for next steps with regard to quality improvement in existing sites and expansion of unit-based MDT investigations to achieve statewide coverage.

## **7. Recommended legislative and/or procedural changes**

- 7.1.** Parent/guardian consent for audio/visual recording of FIs should be waived for investigations of child abuse and neglect.
- 7.2.** At a minimum, for cases involving serious physical harms, and possibly for cases involving sexual abuse and medically-related neglect, scene investigations and witness interviews by LE and DCFS should be conducted within 24 hours of a report. The specific tasks of each entity should be determined at initial case activation. Within 72 hours, there will be a case staffing in which all relevant MDT professionals discuss findings with the CAP and determine next steps regarding the gathering of further evidence.
- 7.3.** During the course of an investigation, DCFS or LE shall request information regarding any medical evaluation of a child and prior medical records relating to the alleged maltreatment or care of the child, including reports of a medical evaluation of the child and prior medical records of the child or of the child's siblings. DCFS and LE shall be provided with these reports within 48 hours of making a written request.

- 7.4. Ensure that all medical services needed in the provision of medical forensic investigation and required monitoring and treatment are compensated by Medicaid (or another source).
  - 7.5. Require that all children under the age of 18 receive an FI at an accredited CAC in all sexual abuse investigations.
  - 7.6. Protect information shared amongst MDT unit members for the purposes of investigation, allowing full privileged communication between members.
  - 7.7. Legislation that would deem mental health information of any child victim as privileged, and therefore protected and excluded from criminal judicial proceedings other than in proceedings under Article II of the Juvenile Court Act.
  - 7.8. All FIs of children should be kept confidential and not shared with or turned over to non-MDT members in any court proceedings, criminal or civil, without accompanying protective orders.
  - 7.9. Maintain all DCFS investigation records in perpetuity, even if unfounded, and maintain reports of calls that were made by mandated reporters. Often, unfounded cases contain valuable information for current investigators to assess potential patterns or history of risk.
  - 7.10. The State's Attorney shall have the authority to attend forensic or other witness interviews conducted pursuant to reports of child abuse or neglect, and to suggest questions to be provided by the interviewer.
  - 7.11. In order to address concerns about prosecutors being called to testify if they witness FIs, new legislation should codify existing Illinois case law. The case law essentially provides that calling a prosecutor as a witness is looked upon with disfavor, especially where there are other witnesses who could testify, or sources of the evidence. In the case of a digitally-recorded FI, those sources would include the interviewer, the recorded interview, or the other observers. Even in the absence of digital recording, the interviewer themselves or the other observers are preferred witnesses under the law. The case law includes *People v. Nelson*, 89 Ill.App.2d 84, 233 NE2d 64 (1<sup>st</sup> Dist, 1967) and *U.S. v. Johnston*, 690 F.2d 368, 642 (7<sup>th</sup> Cir., 1982).
- 8. Other systemic issues to be addressed**
- 8.1. There is a serious lack of support services, including mental health and ongoing medical care, available across the state. This is due to the lack of sustainable funding for long-term, trauma-informed, evidence-based mental health and medical care.
  - 8.2. Included in the plan to train MDT members, there must also be training for judges on the dynamics of child abuse, particularly on how to interpret medical evidence and understand trauma's effect on child sexual abuse survivors.
  - 8.3. The Commission should consider creating a subcommittee to create a more effective architecture to review child deaths caused by abuse, and to consider implementing a similar MDT response, including CAPs, to investigate child deaths.
  - 8.4. It became clear during the writing of this report that there is a dearth of available data, and the collection and analysis of data, and research of other models, will be imperative to creating an effective system.

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## APPENDIX A: PUBLIC ACT 099-0023

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Public Act 099-0023

SB0721 Enrolled            LRB099 07249 KTG 27350 b

AN ACT concerning children.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Children and Family Services Act is amended by changing Section 39.2 as follows:

(20 ILCS 505/39.2) The Illinois Children's Justice Task Force, in compliance with (i) the Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C. 5106c) as amended by Public law 111-320; (ii) the Victims of Crime Act of 1984 (42 U.S.C. 10603), as amended; and (iii) Section 116 of the CAPTA Reauthorization Act of 2010, shall be charged with the exploration, research and development of recommendations on a multidisciplinary team approach for the investigation of reports of abuse or neglect of children under the age of 18.

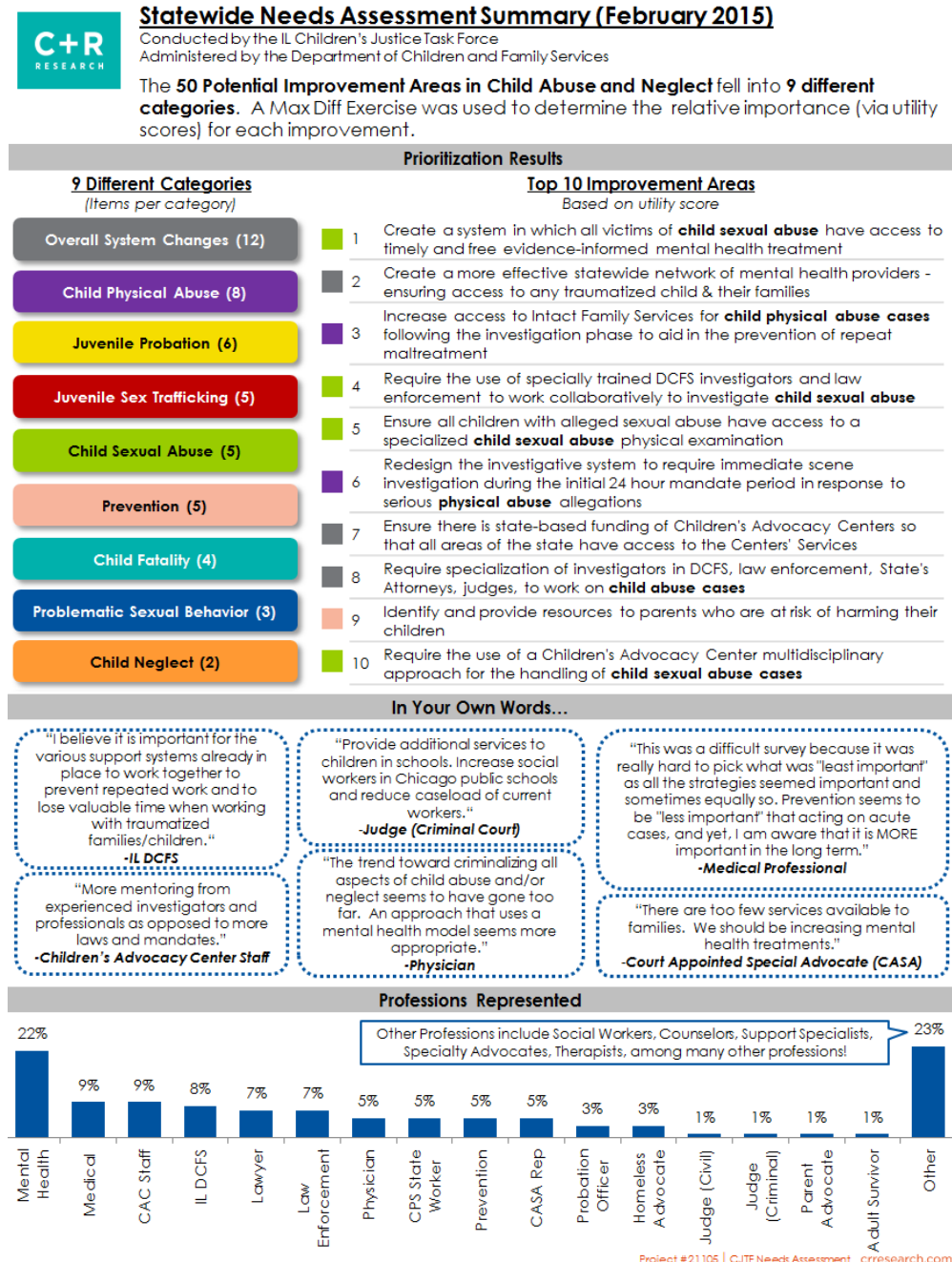
The Illinois Children's Justice Task Force shall submit a report to the General Assembly by January 31, 2016, regarding, but not limited to, its recommendations for a statewide multidisciplinary approach to child abuse or neglect investigations. The Department of Children and Family Services shall continue to provide administrative support to the Task Force through the Department's Children's Justice Grant manager.

(Source: P.A. 98-845, eff. 8-1-14.)

Section 99. Effective date. This Act takes effect upon becoming law.

## APPENDIX B: STATEWIDE NEEDS ASSESSMENT

FIGURE B: TOP 10 AREAS OF IMPROVEMENT IN CHILD ABUSE AND NEGLECT IDENTIFIED



## APPENDIX C: CHILDREN’S ADVOCACY CENTERS AND THEIR USE OF MDTs

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Children’s Advocacy Centers (CACs) in Illinois began as a way to reduce trauma to children and their non-offending family members who were dealing with allegations of abuse as well as effectively coordinate the agencies charged with investigating and prosecuting child abuse cases. Their purpose was to better serve children who are victims of physical abuse, sexual abuse, and/or witness to violent crime. The Lake County and DuPage County CACs were the first in Illinois; they were started in 1989 before the mandatory protocol legislation. Today, 93 of the 102 counties in Illinois have protocols in place for a CAC.

In order to respond to child abuse in communities, CACs use a multidisciplinary team (MDT) approach. The MDT is the heart and soul of the CAC. The Illinois Children’s Advocacy Center Act was recently updated which clarifies the members of the MDT and requires that a protocol be written and reviewed annually for counties that have CACs. There are several CACs who have a functioning MDT process from which to build the unit-based model. The following definition of an MDT is based largely on the National Children’s Alliance accreditation standards. (National Children’s Alliance, 2011). An MDT is defined as a group of professionals who represent various disciplines and work collaboratively beginning with the case initiation in order to assure the most effective response possible for every child. This interagency approach brings together professionals from the fields of law enforcement, social services, medicine, prosecution, victim advocacy and mental health. Interagency collaboration coordinates intervention so as to reduce redundant processes which might cause additional trauma to children and families, improve the quality of services, and preserve and respect the rights and obligations of each agency to pursue their respective mandates. Prior to this model, children would often be treated as adults and were expected to disclose abuse to multiple professionals, sometimes up to a dozen, so that each party could conduct their own investigation. Because forensic interviews are conducted at CACs with specially-trained interviewers attuned to the needs of the child, the number of people with whom a child discloses information is significantly reduced, which helps prevent re-victimization and preserves the integrity of the investigation.

## APPENDIX D: ILLINOIS CHILDREN'S ADVOCACY CENTER ACT

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The Illinois Children's Advocacy Center Act was recently updated which clarifies the members of the MDT and requires that a protocol be written and reviewed annually for counties that have CACs. There are several CACs who have a functioning MDT process from which to build the unit-based model.

### "COUNTIES

(55 ILCS 80/) Children's Advocacy Center Act.

(55 ILCS 80/1) (from Ch. 23, par. 1801)

Sec. 1. Short title. This Act may be cited as the Children's Advocacy Center Act.

(Source: P.A. 86-276.)

(55 ILCS 80/2) (from Ch. 23, par. 1802)

Sec. 2. Legislative findings.

(a) The General Assembly finds that the creation of accredited Children's Advocacy Centers ("CACs") accredited throughout the State of Illinois is essential to providing a formal, comprehensive, integrated, and multidisciplinary response to the investigation and disposition of reports of child maltreatment; by expediting and improving the validation or invalidation of such allegations for the benefit of children, their families and accused perpetrators; by requiring the use of collaborative decision making and case management, thereby reducing the number of times children are questioned and examined, thus preventing further trauma of children; by coordinating therapeutic intervention and services thereby providing safety and treatment for child victims and their families; by developing communication, case coordination, and information sharing policies and protocols among allied professionals and agencies who play a role in child protection in a given jurisdiction; by collecting data to report to partner agencies, the community, and the General Assembly, and to use in continually improving collaborative multidisciplinary investigations; and, by maintaining the confidentiality of client records and records from partner agencies, to ensure the protection of the privacy of children, their families and accused perpetrators. A CAC organized and operating under this Act may accept, receive and disburse in furtherance of its duties and functions any funds, grants and services made available by the State of Illinois and its agencies, the federal government and its agencies, a unit of local government, or private or civic sources. To the extent permitted by applicable law, participating entities shall maintain the confidentiality of case-related information which includes, but is not limited to, case review discussions, case review notes, written reports and records, and verbal exchanges.

(b) The General Assembly further finds that the most precious resource in the State of Illinois is our children. The protection of children from physical abuse, sexual abuse and exploitation, and neglect, hereinafter "child maltreatment", is at the core of the duties and fundamental responsibilities of the General Assembly and provides the highest compelling interest to create and maintain a system to effectively respond to reports of child maltreatment and protect children from harm.

(Source: P.A. 98-809, eff. 1-1-15.)

(55 ILCS 80/2.5)

Sec. 2.5. Definitions. As used in this Section:

"Accreditation" means the process in which certification of competency, authority, or credibility is presented by standards set by the National Children's Alliance to ensure effective, efficient and consistent delivery of services by a CAC.

"Child maltreatment" includes any act or occurrence, as defined in Section 5 of the Criminal Code of 2012, under the Children and Family Services Act or the Juvenile Court Act involving either a child victim or child witness.

"Children's Advocacy Center" or "CAC" is a child-focused, trauma-informed, facility-based program in which representatives from law enforcement, child protection, prosecution, mental health, forensic interviewing, medical, and victim advocacy disciplines collaborate to interview children, meet with a child's parent or parents, caregivers, and family members, and make team decisions about the investigation, prosecution, safety, treatment, and support services for child maltreatment cases.

"Children's Advocacy Centers of Illinois" or "CACI" is a state chapter of the National Children's Alliance ("NCA") and organizing entity for Children's Advocacy Centers in the State of Illinois. It defines membership and engages member CACs in the NCA accreditation process and collecting and sharing of data, and provides training, leadership, and technical assistance to existing and emerging CACs in the State.

"Forensic interview" means an interview between a trained forensic interviewer, as defined by NCA standards, and a child in which the interviewer obtains information from children in an unbiased and fact finding manner that is developmentally appropriate and culturally sensitive to support accurate and fair decision making by the multidisciplinary team in the criminal justice and child protection systems. Whenever practical, all parties involved in investigating reports of child maltreatment shall observe the interview, which shall be digitally recorded.

"Multidisciplinary team" or "MDT" means a group of professionals working collaboratively under a written protocol, who represent various disciplines from the point of a report of child maltreatment to assure the most effective coordinated response possible for every child. Employees from each participating entity shall be included on the MDT. A CAC's MDT must include professionals involved in the coordination, investigation, and prosecution of child abuse cases, including the CAC's staff, participating law enforcement agencies, the county state's attorney, and the Illinois Department of Children and Family Services, and must include professionals involved in the delivery of services to victims of child maltreatment and non-offending parent or parents, caregiver, and their families.

"National Children's Alliance" or "NCA" means the professional membership organization dedicated to helping local communities respond to allegations of child abuse in an effective and efficient manner. NCA provides training, support, technical assistance and leadership on a national level to state and local CACs and communities responding to reports of child maltreatment. NCA is the national organization that provides the standards for CAC accreditation.

"Protocol" means a written methodology defining the responsibilities of each of the MDT members in the investigation and prosecution of child maltreatment within a defined jurisdiction. Written protocols are signed documents and are reviewed and/or updated annually, at a minimum, by a CAC's Advisory Board.

(Source: P.A. 98-809, eff. 1-1-15.)

(55 ILCS 80/3) (from Ch. 23, par. 1803)

Sec. 3. Child Advocacy Advisory Board.

(a) Each county or group of counties in the State of Illinois shall establish a Child Advocacy Advisory Board ("Advisory Board").

Each of the following county officers or State agencies or allied professional entities shall designate a representative to serve on the Advisory Board: law enforcement within the appropriate jurisdiction(s), the Illinois Department of Children and Family Services, the State's attorney, and the Children's Advocacy Center.

The Advisory Board may appoint additional members of the Advisory Board as is deemed necessary to accomplish the purposes of this Act, the additional members to include but not be limited to representatives of local law enforcement agencies, allied professionals, and the Circuit Courts.

(b) The Advisory Board shall have the authority to organize itself and appoint, assign, or elect leaders. The Advisory Board shall determine the voting rights of multiple members from the same agency or entity.

(c) The Advisory Board shall adopt, by a majority of the members, a written operational protocol. The Advisory Board shall, prior to finalization, submit a draft to the Children's Advocacy Center of Illinois ("CACI") for review and comments to ensure compliance with accreditation standards from NCA. After considering the comments of the CACI and upon finalization of its protocol, the Advisory Board shall file the protocol with the Department of Children and Family Services and the CACI. If requested, a copy shall be made available to the public by the local CAC. Each Advisory Board shall, on an annual basis, review and/or update the written protocol. Any changes made to the written protocol shall be approved by majority vote and, prior to finalization, a draft shall be submitted to the CACI for review and comments to ensure compliance with accreditation standards from NCA. After considering the comments of the CACI and upon finalization of its protocol, the Advisory Board shall file the protocol with the Department of Children and Family Services and the CACI.

(d) The purpose of the protocol shall be to ensure coordination and cooperation among all agencies involved in child maltreatment cases so as to increase the efficiency and effectiveness of those agencies, to minimize the trauma created for the child and his or her non-offending parents, caregivers, or family members by the investigatory and judicial process, and to ensure that more effective treatment is provided for the child and his or her non-offending parents, caregivers, or family members. Agencies that are members of the Advisory Board are encouraged to amend their internal operating protocol in a manner that further facilitates coordination and cooperation among all agencies.

(e) The protocol shall be a written document outlining in detail the procedures to be used in investigating and responding to cases arising from alleged child maltreatment and in coordinating treatment referrals for the child and his or her non-offending parents, caregivers, or family members. In preparing the written protocol, the Advisory Board shall ensure that the CAC includes all of the components listed in Section 4 of this Act.

(f) The Advisory Board shall evaluate the implementation and effectiveness of the protocol required under subsection (c) of this Section on an annual basis, and shall propose appropriate modifications to the protocol to maximize its effectiveness. A report of the Advisory Board's review, along with proposed modifications, shall be submitted to the CACI for its review and comments. After considering the comments of the CACI and adopting modifications, the Advisory Board shall file its amended protocol with the Department of Children and Family Services. A copy of the Advisory Board's review and amended protocol shall be furnished to the CACI and to the public.

(g) (Blank).

(Source: P.A. 98-809, eff. 1-1-15.)

(55 ILCS 80/4) (from Ch. 23, par. 1804)

Sec. 4. Children's Advocacy Center.

(a) A CAC may be established to coordinate the activities of the various agencies involved in the investigation, prosecution and treatment of child maltreatment. The individual county or regional Advisory Board shall set the written protocol of the CAC within the appropriate jurisdiction. The operation of the CAC may be funded through public or private grants, contracts, donations, fees, and other available sources under this Act. Each CAC shall operate to the best of its ability in accordance with available funding. In counties in which a referendum has been adopted under Section 5 of this Act, the Advisory Board, by the majority vote of its members, shall submit a proposed annual budget for the

operation of the CAC to the county board, which shall appropriate funds and levy a tax sufficient to operate the CAC. The county board in each county in which a referendum has been adopted shall establish a Children's Advocacy Center Fund and shall deposit the net proceeds of the tax authorized by Section 6 of this Act in that Fund, which shall be kept separate from all other county funds and shall only be used for the purposes of this Act.

(b) The Advisory Board shall pay from the Children's Advocacy Center Fund or from other available funds the salaries of all employees of the Center and the expenses of acquiring a physical plant for the Center by construction or lease and maintaining the Center, including the expenses of administering the coordination of the investigation, prosecution and treatment referral of child maltreatment under the provisions of the protocol adopted pursuant to this Act.

(c) Every CAC shall include at least the following components:

(1) A multidisciplinary, coordinated systems approach to the investigation of child maltreatment which shall include, at a minimum:

- (i) an interagency notification procedure;
- (ii) a policy on multidisciplinary team collaboration and communication that requires MDT members share information pertinent to investigations and the safety of children;
- (iii) (blank);
- (iv) a description of the role each agency has in responding to a referral for services in an individual case;
- (v) a dispute resolution process between the involved agencies when a conflict arises on how to proceed on the referral of a particular case;
- (vi) a process for the CAC to assist in the forensic interview of children that witness alleged crimes;
- (vii) a child-friendly, trauma informed space for children and their non-offending family members;
- (viii) an MDT approach including law enforcement, prosecution, medical, mental health, victim advocacy, and other community resources;
- (ix) medical evaluation on-site or off-site through referral;
- (x) mental health services on-site or off-site through referral;
- (xi) on-site forensic interviews;
- (xii) culturally competent services;
- (xiii) case tracking and review;
- (xiv) case staffing on each investigation;
- (xv) effective organizational capacity; and
- (xvi) a policy or procedure to familiarize a child and his or her non-offending family members or guardians with the court process as well as preparations for testifying in court, if necessary;

(2) A safe, separate space with assigned personnel designated for the investigation and coordination of child maltreatment cases;

(3) A multidisciplinary case review process for purposes of decision-making, problem solving, systems coordination, and information sharing;

(4) A comprehensive client tracking system to receive and coordinate information concerning child maltreatment cases from each participating agency;

(5) Multidisciplinary specialized training for all professionals involved with the victims and non-offending family members in child maltreatment cases; and

(6) A process for evaluating the effectiveness of the CAC and its operations.

(d) In the event that a CAC has been established as provided in this Section, the Advisory Board of that CAC may, by a majority vote of the members, authorize the CAC to coordinate the activities of the various agencies involved in the investigation, prosecution, and treatment referral in cases of serious or fatal injury to a child. For CACs receiving funds under Section 5 or 6 of this Act, the Advisory Board shall

provide for the financial support of these activities in a manner similar to that set out in subsections (a) and (b) of this Section and shall be allowed to submit a budget that includes support for physical abuse and neglect activities to the County Board, which shall appropriate funds that may be available under Section 5 of this Act. In cooperation with the Department of Children and Family Services Child Death Review Teams, the Department of Children and Family Services Office of the Inspector General, and other stakeholders, this protocol must be initially implemented in selected counties to the extent that State appropriations or funds from other sources for this purpose allow.

(e) CACI may also provide technical assistance and guidance to the Advisory Boards.  
(Source: P.A. 98-809, eff. 1-1-15; 99-78, eff. 7-20-15.)

(55 ILCS 80/5) (from Ch. 23, par. 1805)

Sec. 5. Referendum.

(a) Whenever a petition signed by 1% of the electors who voted in the last general election in any county is presented to the county board requesting the submission of the proposition whether an annual tax of not to exceed .004% of the value, as equalized or assessed by the Department of Revenue, of all taxable property in the county shall be levied for the purpose of establishing and maintaining a Children's Advocacy Center, the county board shall adopt a resolution for the submission of the proposition to the electors at the next regular election held in the county in accordance with the general election law.

(b) Upon the adoption and certification of the resolution, the proposition shall be submitted at the next regular election held in the county. The proposition shall be in substantially the following form:

"Shall an annual tax of not more than .....

per cent be levied on the value of all taxable property in ..... County (this tax will amount to an annual increase of approximately ..... on a home with a market value of \$100,000) for the purpose of establishing and maintaining a Children's Advocacy Center to coordinate the investigation, prosecution, and treatment referral of child sexual abuse in ..... County?"

The election authority must record the votes as "Yes" or "No".

(c) If a majority of the electors of the county voting on the proposition vote in favor thereof, the proposition shall be deemed adopted.

(d) The adoption of a referendum is not required to establish a Children's Advocacy Center if the Center may be or is operated with funds other than the proceeds of the annual tax that is authorized by referendum.

(Source: P.A. 92-785, eff. 8-6-02; 93-203, eff. 7-14-03.)

(55 ILCS 80/6) (from Ch. 23, par. 1806)

Sec. 6. Tax. (a) Upon the adoption of the proposition by the electors pursuant to Section 5, each affected county board shall cause an annual tax of not to exceed .004% of the value, as equalized or assessed by the Department of Revenue, of all taxable property of the county to be levied upon all the taxable property in the county for the purpose of establishing and maintaining a Children's Advocacy Center. The tax shall be in addition to all other taxes authorized by law to be levied and collected in the county and shall be in addition to the maximum of taxes authorized by law for county purposes. The foregoing limitations upon tax rates may be increased or decreased according to the referendum provisions of the General Revenue Law of Illinois.

(b) The proceeds of the tax authorized by this Section shall be paid into the county treasury and deposited in a fund to be known as the Children's Advocacy Center Fund. The Fund may be used by the county board or boards for the establishment, operation and maintenance of a Children's Advocacy Center. Expenditures from the Fund shall be made in the same manner and subject to the same requirements as other county expenditures.



(Source: P.A. 86-276.)

(55 ILCS 80/7) (from Ch. 23, par. 1807)

Sec. 7. Discontinuance.

(a) Upon a petition signed by 1% of the electors who voted in the last general election in a county which has levied and collected a tax for Children's Advocacy Center purposes under this Act being presented to the county board, requesting that the tax for Children's Advocacy Center purposes be discontinued, the county board shall adopt a resolution providing for the submission of the proposition to the electors of the county in the same manner as provided for the submission of the proposition for the levy of the tax.

(b) Upon the adoption and certification of the resolution, the proposition shall be submitted at the next regular election held in the county. The proposition shall be in substantially the following form: "Shall the tax for the purpose of establishing and maintaining a Children's Advocacy Center be discontinued?"

(c) If a majority of the electors of the county voting upon the proposition vote in favor thereof, the proposition shall be deemed adopted, and the tax shall no longer be levied or collected in the county. Any monies remaining in the Children's Advocacy Center Fund in the county shall be used to pay the expenses of the Center, including expenses of winding up its operations if it is discontinued by the Advisory Board. In that case, after all expenses of the Center have been paid, any remaining monies in the Fund shall be paid into the general fund for county purposes in the county treasury.

(Source: P.A. 92-785, eff. 8-6-02.)

(55 ILCS 80/7.1)

Sec. 7.1. The changes made by this amendatory Act of the 92nd General Assembly are intended to be declarations of existing law and are not intended to be a new enactment.

(Source: P.A. 92-785, eff. 8-6-02.)"

## APPENDIX E: CERTIFIED CHILD ABUSE PEDIATRICIANS (CAPS) IN ILLINOIS

CAP MD	Status - FTE	Practice Location	Affiliation	Hospital	Practice type
Davis , Ray	Full time CAP	Rockford	University of Illinois	Hospital Teaching Adult trauma	Merit
Fingarson, Amanda	Part time CAP	Chicago	Anne and Robert H Lurie Children's Hospital of Chicago	Free standing children's hospital Pediatric Level 1 trauma Teaching	MPEEC
Flaherty, Emalee	Part time CAP	Chicago	Lurie Children's	Free standing	MPEEC-retired
Fujara, Marjorie	Full time CAP	Chicago	John H Stroger Jr Hospital of Cook County	Children's hospital medical complex	MPEEC
Glick, Jill	Full time CAP	Chicago	Comer Children's Hospital	Children's hospital medical complex	MPEEC
Jones, Mary	Full time pediatrician; CAP < 50%	Maywood	Ronald McDonald House	Children's hospitals medical complex	Basic, advanced
Lorand, Michele	Retired	Chicago	Stroger	Stroger	MPEEC-retired
Narang, Sandeep	Full time CAP	Chicago	Lurie Children's	Lurie Children's	MPEEC
Petrak, Channing	Full time CAP	Peoria	OSF Saint Francis Medical Center	Children's medical complex	Pediatric Resource Center
Ramaiah, Veena	ER .5 FTE; CAP .5 FTE	Chicago	Comer	Comer	MPEEC
Rosado, Norell	Full time CAP	Chicago	Lurie Children's	Lurie Children's	MPEEC
Savings, Kay	Retired	Peoria	Peoria	Peoria	Pediatric Resource Center
Scotellaro, Margaret	Full time pediatrician	Chicago	Rush	Children's hospitals medical complex	Basic level
Sifferman, Emily	Full time	Chicago	Stroger	Stroger	MPEEC
Staley, Kelley	Retired	Chicago	Retired	Retired	Retired
Swafford, Kathy	Full time	Anna, Carbondale	SIU School of Medicine	Memorial Hospital of Carbondale, Union County Hospital, Anna	Children's Medical Resource Network

## APPENDIX F: MULTIDISCIPLINARY PEDIATRIC EDUCATION AND EVALUATION CONSORTIUM (MPEEC)

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The Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) is collaboration between three pediatric child abuse medical teams (Comer Children's Hospital, Stroger Hospital, and Lurie Children's Hospital), ChicagoCAC, DCFS and law enforcement. MPEEC is activated to investigate cases of severe injury in children under the age of 3. In addition to being an example of a good model to build from in cases of severe injury cases, the MPEEC doctors also provide an exemplary training for investigators.

The following information about the definition, history, role, and purpose of the MPEEC is taken from Chicago Children's Advocacy Center's website (2016):

"Chicago Children's Advocacy Center convenes the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC). This landmark partnership provides timely, comprehensive investigation, diagnosis and treatment of suspected physical abuse of children under age 3, ensuring the best outcome for children and families. Our MPEEC partners are:

- John H. Stroger, Jr. Hospital of Cook County
- Ann & Robert H. Lurie Children's Hospital of Chicago
- The University of Chicago Comer Children's Hospital
- Illinois Department of Children & Family Services
- Chicago Police Department

*Prevalence of Physical Abuse:* In Illinois, children under age 3 experience the highest rates of abuse and neglect. In their 2014 fiscal year, Illinois Department of Children & Family Services indicated abuse or neglect in more than 6,300 cases of children under age 3. These children are most vulnerable to the long-term impacts of abuse, and most are too young to speak. When initial signs of abuse are overlooked, repeat injury occurs in up to 80% of victims, with mortality rates as high as 50%.

*How We Help:* MPEEC responds to reports of serious injuries of children under age 3 who are either treated at one of our partner hospitals, or who are Chicago residents treated at any area hospital. These injuries include cuts, welts, bruises, burns, internal injuries, bone fractures and head trauma. MPEEC team members collaborate to provide case coordination, forensic medical evaluation by board-certified child abuse pediatricians, child welfare investigation and criminal investigation. MPEEC also provides second opinions for child protection specialists investigating suspected abuse of children of any age. When abuse is properly identified, health professionals, child protection specialists and others can take necessary actions to protect the child from future harm. Similarly, rapidly identifying injuries that are the result of non-abusive trauma minimizes the interruption to children and families.

*Trainings:* Our MPEEC team conducts trainings for first responders including Chicago Police Department, Chicago Fire Department and Illinois Department of Children & Family Services. These trainings are not open to the public. Contact us for more information.

*Our Founding:* MPEEC was created in response to the death of 15-month-old Gabriella Elise Manzardo, who died from abusive head trauma. A prolonged 14-month investigation led to the indictment of her child care provider. Gabriella's mother, Laurie Manzardo, was frustrated by the lack of medical expertise and interagency communication, both of which hindered the investigation. As a result, Laurie founded G.E.M. Child Protection Foundation. G.E.M. collaborated with Dr. Jill Glick, Dr. Michele Lorand and Dr. Emalee Flaherty to form an interdisciplinary task force of child advocates to address deficiencies in the system. The task force recommended the development and implementation of a statewide system to ensure child abuse pediatricians provide medical evaluations when abuse is alleged. In Chicago, this coordinated response is called MPEEC."

## APPENDIX G: CHILD DEATH INVESTIGATION TASK FORCE IN THE DCFS SOUTHERN REGION

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Public Act 096-0955, effective June 30, 2010, makes the following amendment to Section 45 of The Child Death Review Team Act:

“(20 ILCS 515/45) Sec. 45. Child Death Investigation Task Force; pilot program. The Child Death Review Teams Executive Council may, from funds appropriated by the Illinois General Assembly to the Department and provided to the Child Death Review Teams Executive Council for this purpose, or from funds that may otherwise be provided for this purpose from other public or private sources, establish an 18-month pilot program in the Southern Region of the State, as designated by the Department, under which a special Child Death Investigation Task Force will be created by the Child Death Review Teams Executive Council to develop and implement a plan for the investigation of sudden, unexpected, or unexplained deaths of children under 18 years of age occurring within that region. The plan shall include a protocol to be followed by child death review teams in the review of child deaths authorized under paragraph (a)(5) of Section 20 of this Act. The plan must include provisions for local or State law enforcement agencies, hospitals, or coroners to promptly notify the Task Force of a death or serious life-threatening injury to a child, and for the Child Death Investigation Task Force to review the death and submit a report containing findings and recommendations to the Child Death Review Teams Executive Council, the Director, the Department of Children and Family Services Inspector General, the appropriate State's Attorney, and the State Representative and State Senator in whose legislative districts the case arose. The plan may include coordination with any investigation conducted under the Children's Advocacy Center Act. By July 1, 2011, the Child Death Review Teams Executive Council shall submit a report to the Director, the General Assembly, and the Governor summarizing the results of the pilot program together with any recommendations for statewide implementation of a protocol for the investigation of all sudden, unexpected, or unexplained child deaths.”

## APPENDIX H: RELEVANT OIG RECOMMENDATIONS

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The following are a selection of systematic recommendations from DCFS's Office of the Inspector General (OIG) "Report to the Governor and the General Assembly" (2015) relevant to the unit-based MDT recommendations proposed in this report:

*With regard to Child Protection Investigations:*

- If child protection investigators cannot meet their obligation to assess child(ren) in a timely manner the supervisor should assure that the police are contacted for a welfare check.
- The investigative field should be trained that in cases with abusive injuries and multiple caretakers, the investigator must develop a timeline of caretakers during the critical period of time in which the injuries could have been inflicted.
- The Department should develop a training to focus on honing interviewing skills for child protection, identifying critical facts and developing information early on regarding critical facts.

*With regard to Children's Advocacy Centers:*

- The Child Advocacy Advisory Committee should request that medical clinics that are co-located within Child Advocacy Centers will include body charts or photographs to document any observed injuries and if the injuries may be suggestive of abuse, will ensure that the child is questioned separately from caretakers.
- The Child Advocacy Center should institute procedures or protocol to ensure that critical information learned by the Medical Clinic, which is co-located at the Child Advocacy Center, is collaboratively shared with members of the interdisciplinary team.

*With regard to law enforcement coordination:*

- When there has been a prior serious indicated abuse finding or a prior conviction for serious battery to a child, and a parent is permitting continued access to the child by the abuser, the Department must secure the full investigative file from law enforcement prior to closing the child protection investigation.
- The Department should ensure that investigations are not approved for closure when alleged perpetrators have not been interviewed by child protection investigators when there was a pending police investigation without retrieving and reviewing a copy of the police investigation, including interview reports.
- The OIG has previously made recommendations concerning the need for collaboration between child protection investigators and police in Chicago, including specific recommendations to develop regional law enforcement liaisons within the Department to facilitate coordination. DCFS Chicago Police Department liaisons and the Chicago Police Department coordinators should conduct a case review to address future collaborative efforts between the Chicago Police Department and the Department.

## APPENDIX I: DCFS MALTREATMENT ALLEGATIONS TARGETED FOR MDT RESPONSE

The following table lists the code numbers DCFS uses for selected abuse and neglect allegations that are a priority for MDTs, current as of January 2016. The allegations are stratified by physical harms for children, lack of health care, and sexual abuse. Note that physical harms can result from either abuse or neglect, represented by separate abuse and neglect allegations for each type of physical harm. Unit-based MDTs will target allegations of physical harms for children under 3 years old and lack of health care and sexual abuse allegations for children under 18 years old.

TABLE I: DCFS CODES OF ABUSE AND NEGLECT ALLEGATIONS PRIORITIZED FOR MDT REVIEW

Description	Abuse Allegation Codes	Neglect Allegation Codes
<b>Physical Harms</b>		
Brain Damage/Skull Fracture	2	52
Internal Injuries	4	54
Burns	5	55
Poison/Noxious Substances	6	56
Wounds	7	57
Bone Fractures	9	59
Cuts, Welts, and Bruises	11	61
Human Bites	12	62
Sprains	13	63
<b>Lack of Health Care†</b>		
Medical Neglect		79
Failure to Thrive		81
Malnutrition		83
Disabled Infant Neglect		85
<b>Sexual Abuse</b>		
Sexually Transmitted Diseases	18	
Sexual Penetration	19	
Sexual Exploitation*	20	
Sexual Molestation	21	

\*Note: Only those human trafficking of children cases that involve sexual exploitation are included in this table.

†Note: Throughout the report, this DCFS category is referred to as neglect involving or related to medical concerns.

## APPENDIX J: ILLINOIS CHILD MALTREATMENT STATISTICS FROM DCFS

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The following tables show the broader statistics of child maltreatment in the state of Illinois. The data has been collected from the Illinois DCFS 10/31/2015 Executive Statistical Summary (2015). Estimates on the number of children under 18 in Illinois were taken from 2014 updates from the US Census Bureau (2014):

The phrase “Child Reports” is a duplicated count; children are counted more than once if reported more than once during that year. The number of unique child victims (either reported or indicated) over time is not available; however, based on FY14 statistics, these figures were roughly 90% of these counts. Additionally, increases in indicated reports over time may be partly due to retroactive changes in the data from earlier years; an earlier indicated decision could be overturned to unfounded for neglect allegation #60 (substantial risk of injury due to neglect) in an appeal mandated by class action lawsuits.

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TABLE J1: CHILD ABUSE AND NEGLECT TRENDS IN ILLINOIS

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Reports and Indicated Reports	FY11	FY12	FY13	FY14
Number of Accepted Child Reports	101,508	106,237	108,606	109,783
Number of <i>Indicated</i> Child Reports	17,385	20,822	19,679	24,627
Percent of Child Reports that were <i>Indicated</i>	17.1%	19.6%	18.1%	24.3%

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TABLE J2: CHILD DEATH TRENDS IN ILLINOIS

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Reports	FY11	FY12	FY13	FY14
Total Child Death Reports Investigated	202	194	214	211
Indicated Abuse	38	32	33	36
Indicated Neglect	57	66	80	69
Unfounded Abuse	21	10	13	14
Unfounded Neglect	86	86	88	89
Pending Investigations	0	0	0	3
Total Indicated Abuse + Neglect	95	98	113	105
Investigative Findings Overturned on Appeal	5	5	6	3



TABLE J3: REPORTED CHILD SEXUAL ABUSE VICTIMS

	FY11	FY12	FY13	FY14	FY15
<b>Reported Sex Abuse Victims</b>					
Cook	2,636	2,801	2,637	2,632	2,529
Downstate	5,120	5,407	5,243	4,937	5,018
Statewide	7,756	8,208	7,880	7,569	7,547
<b>Indicated Sex Abuse Victims</b>					
Cook	666	757	682	741	673
Downstate	1,448	1,415	1,362	1,367	1,477
Statewide	2,122	2,204	2,044	2,108	2,150
<b>% Indicated</b>					
Cook	25%	27%	26%	28%	27%
Downstate	28%	27%	26%	28%	30%
Statewide	27%	27%	26%	28%	29%

## APPENDIX K: SUPPLEMENTAL CHILD MALTREATMENT ANALYSES FOR TASK FORCE: SERIOUS HARMS

The analyses and findings presented in this section were provided to the committee for the purposes of discussion; analysis for the following tables was made by Dr. Tamara Fuller with additional analyses provided by Dr. Stephen Budde, Project Manager/Writer. Rates of serious harm reports for children under 3 used the population of children under 5 as a denominator since this information is easily available through the census data. This strategy is useful in providing relative rates across regions, but leads to two biases: the denominator is too large, which underestimates the prevalence rates for children under 3, and some children under 3 had multiple reports and so the numbers reported here are duplicated. Nevertheless, this rate is included because it illustrates relative population level differences in serious harms reports across regions, which can be compared to subregions in Appendix Q.

Only two of the four serious harm allegations are related to lack of health care: medical neglect of disabled infants and failure to thrive. Medical neglect and malnutrition were added to the serious harms allegations at a later date. About 8% of all reports involve one of the serious harms examined, and Cook Region had a relatively high percentage of reports involving serious harms. Both the Central and Southern Regions have much higher rates of serious harm reports for children under 3 than Cook or Northern Regions. Cook Region has the largest number of serious harms in total, and the highest number of Brain Damage/Skull fractures, burns, and FTT cases; the DCFS Southern Region had the lowest numbers for these three measures. Thus, while the numbers of serious harms and head trauma reports were relatively low in Southern, the population rates were reversed.

**TABLE K1: CHILD REPORTS IN FY14 INVOLVING SERIOUS HARMS FOR CHILDREN ≤ 3 YEARS OLD, BY DCFS REGION**

	Central	Cook	Northern	Southern	Total
<b>Serious harms</b>					
Head Trauma	37	69	39	23	168
Burns/Scalding	40	53	44	20	157
Wounds	2	0	0	0	2
Fractures	73	70	74	29	246
Cuts, Welts, and Bruises	289	308	250	173	1020
Sprains/Dislocations	2	2	1	2	7
Medical Neglect of Disabled Infants	0	5	0	0	5
Failure to Thrive (FTT)	46	62	27	29	164
<b>Overview</b>					
Number of all child reports involving children under 3	6663	5881	5522	3576	21642
Number of serious harms above	489	569	435	276	1769
Percent of Reports that were serious harms	7.3%	9.7%	7.9%	7.7%	8.2%
<b>Rates per 100 children under 5 (2010 census)</b>					
Physical harm & medical neglect reports	2.62	1.66	1.88	3.67	2.12
Head Trauma (only) report rates	.20	.20	.17	.31	.20

The data in Table K3 presents county-level data for the numbers and population of DCFS reports of serious harms for children under 3 years old; the numbers of specific types of harms reports for those children; and the population rate for the total serious harms. Of the serious harms listed in Table K1, subdural hematomas are excluded from the following table since there were no reports of subdural hematoma among children under 3 in 2014. Child age was calculated at the time of the maltreatment report date. Child report refers to an individual child reported as alleged victim of maltreatment on a given date. During the fiscal year a child may be the subject of multiple reports thus they would appear multiple times in the table. The columns for each allegation count the number of child reports with that particular allegation in the county for the fiscal year; the count of child reports for each allegation is independent of any other allegation type and regardless of indication.

TABLE K2: LEGEND FOR TABLE K3

Heading	Definition
Region	DCFS regional code
Subreg	DCFS subregion code
County	Illinois county
N Reports	Total number of reports
# SH	Total number of serious harms reports
SH Rate*	Serious harms reports (total) of children under 3 per 1,000 children under 5 in county
HT Rate*	Head trauma reports of children under 3 per 1,000 children under 5 in county
Brain Dam Skull Frac	Brain damage/skull fractures
Burns	Burns/scalding
Wounds	Wounds
Fract	Fractures
CW&B	Cuts, welts, and bruises
Sprains/Disl	Sprains/dislocations
FTT	Failure to thrive
Med Neg Dis Infants	Medically disabled infants
County Population	County population (from 2010 census)

*\*Note: For these analyses, Dr. Budde used the population of children under 5 (rather than under 3) as a denominator for these rates because that was what was easily available through the census data. This strategy is problematic because it produces underestimates of the prevalence rates of serious harm and head trauma reports for children under 3, and because it does not unduplicate the count of children under 3 (some of whom had multiple reports). Despite these limitations, these rates are included because they illustrate relative population level differences in serious harms reports across regions, subregions, and counties.*

**TABLE K3: NUMBER OF CHILDREN UNDER 3 YEARS AND POPULATION RATES WITH  
SPECIFIC TYPES OF SERIOUS HARMS BY COUNTY FOR FY14**

Location			Serious Harms: Totals and Rates		Specific Types of Serious Harm									2010 Population Data	
Region	Subreg	County	N Reports	# SH	HT Rate	Brain Dam Skull Fract	Burns	Wounds	Fract	CW&B	Sprains/ Disl	FTT	Med Neg Dis Infants	County Population	SH Rate
Central	1B	Bureau	78	1		0	0	0	0	1	0	0	0	34,978	0.49
Central	1B	Fulton	124	4		0	1	0	0	3	0	0	0	37,069	2.08
Central	1B	Henderson	14	0		0	0	0	0	0	0	0	0	7,331	0.00
Central	1B	Henry	115	6		0	0	0	1	5	0	0	0	50,486	1.98
Central	1B	Knox	168	16		0	0	0	2	13	0	1	0	52,919	5.81
Central	1B	La Salle	342	16	.02	1	1	0	1	13	0	0	0	703,462	0.34
Central	1B	Marshall	31	4		0	0	0	0	4	0	0	0	12,640	5.86
Central	1B	McDonough	93	5	.67	1	0	0	0	3	0	1	0	32,612	3.33
Central	1B	Mercer	29	1		0	0	0	0	1	0	0	0	16,434	1.03
Central	1B	Peoria	651	51	.32	4	6	0	8	30	0	3	0	186,494	4.02
Central	1B	Putnam	12	1		0	0	0	1	0	0	0	0	6,006	3.20
Central	1B	Rock Island	472	36		0	3	1	7	20	0	5	0	147,546	3.81
Central	1B	Stark	12	3		0	1	0	0	2	0	0	0	5,994	9.44
Central	1B	Tazewell	291	32	.35	3	3	0	5	18	0	3	0	135,394	3.69
Central	1B	Warren	66	7	.97	1	1	0	1	4	0	0	0	17,707	6.82
Central	1B	Woodford	61	7		0	0	0	0	7	0	0	0	38,664	2.79
Central	3A	Adams	236	11	.24	1	0	1	1	7	0	1	0	67,103	2.60
Central	3A	Brown	7	0		0	0	0	0	0	0	0	0	6,937	0.00
Central	3A	Calhoun	9	1		0	0	0	0	1	0	0	0	5,089	3.64
Central	3A	Cass	33	1		0	0	0	1	0	0	0	0	13,642	1.08
Central	3A	Christian	96	8	.48	1	0	0	1	3	0	3	0	34,800	3.83
Central	3A	Greene	31	3		0	0	0	0	3	0	0	0	13,886	3.66
Central	3A	Hancock	36	4		0	1	0	0	2	0	1	0	19,104	3.55
Central	3A	Jersey	31	3		0	0	0	1	1	0	1	0	22,985	2.33
Central	3A	Logan	105	6		0	2	0	0	4	0	0	0	30,305	3.74
Central	3A	Macoupin	135	7		0	1	0	0	4	0	2	0	47,765	2.48
Central	3A	Mason	39	2		0	0	0	0	2	0	0	0	14,666	2.62
Central	3A	Menard	28	3		0	0	0	0	3	0	0	0	12,705	4.07
Central	3A	Montgomery	61	4	.58	1	0	0	1	2	0	0	0	30,104	2.33
Central	3A	Morgan	113	4	.51	1	0	0	1	2	0	0	0	35,547	2.05
Central	3A	Pike	30	5		0	0	0	2	3	0	0	0	16,430	4.91
Central	3A	Sangamon	614	41	.24	3	2	0	5	29	0	2	0	197,465	3.30
Central	3A	Schuyler	5	1		0	0	0	1	0	0	0	0	7,544	2.37
Central	3A	Scott	8	1		0	0	0	1	0	0	0	0	5,355	3.11
Central	3B	Champaign	536	34	.26	3	4	0	3	17	0	7	0	201,081	2.92
Central	3B	Clark	47	4		0	0	0	1	3	0	0	0	16,335	4.30
Central	3B	Coles	168	17	1.07	3	1	0	2	10	0	1	0	53,873	6.07
Central	3B	Cumberland	12	1		0	1	0	0	0	0	0	0	11,048	1.37

Location			Serious Harms: Totals and Rates		Specific Types of Serious Harm									2010 Population Data	
Region	Subreg	County	N Reports	# SH	HT Rate	Brain Dam Skull Fract	Burns	Wounds	Fract	CW&B	Sprains/ Disl	FTT	Med Neg Dis Infants	County Population	SH Rate
Central	3B	De Witt	47	2		0	0	0	0	1	0	1	0	105,160	0.30
Central	3B	Douglas	31	2		0	0	0	0	2	0	0	0	19,980	1.43
Central	3B	Edgar	65	6		0	1	0	2	1	0	2	0	18,576	5.67
Central	3B	Ford	30	2	1.22	1	0	0	1	0	0	0	0	14,081	2.45
Central	3B	Iroquois	71	4	.61	1	1	0	0	2	0	0	0	29,718	2.45
Central	3B	Livingston	88	9	.45	1	0	0	1	7	0	0	0	38,950	4.05
Central	3B	Macon	474	46	.72	5	7	0	13	16	0	5	0	110,768	6.59
Central	3B	McLean	407	31	.19	2	0	0	6	20	2	1	0	169,572	2.90
Central	3B	Moultrie	36	1		0	0	0	1	0	0	0	0	14,846	1.01
Central	3B	Piatt	31	3	1.07	1	0	0	1	1	0	0	0	16,729	3.20
Central	3B	Shelby	74	3	.78	1	0	0	0	2	0	0	0	22,363	2.35
Central	3B	Vermilion	370	29	.37	2	3	0	1	17	0	6	0	81,625	5.30
Cook	Cook	Cook	5881	56 9	.20	69	53	0	70	30 8	2	6 2	5	5,194,675	1.66
Northern	1A	Boone	56	6		0	2	0	0	4	0	0	0	54,165	1.61
Northern	1A	Carroll	24	0		0	0	0	0	0	0	0	0	15,387	0.00
Northern	1A	De Kalb	202	16	2.08	2	1	0	4	8	1	0	0	16,561	16.6 6
Northern	1A	Jo Daviess	34	4		0	1	0	0	3	0	0	0	22,678	3.33
Northern	1A	Lee	92	6		0	1	0	0	4	0	1	0	36,031	2.92
Northern	1A	Ogle	94	6	.32	1	0	0	0	4	0	1	0	53,497	1.90
Northern	1A	Stephenson	128	11		0	3	0	0	8	0	0	0	47,711	3.91
Northern	1A	Whiteside	137	9	.28	1	2	0	1	5	0	0	0	58,498	2.56
Northern	1A	Winnebago	1083	56	.10	2	8	0	9	31	0	6	0	295,266	2.83
Northern	2A	Du Page	621	57	.09	5	6	0	13	29	0	4	0	916,924	1.00
Northern	2A	Grundy	64	11		0	2	0	1	8	0	0	0	50,063	3.01
Northern	2A	Kane	824	65	.15	6	2	0	11	42	0	4	0	515,269	1.64
Northern	2A	Kankakee	147	21	.52	4	2	0	3	11	0	1	0	113,449	2.72
Northern	2A	Kendall	121	11		0	1	0	1	9	0	0	0	114,736	1.09
Northern	2A	Lake	824	74	1.36	9	5	0	17	40	0	3	0	113,924	11.2 0
Northern	2A	McHenry	338	25	.10	2	2	0	5	14	0	2	0	308,760	1.27
Northern	2A	Will	733	57	.14	7	6	0	9	30	0	5	0	677,560	1.17
Southern	4A	Bond	43	4		0	0	0	0	4	0	0	0	17,768	4.17
Southern	4A	Clinton	65	5	.46	1	0	0	1	3	0	0	0	37,762	2.28
Southern	4A	Madison	679	58	.18	3	5	0	3	40	0	7	0	269,282	3.53
Southern	4A	Monroe	19	4	.51	1	0	0	1	2	0	0	0	32,957	2.06
Southern	4A	Randolph	83	6	.59	1	1	0	0	4	0	0	0	33,476	3.51
Southern	4A	St. Clair	633	54	.33	6	5	0	8	30	1	4	0	270,056	2.94
Southern	4A	Washington	28	1		0	0	0	0	1	0	0	0	14,716	1.19
Southern	5A	Alexander	28	1		0	1	0	0	0	0	0	0	8,238	1.71
Southern	5A	Clay	38	1		0	0	0	0	1	0	0	0	13,815	1.17

Location			Serious Harms: Totals and Rates		Specific Types of Serious Harm									2010 Population Data	
Region	Subreg	County	N Reports	# SH	HT Rate	Brain Dam Skull Fract	Burns	Wounds	Fract	CW&B	Sprains/ Disl	FTT	Med Neg Dis Infants	County Population	SH Rate
Southern	5A	Crawford	62	2		0	0	0	0	2	0	0	0	19,817	1.98
Southern	5A	Edwards	22	0		0	0	0	0	0	0	0	0	6,721	0.00
Southern	5A	Effingham	64	4	.44	1	0	0	1	2	0	0	0	34,242	1.77
Southern	5A	Fayette	67	7	.78	1	1	0	2	3	0	0	0	22,140	5.45
Southern	5A	Franklin	147	12		0	0	0	1	10	0	1	0	39,561	5.06
Southern	5A	Gallatin	22	2		0	0	0	0	2	0	0	0	5,589	6.07
Southern	5A	Hamilton	20	3		0	0	0	0	2	0	1	0	8,457	6.01
Southern	5A	Hardin	14	0		0	0	0	0	0	0	0	0	4,320	0.00
Southern	5A	Jackson	225	13		0	1	0	1	9	0	2	0	60,218	4.15
Southern	5A	Jasper	19	3		0	0	0	1	2	0	0	0	9,698	5.43
Southern	5A	Jefferson	224	11	.41	1	0	0	1	7	0	2	0	38,827	4.50
Southern	5A	Johnson	32	4		0	1	0	0	3	0	0	0	12,582	7.06
Southern	5A	Lawrence	55	6	1.14	1	0	0	1	3	0	1	0	16,833	6.85
Southern	5A	Marion	179	13	.78	2	1	0	1	6	0	3	0	39,437	5.07
Southern	5A	Massac	33	3		0	1	0	1	1	0	0	0	15,429	3.14
Southern	5A	Perry	60	8		0	0	0	1	6	0	1	0	22,350	6.75
Southern	5A	Pope	12	0		0	0	0	0	0	0	0	0	4,470	0.00
Southern	5A	Pulaski	14	1		0	0	0	0	1	0	0	0	6,161	2.80
Southern	5A	Richland	72	5		0	0	0	1	3	0	1	0	16,233	5.13
Southern	5A	Saline	140	16	.69	1	2	0	2	10	0	1	0	24,913	11.07
Southern	5A	Union	62	3		0	0	0	1	1	0	1	0	17,808	2.90
Southern	5A	Wabash	43	4		0	0	0	1	2	0	1	0	11,947	5.58
Southern	5A	Wayne	58	3		0	0	0	0	2	0	1	0	16,760	2.89
Southern	5A	White	65	4	1.14	1	0	0	0	3	0	0	0	14,665	4.55
Southern	5A	Williamson	249	15	.74	3	1	0	0	8	1	2	0	66,357	3.71

The following two graphs show the number and population rates of serious harms report for children under 3 for FY2014 by DCFS subregions; data for the three subregions within Cook were not available. Note that the Aurora subregion, like Cook County, had a large number of serious harms (321) but a relatively low rate of serious harms (1.7 children under 3 per 1,000 children under 5). Marion and Champaign subregions had the highest rates of serious harms reports.

FIGURE K1: NUMBER OF SERIOUS HARMS REPORTS FOR CHILDREN UNDER 3 IN FY14, BY DCFS SUBREGION

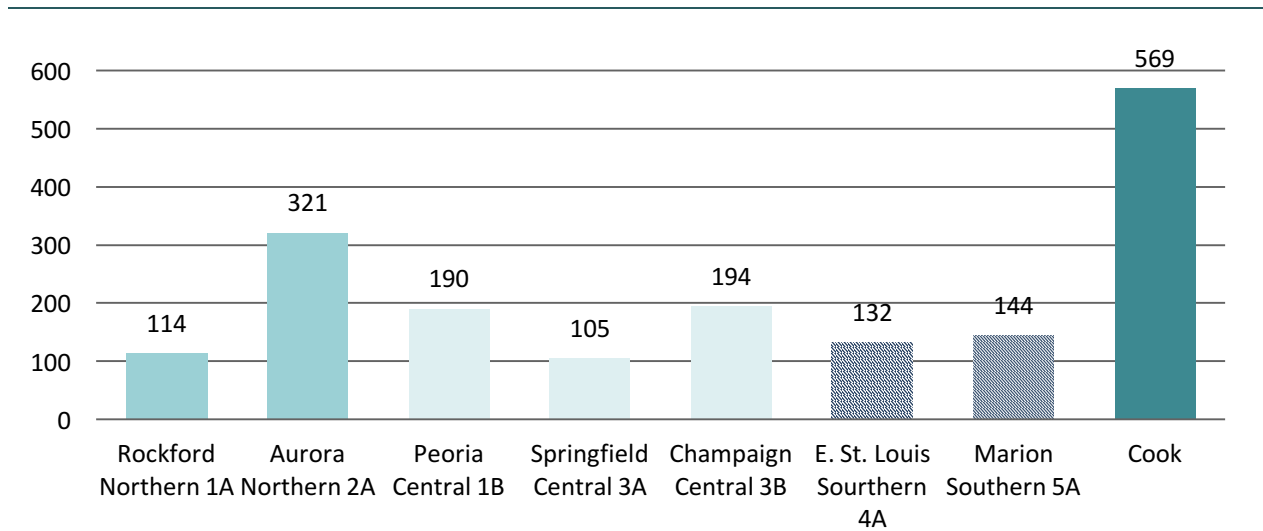
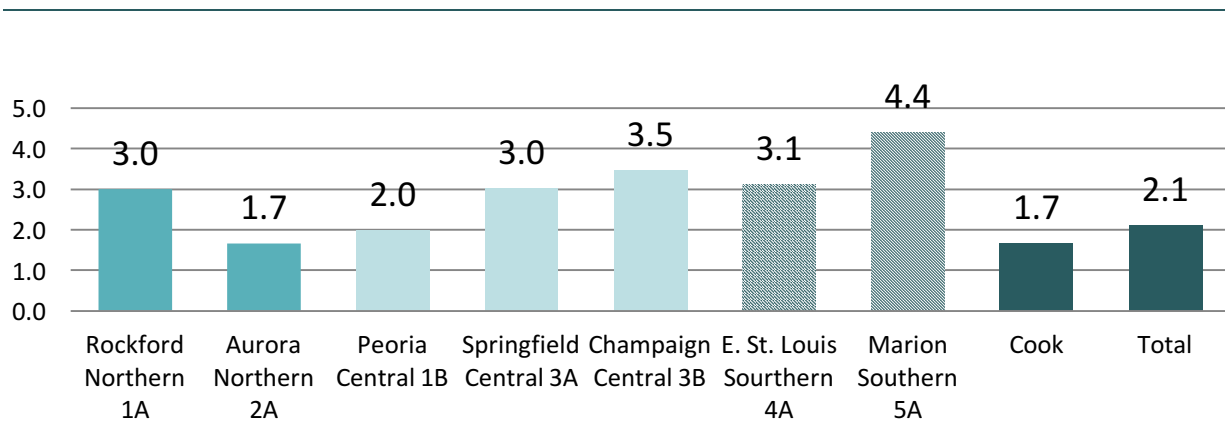


FIGURE K2: RATE OF SERIOUS HARMS REPORTS FOR CHILDREN UNDER 3 IN FY14, BY DCFS SUBREGION



## APPENDIX L: SUPPLEMENTAL CHILD MALTREATMENT ANALYSES FOR TASK FORCE: SEXUAL ABUSE

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The analyses and findings presented in this section were provided to the committee for the purposes of discussion.

This section displays supplemental analyses examining non-pending child sexual abuse allegations from July 1, 2012 thru March 2015; pending cases are excluded from the FY15 figures. Four types of sexual abuse allegations were included: Sexually Transmitted Diseases (abuse allegation #18), Sexual Penetration (#19), Sexual Exploitation (#20), and Sexual Molestation (#21). The data for a fifth allegation, Substantial Risk of Sexual Injury (#22) appears to be unreliable (more than double the number of all other allegations).

The larger dataset contains 98,084 maltreatment reports on 83,739 individual children that were accepted by DCFS for investigation. Of the 83,739 children, 16,874 (20.2%) were alleged victims in one of the four child sexual abuse allegations. These 16,874 children were involved in a total of 18,287 child sexual abuse related reports. A total of 1,193 children were involved in two or more reports that included a child sexual abuse allegation.

Table L1 below provides information on the number of reports involving any of the four sexual abuse allegations listed above and the indication rates for DCFS regions and subregions. Each DCFS region investigated at least 1,000 child sexual abuse reports annually in FY13 and FY14, with Cook County having over 2,500 reports. All subregions had at least 475 reports (assuming Cook administrative cases were roughly evenly distributed to the Cook subregions). The geographic breakdowns illustrate that sexual abuse reports are widespread. Total indication rates varied little by region, ranging from 24% to 27%. Among subregions, Cook South had much lower indication rates (18%) than all other subregions. The reason for this is unclear.

Unfortunately, county level and zip code data were not available, so this analysis cannot show us how child sexual abuse investigations are dispersed within subregions. Especially outside of Cook County and East St. Louis, the DCFS subregions in Illinois cover large geographic areas and between 8 and 27 counties. Figure Q4, a map of CAC locations and coverage in Illinois, provides information about locations and catchment areas by county.



**TABLE L1: CHILD REPORTS INVOLVING AT LEAST ONE SEXUAL ABUSE ALLEGATION  
AND INDICATION RATES BY DCFS REGION AND SUBREGION AND FISCAL YEAR**

Region	SubRegion	Code	FY13			FY14			FY15 (thru March 2015)			TOTAL		
			Alleg	Indicated	% Indic	Alleg	Indicated	% Indic	Alleg	Indicated	% Indic	Alleg	Indicated	% Indic
Northern	Rockford	1A	515	118	23%	476	127	27%	320	104	33%	1311	349	27%
	Aurora	2A	1429	358	25%	1372	398	29%	820	241	29%	3621	997	28%
	Peoria	1B	801	211	26%	722	190	26%	463	126	27%	1986	527	27%
Central	Springfield	3A	604	152	25%	508	140	28%	301	93	31%	1413	385	27%
	Champaign	3B	646	178	28%	736	207	28%	426	110	26%	1808	495	27%
Southern	East St. Louis	4A	571	134	23%	510	113	22%	345	82	24%	1426	329	23%
	Marion	5A	608	155	25%	520	131	25%	369	94	25%	1497	380	25%
Cook	Cook Admin	6A	1526	407	27%	1519	442	29%	902	268	30%	3947	1117	28%
	Cook North	6B	403	119	30%	409	116	28%	210	60	29%	1022	295	29%
	Cook Central	6C	282	86	30%	260	78	30%	132	35	27%	674	199	30%
	Cook South	6D	400	63	16%	393	84	21%	255	42	16%	1048	189	18%
<b>Totals</b>			<b>7785</b>	<b>1981</b>	<b>25%</b>	<b>7425</b>	<b>2026</b>	<b>27%</b>	<b>4544</b>	<b>1255</b>	<b>28%</b>	<b>19754</b>	<b>5262</b>	<b>27%</b>
<b>Regional</b>	<b>Totals</b>													
Northern			1944	476	24%	1848	525	28%	1140	345	30%	4932	1346	27%
Central			2051	541	26%	1966	537	27%	1190	329	28%	5207	1407	27%
Southern			1179	289	25%	1030	244	24%	714	176	25%	2923	709	24%
Cook			2611	675	26%	2581	720	28%	1499	405	27%	6691	1800	27%

Alleg = # of non-pending child reports with at least one of the 4 sexual abuse allegations

Indicated = # of child reports in which at least 1 sexual abuse allegation was indicated

% Indic = Indicated (defined above) as a percentage of Alleg (defined above)

Table L2 below shows the rates of child sex abuse reports and indicated reports per 10,000 children under 18 years; sexual abuse allegation #22 (substantial risk of sexual injury) was excluded due to concerns about the data validity. The population data was obtained from the 2010 census. There was substantial variation in both rates across DCFS subregions and regions. Three subregions (Springfield, Marion, and Champaign) had about double the rates of reports and indicated reports of the Aurora and Peoria subregions and Cook County. While the Southern Region had the highest regional rates, the subregions within Southern Region differed substantially—with Marion having much higher rates than East St. Louis.

TABLE L2: RATES OF CHILD SEX ABUSE REPORTS AND INDICATED REPORTS PER 10,000 CHILDREN UNDER 18 YEARS, BY DCFS REGION AND SUBREGION

Subregions	Reports	Indicated	# < 18
Rockford (N)	32	9	146,517
Aurora (N)	18	5	762,886
Peoria (Cen)	19	5	371,404
Springfield (Cen)	39	11	131,857
Champaign (Cen)	36	10	203,605
East St. Louis (S)	32	7	159,891
Marion (S)	43	11	121,117
Cook: NA	N/A	N/A	N/A
Regions	Reports	Indicated	# < 18
Northern	20	6	909,403
Central	28	8	706,866
Southern	37	9	281,007
Cook	21	6	1,231,138
<b>State Totals</b>	<b>24</b>	<b>6</b>	<b>3,128,415</b>

The following table shows the number of sexual abuse reports and the number of them which were indicated. The indication rate here is per allegation rather than per report, as in Table L1. There are more allegations than reports because a report can involve more than one sexual abuse allegations.

TABLE L3: SEXUAL ABUSE REPORTS AND INDICATE FINDINGS BY ALLEGATION

Allegation	Reports	Indicated	Indication Rate
Sexually Transmitted Diseases (#18)	247	91	37%
Sexual Penetration (19)	8472	2857	34%
Sexual Exploitation (20)	3389	879	26%
Sexual Molestation (21)	10922	3092	28%
<b>ALL</b>	<b>23030</b>	<b>6919</b>	<b>30%</b>

## APPENDIX M: SUPPLEMENTAL CHILD MALTREATMENT ANALYSES FOR TASK FORCE: ABUSIVE HEAD TRAUMA

The analyses and findings presented in this section were provided to the committee for the purposes of discussion.

This section illustrates some of the information that can be gleaned from analyzing the statewide dataset recently provided by DCFS. These supplemental analyses were provided by Dr. Stephen Budde, the Project Manager. The dataset contains all accepted reports of child abuse and neglect between 7/1/2012 and mid-April 2015. The way the dataset is structured, it is easier to start with a specific allegation and review this information. Although serious physical harm has been a topic of interest for the MDT Workgroup, these analyses focus on allegations of abusive head trauma. The analysis shows that both the number of head injury reports and the rates of indicated reports varied little across years. The number of reports in FY15 is right on target to match the number the previous two years.

**TABLE M1: NON-PENDING ABUSIVE HEAD INJURY (PHYSICAL ABUSE ALLEGATION #2): REPORTS IN ILLINOIS AND INDICATION DECISION BY FISCAL YEAR**

<b>Decision on Allegation</b>	<b>FY13</b>	<b>FY14</b>	<b>FY15 to 4/15</b>	<b>Total</b>
Not Indicated	126	125	80	331
Indicated	72	72	44	188
Pending			30	30
<b>Total # Reports*</b>	<b>198</b>	<b>197</b>	<b>154</b>	<b>549</b>
<b>% Indicated (excluding pending)</b>	<b>36%</b>	<b>37%</b>	<b>35%</b>	<b>36%</b>

*\*Note: A Child Report (N=549, including pending) is the Unit of Analysis (not a "child")*

*Accepted Reports for Allegation #2: Head Injuries (brain damage/skull fracture) due to Physical Abuse*

Figures M1 and M2 below show the geographical distribution of the numbers of non-pending abusive head trauma allegations (#2) reports, the number of those reports which were indicated, and the number of indicated reports as a percentage of the number of reports.

The large number of head injury reports in the Aurora subregion (i.e., collar counties around Cook—see map) is striking. This could result from actual differences in Aurora, higher rates of reporting in Aurora, or other factors. The indication rates for this allegation are lower than published DCFS reports for this allegation in the past (45% in FY12); this could mean a drop in indication rates or differences in measurement. The analysis specifically examined whether the specific allegation was indicated, not the overall report, which can involve multiple allegations. Indication rates are particularly high in Champaign and Marion, and relatively low in Marion, Springfield, and Aurora. Differences in reporting patterns, medical staffing, county courts and other factors might account for these fairly large differences.

FIGURE M1: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2) FROM 7/1/2012-4/1/15: NUMBER OF NON-PENDING REPORTS AND NUMBER OF INDICATED REPORTS, BY SUBREGION

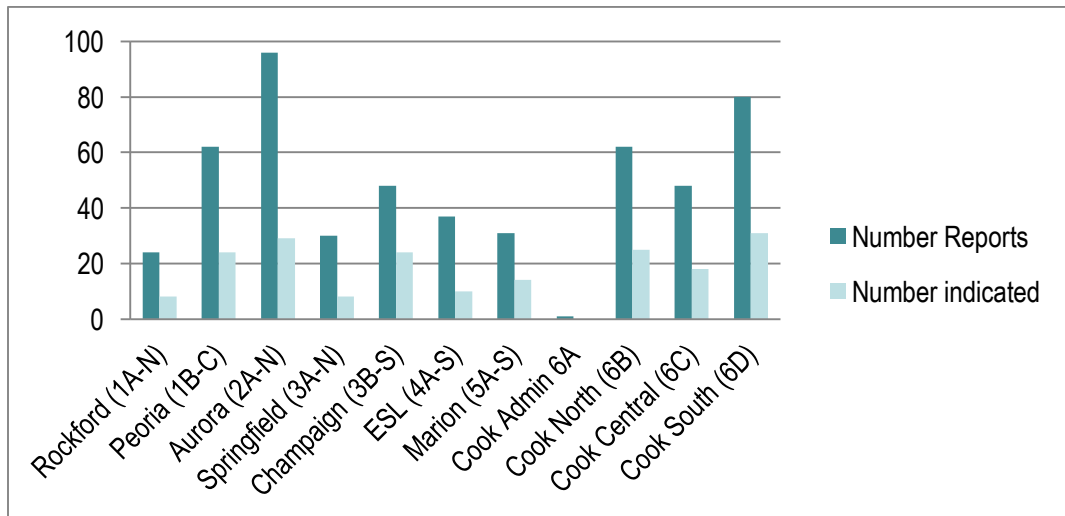


FIGURE M2: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2) FROM 7/1/2012-4/1/15: PERCENT OF NON-PENDING REPORTS INDICATED, BY SUBREGION: 37% OVERALL

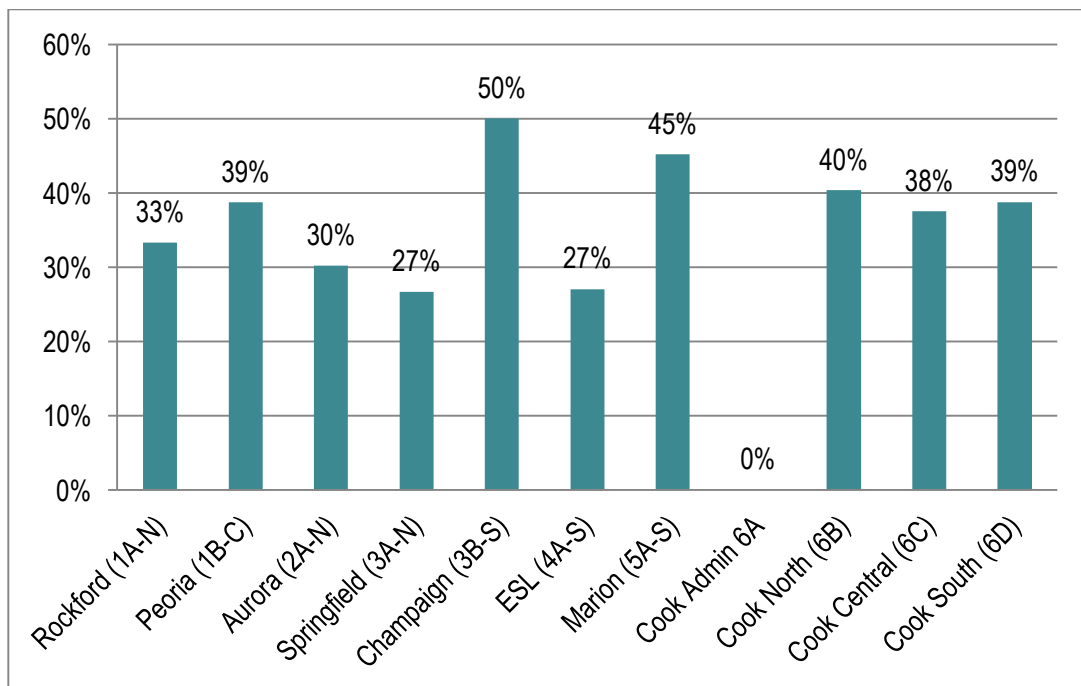
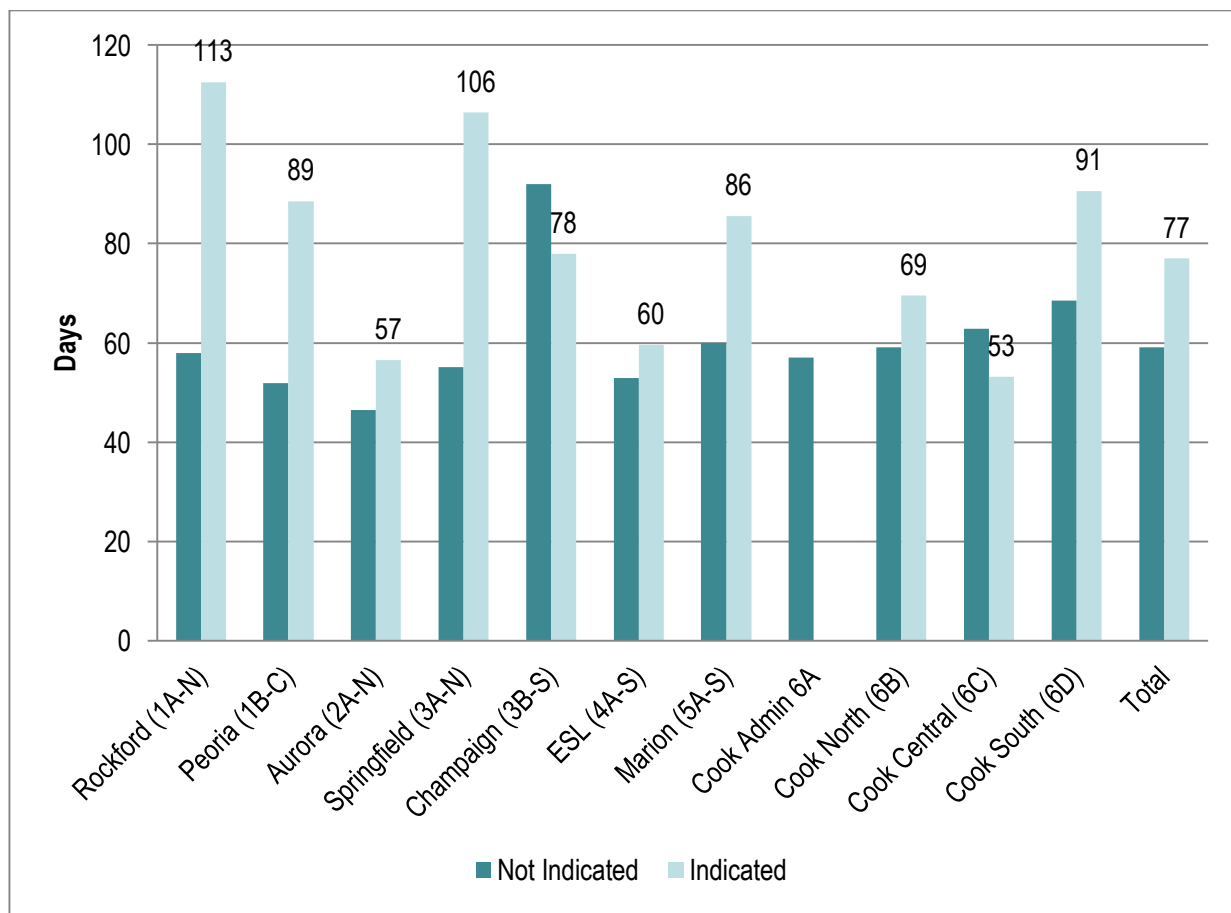


Figure M3 below shows the subregion-level average (mean) number of days to complete investigations by DCFS. 1. Investigations took longer in indicated cases (mean of 77 days) than in non-indicated cases (mean of 59 days), though these differences in length varied by subregion. It appears that some cases go well beyond the 60 days that is usually allocated to make the indication decision; this is not surprising given the complexity of the cases.

Champaign took a relatively long time to investigate the not-indicated cases, which may be consistent with efforts to make sure that the case should not be indicated; this could explain the high indication rate in Champaign. Relatively long average investigation times in indicated cases in Rockford, Springfield, and Marion compared with relative short mean times for indicated cases in Aurora, ESL, and Cook Central could reflect differences in access to medical opinions, DCFS or law enforcement practices, or other factors.

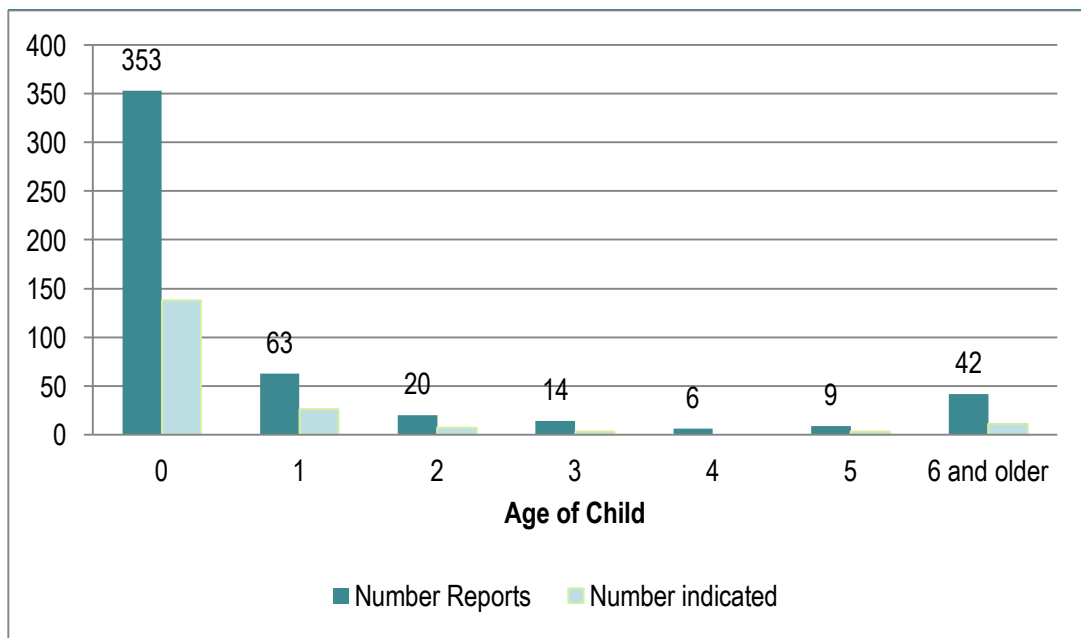
**FIGURE M3: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2) FROM 7/1/2012-4/1/15: AVERAGE (MEAN) NUMBER OF DAYS TO COMPLETE INVESTIGATION BY DCFS, BY SUBREGION**



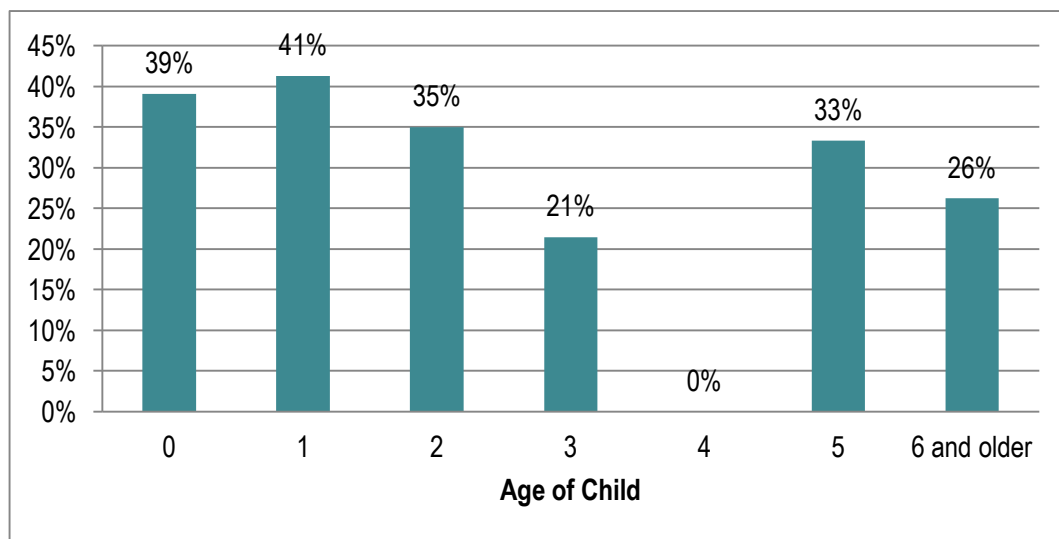
Figures M4 and M5 below analyze the age-level numbers of non- pending abusive head trauma allegations (#2) reports, the number of those reports which were indicated, and the number of indicated reports as a percentage of the number of reports. Head injury allegations are much more common for

children under the age of 1 year, with the number of such allegations continuing to reduce by the age of the child. Seventy percent of all reports involved children under the age of 1. This is certainly consistent with other research. Indication rates are somewhat higher for children between 0 and 1 year olds, and substantially lower for children 6 and older.

**FIGURE M4: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2) FROM 7/1/2012-4/1/15: NUMBER OF NON-PENDING REPORTS AND NUMBER OF INDICATED REPORTS, BY CHILD AGE**

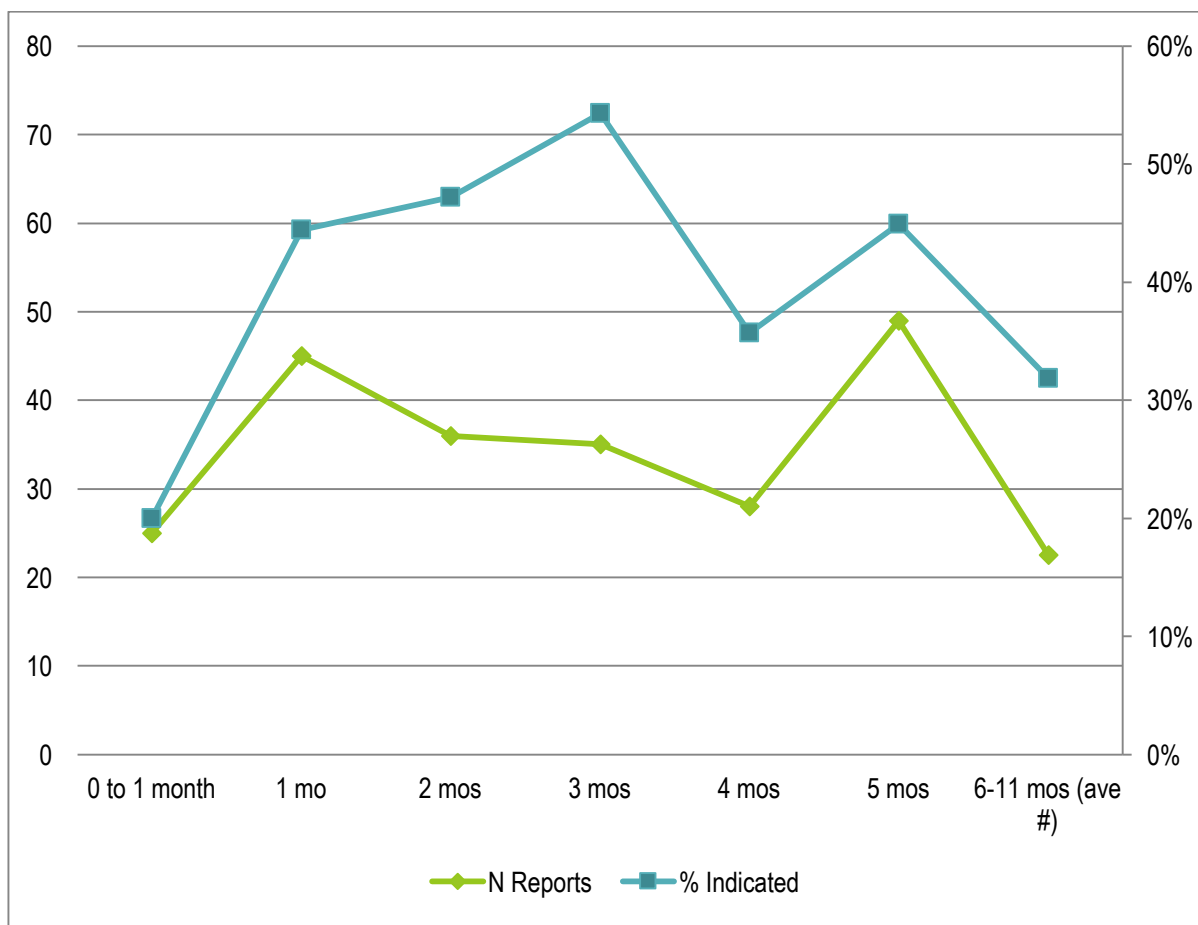


**FIGURE M5: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2) FROM 7/1/2012-4/1/15: PERCENT OF NON-PENDING REPORTS THAT WERE INDICATED, BY CHILD AGE**



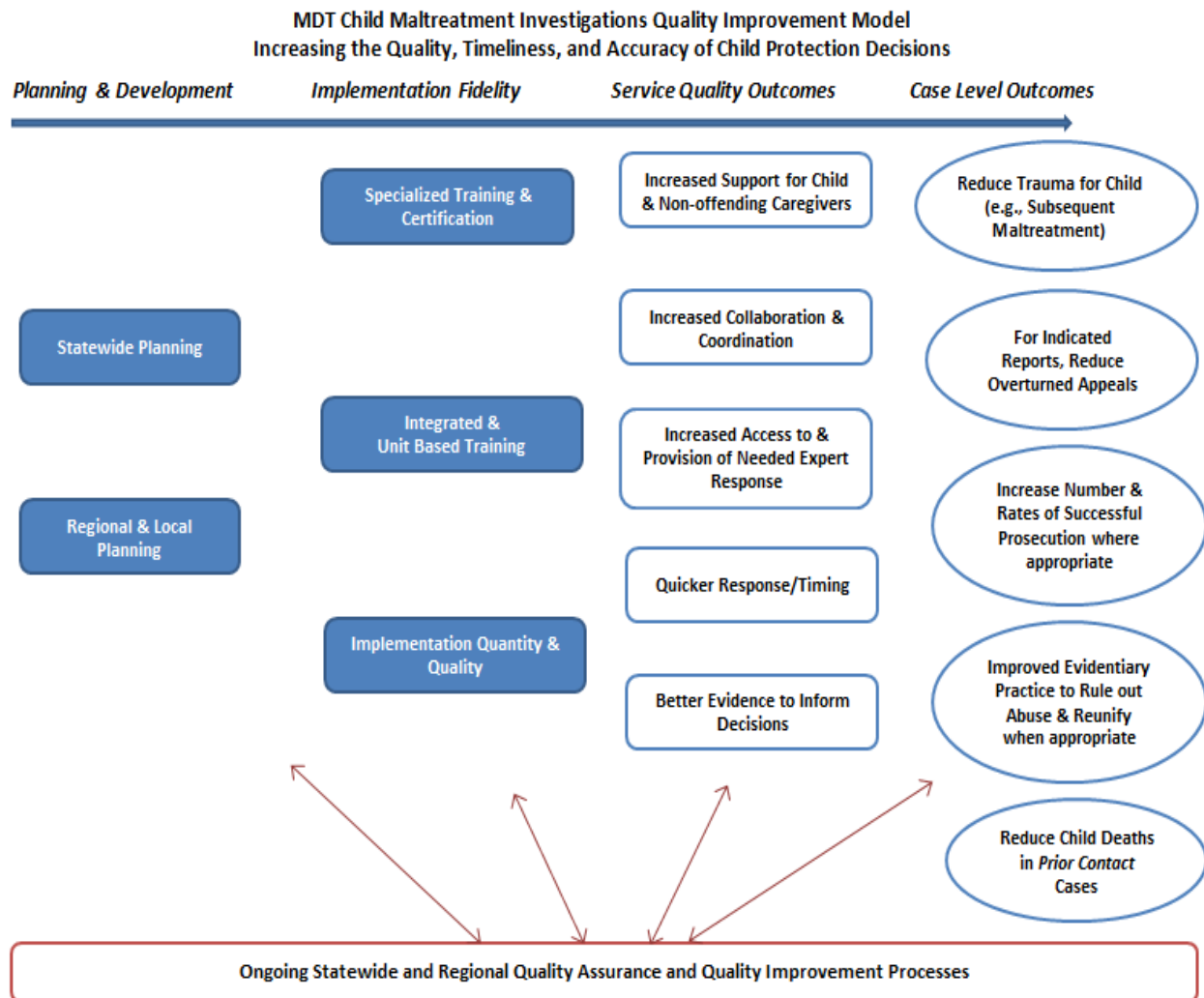
The following analysis in Figure M6 focuses on infants less than 1 year. Newborns less than a month old appear less likely than 2 month olds to be reported for head injuries. This could be due to parents getting more frustrated after a couple of months, especially as infant crying increases a bit over time. It is also possible that reporting is delayed because injuries are uncovered later. There is also an increase in reports for 5 month olds, perhaps as babies become more active. Rates of indication are also lower for babies less than a month old (20%), and they are roughly double for children between 1 and 5 months old. One possible explanation is that medical conditions causing head injuries that are unrelated to maltreatment are more likely to be present at birth—resulting in lower rates of indication when the alternate causes are properly diagnosed.

**FIGURE M6: ABUSIVE HEAD TRAUMA (ABUSE ALLEGATION #2): NUMBER OF REPORTS AND INDICATION RATES BY AGE OF INFANT LESS THAN 1 YEAR**



## APPENDIX N: CQI FLOW CHART

The following figure is the Continuous Quality Improvement (CQI) model for the unit-based MDT recommendations.





## APPENDIX O: THE NEED TO LINK DATABASES ACROSS ORGANIZATIONS

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Unit-based multidisciplinary teams attempt to break down bureaucratic barriers within and across organizations that can inhibit effective coordination, communication, and accurate decision making. One of the many problems with service silos is that important information gathered through one service cannot be connected to information on the same child or family existing in other service's database. Although it is essential to respect privacy considerations, linking information from different data sources related to child abuse is necessary for informing continuous quality improvement in unit-based MDTs. At the ChicagoCAC, for example, lack of regular access and linkage to DCFS data has severely limited the ability of ChicagoCAC to know the results of investigations and evaluate short and long term outcomes for both child sexual abuse cases and physical abuse cases of children under 3 that received medical evaluations by expert child abuse pediatricians through the MPEEC program.

To illustrate, efforts have been made for over ten years to link information gathered by MPEEC as part of DCFS investigations to DCFS databases for over 10 years. Access to certain data elements in DCFS databases can potentially help the ChicagoCAC and MPEEC to understand more about the timing of MPEEC's involvement once a case is referred in the DCFS investigative process, the location and source of MPEEC referrals, and, perhaps most importantly, what happens to children (i.e., their maltreatment and placement outcomes) after MPEEC makes recommendations to DCFS investigators.

Evaluation questions that could be addressed **for children served through MPEEC** include:

- To what extent are allegations of physical abuse actually substantiated (i.e., indicated) in these cases?
- What is the relationship between the MPEEC recommendation and the results of the investigations?
- Does the relationship between MPEEC recommendations/conclusions and DCFS investigative findings vary by the type or severity of the maltreatment allegation?
- To what extent were children involved in subsequent (i.e., post-MPEEC) reports over a certain period of time?
- How many children were placed in foster care at the start of or later in the investigation?
- How do rates of subsequent maltreatment and foster care placement for children served through MPEEC compare to similar cases not served through MPEEC?

Through a request to DCFS to provide data on child abuse and neglect allegations and findings, the Task Force was able to acquire a dataset that was analyzed by the MDT Project Manager, Dr. Budde, to inform Task Force deliberations. As part of this work, he successfully linked the DCFS investigations data to an MPEEC dataset on findings and recommendations in 533 (95%) of 563 MPEEC cases for investigations occurring during the time frame covered by the DCFS dataset (7/1/2012 thru 4/1/2015). This was done relatively easily and illustrates the viability of linking MPEEC and DCFS datasets. The combined/linked MPEEC/DCFS dataset provides for unit-based MDTs and the Task Force a rich array of possibilities for analysis and using data for planning and quality improvement purposes. This has been known for years, but has never before been made available.

For the purposes of illustrating the potential utility for unit-based MDTs of using linked datasets, Dr. Budde examined the relationship between the MPEEC recommendations (whether abuse occurred) and the results of the investigations (whether abuse allegations were indicated) in cases involving allegations of abusive head trauma. From just this one simple analysis (see table below), there were two important

findings. First, in 23 cases in which MPEEC identified head trauma injuries and determined that abuse did **not** occur, 22 (96%) of 23 head trauma allegations were ultimately not indicated by DCFS. This suggests that MPEEC recommendations that abuse did not occur were almost always consistent with DCFS decisions. However, we also found that in 23 cases when MPEEC determined that physical abuse had occurred, DCFS indicated the head trauma allegation in only 16 (70%) of 23 cases. Thus, in thirty percent of cases in which MPEEC determined that abusive head trauma occurred, DCFS made decisions (not to indicate allegations) that appear inconsistent with those of medical experts. At a minimum, this inconsistency related to a very severe injury to the child warrants further inquiry about the indicate decisions in these cases. From a unit-based MDT perspective, this kind of information has never been available to MPEEC and the ChicagoCAC. These simple and concerning findings illustrate the need for CQI and evaluation experts to be able to examine data across partner organizations so that they can promote accurate and consistent decisions.

**FIGURE O: MPEEC DETERMINATIONS AND DCFS INDICATE DECISIONS IN CASES WITH ABUSIVE HEAD TRAUMA ALLEGATIONS**

MPEEC Case Closing Reason/Determination	Indicated by DCFS?			% Indicated
	No	Yes	Total	
Abuse	7	16	23	70%
Not Abuse	22	1	23	4%
Indeterminate	12	3	15	20%
Indeterminate-Risk Factors Identified	4	4	8	50%
Negligent	3	1	4	25%
Death of a Child	3	1	4	25%
2nd Opinion Not Accepted	1		1	0%
2nd Opinion Withdrawal of DCFS Request		1	1	100%
<b>Total</b>	<b>52</b>	<b>27</b>	<b>79</b>	<b>34%</b>

*Notes for table:* a) these cases were coded by MPEEC as “Head Trauma” injuries; b) pending DCFS investigations excluded

## APPENDIX P: CHILDREN’S HOSPITAL ASSOCIATION STANDARDS OF CARE

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The Children’s Hospital Association (CHA), formerly the National Association of Children’s Hospitals and Related Information, is a national membership of children’s hospitals which develops national benchmarks and standards of care for the hospital response to child maltreatment. CHA (2011), in efforts to provide optimal care of children with suspected maltreatment and benchmarks of service, developed three tiers of care to be followed by children’s hospitals:

- *Basic level:* In order to achieve this level, which is the level all acute care children’s hospitals should meet, there are three necessary functions to perform: medical leadership, administrative coordination, and social work services. Staffing should include, at the minimum, a physician who provides these functions.
- *Advanced level:* An acute care children’s hospital has achieved an advanced level if they have one or more of the following: designation level 1 or 2 adult or pediatric trauma center; intensive care unit; residency; or burn unit. The full-time medical director must be boarded in child abuse pediatrics. The administrative unit in the hospital coordinates with community agencies in child protection and maintains a larger catchment area than the basic level.
- *Centers of excellence:* This level is distinguished from the advanced level by additional education and research capabilities. Larger interdisciplinary teams offer diagnostic and treatment services that require consultation with subspecialists. They may sponsor multidisciplinary trials. They provide regional and national leadership in child maltreatment and advocate for prevention services.

## APPENDIX Q: MAPS

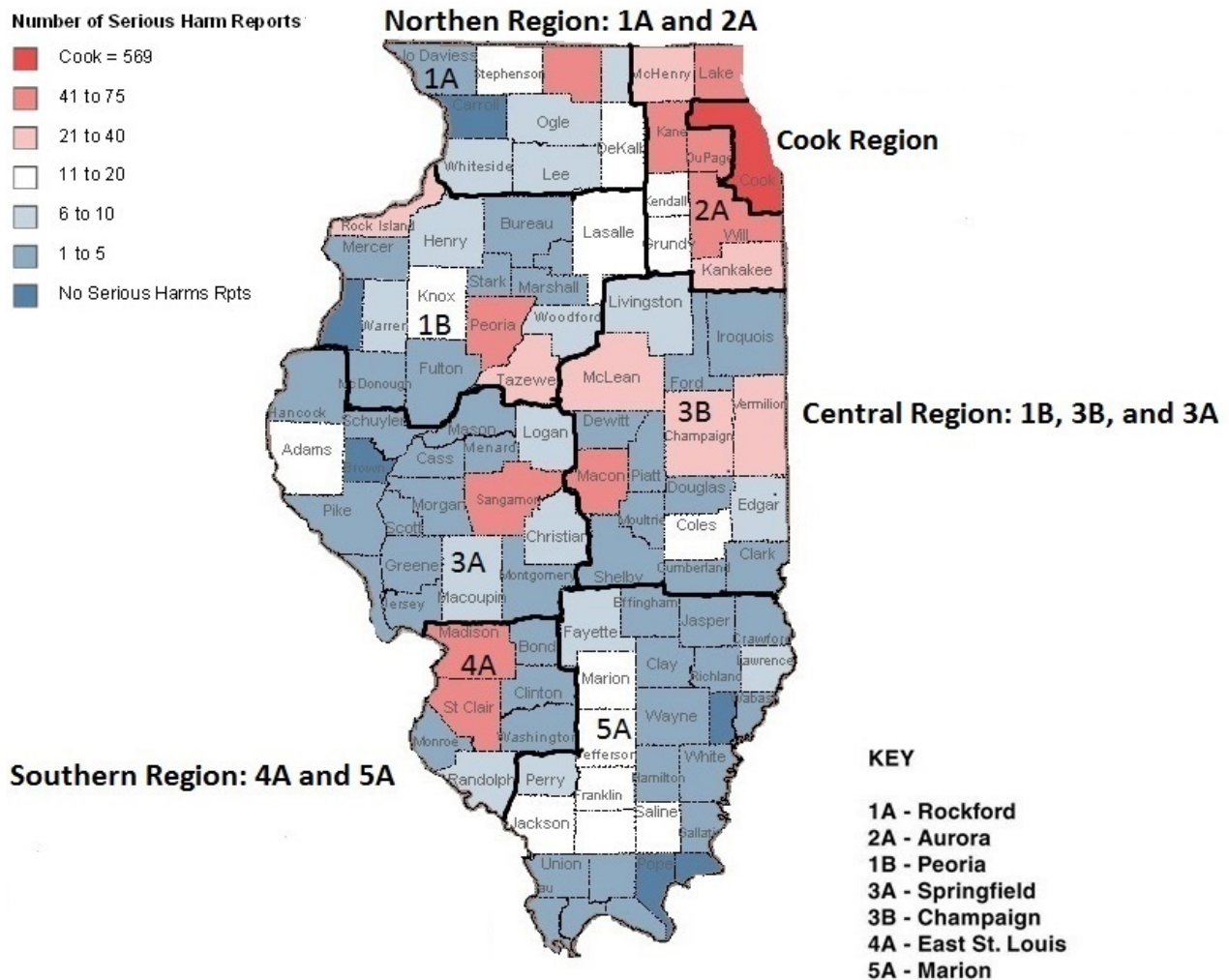
FIGURE Q1: DCFS REGION AND SUBREGION MAP

This map shows the counties included in the regions and subregions served by DCFS, along with the locations of DCFS offices and headquarters. The DCFS regions are labeled directly on the map and the key lists the subregions. The Northern Region consists of subregions 1A and 2A; the Central Region consists of subregions 1B, 3A, and 3B; and the Southern Region consists of subregions 4A and 5A.



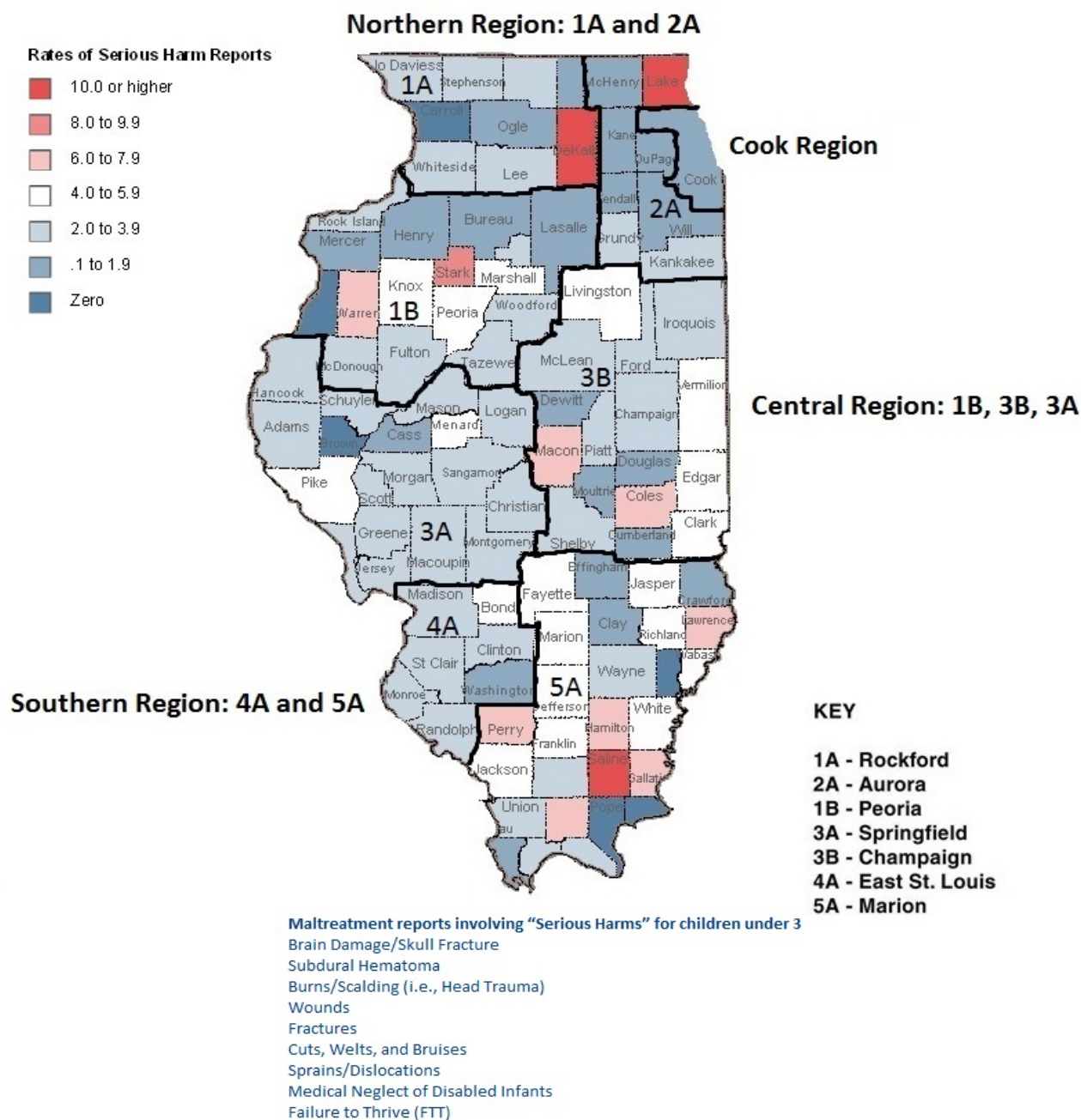
**FIGURE Q2: NUMBER OF SERIOUS HARM REPORTS TO ILLINOIS DCFS FOR CHILDREN UNDER 3**

The following map shows all of the counties in the state, color coded by the number of serious harm reports (see key for list) made to DCFS for children under 3 years old. Labels for DCFS regions and a key for DCFS subregions are also included.



**FIGURE Q3: RATE OF SERIOUS HARM REPORTS TO DCFS FOR CHILDREN UNDER 3 PER 1000 CHILDREN UNDER 5**

The following map shows all of the counties in the state, color coded by the rate of serious harm reports (see key for list) made to DCFS for children under 3 years old per 1000 children under 5 years old. Labels for DCFS regions and a key for DCFS subregions are also included.





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FIGURE Q5: ILLINOIS CACS AND COUNTY COVERAGE

The following map shows the locations of Children's Advocacy Centers (CACs) in Illinois. A cluster of adjacent counties with the same color indicates the range of coverage for the CAC within that cluster. There are 92 counties receiving formal coverage from a CAC; 3 counties (Kendall, Grundy, and Fulton) receive some CAC-related services; and 7 counties (Montgomery, Fayette, Effingham, Jasper, Iroquois, Ford, and Vermilion) are not currently served by a CAC.

**Name and city location of Illinois CACs**

1. Tyler's Justice CAC, Stockton
2. Carrie Lynn's Children Center, Rockford
3. CAC of McHenry County, Inc., Woodstock
4. Lake County CAC, Gurnee
5. April House, Morrison
6. Shining Star Children's Center, Dixon
7. Family Service Agency's CAC of DeKalb County, DeKalb
8. Kane County CAC, Geneva
9. DuPage County CAC, Wheaton
10. CAC of North & Northwest Cook County, Hoffman Estates
11. Proviso CAC, Broadview
12. ChicagoCAC, Chicago
13. CAC of Southwest Cook County, Justice
14. LaRabida Joli Burrell CAC, Park Forest
15. Rock Island County CAC, Rock Island
16. Braveheart CAC, Cambridge
17. The Dani-Brandon CAC, Ottawa
18. Will County CAC, Joliet
19. Mercer County CAC, Aledo
20. Child Network, Bradley
21. Knox County CAC, Galesburg
22. Peoria County CAC, Peoria
23. Tazewell County CAC, Pekin
24. CAC of McLean County, Bloomington
25. Advocacy Network for Children, Quincy
26. Champaign County CAC, Champaign
27. Sangamon County CAC, Springfield
28. Macon County CAC, Decatur
29. CAC of East Central Illinois, Charleston
30. New Beginnings CAC, Carlinville
31. Madison County CAC, Wood River
32. St. Clair County CAC, Belleville
33. Amy Schulz CAC, Mt. Vernon
34. Perry-Jackson CAC, Pinckneyville
35. The Guardian Center, Carmi & Healing Harbor, Robinson
36. Williamson County CAC, Herrin
37. Two Rivers CAC, Anna

