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APSAC Practice Guidelines

Guidance for Supervised Visits in Suspected or Substantiated Munchausen by Proxy (MBP)

When ordered as part of the case plan, supervised visitation in suspected or substantiated cases of Munchausen by proxy (i.e., Medical Child Abuse due to Factitious Disorder Imposed on Another) requires heightened vigilance, structure, and meticulous documentation. These cases present an ongoing risk during any caregiver–child contact. The primary responsibility of the visit supervisor is child safety. Supervised visits are not a therapeutic service unless explicitly designated as *Therapeutic Supervised Visitation* and delivered by appropriately qualified clinicians.

All involved professionals and nonprofessionals are vulnerable to being successfully misled by the abuser, underscoring the importance of team-based management. In addition to posing a safety risk, the abuser may engage in manipulative behaviors with the visitation monitor such as falsifying information about the victim's health, behavior, social history, or case-related matters to serve their own interests or provoke desired reactions. They may push boundaries by claiming to misunderstand court orders, requesting exceptions or changes to the case plan, violating visitation guidelines, or demanding urgent responses. They may attempt to create chaos and division by aligning with professionals to advocate on their behalf, promoting false narratives through media or social media to gain public support, or filing legal actions or unsubstantiated complaints against professionals involved in the case.

Staffing and Level of Supervision

- Avoid using foster parents, relatives, or other nonprofessionals as visitation monitors; these cases require clinically informed supervision.
- Visitation is ideally overseen by staff with master's-level training in child development, trauma, and MBP. • Supervisors should be part of the multidisciplinary treatment team and familiar with the child's history, safety concerns, and court orders.
- Supervision must be active, continuous, and structured; passive or observational monitoring is insufficient.

Assumption of Risk and Structure

- Assume risk of harm is present during all contact. Abuse often occurs *in the presence of professionals*. Supervision must be continuous, with no unsupervised interaction.
- Maintain continuous visual and auditory supervision at all times. The caregiver must never be alone with the child, including during toileting, feeding, comforting, or personal care.
- Visits should occur in a neutral, controlled setting approved by the court or supervising agency. • Contact should be limited to supervised visits only, with no outside communication unless explicitly authorized.

Environmental Controls

- Supervisors must prohibit caregiver access to:
    - Medications, medical equipment, topical or aerosol products, supplements, or remedies

    - Food, drinks, candy, gum, or other consumables
    - Phones or private communication
    - Unapproved medical or health-related discussions, including diet
- The alleged abuser (or their close contacts, such as their spouse) must never give the child anything to ingest or apply to their body due to risk of illness induction.

Behavioral Monitoring

Supervisors should monitor for subtle verbal, nonverbal, or written behaviors, including:

- Symptom coaching, exaggeration, or prompting illness reports
- Encouraging physical complaints to obtain attention or care
- Interfering with eating, breathing, comfort, or emotional regulation
- Seeking staff validation or attempting to influence care decisions
- Undermining supervision rules or discrediting child welfare, foster caregivers, or the treatment team

Child Considerations

- Many children desire contact with the suspected abuser. Visitation may be appropriate if not retraumatizing and only when supervision is sufficiently intensive and safety controls are enforced.
- Visitation should not be forced on youth who wish to avoid them or who are clearly triggered by the contact.
- Supervisors should remain mindful of the developmental and psychological effects of prior abuse and neglect on the child's behavior during visits.
- Supervisors should monitor for the child's use of physical complaints or distress to regain caregiver attention, recognizing this as a learned survival behavior.

Communication Boundaries

- Caregivers must not discuss health-related issues, symptoms, diagnoses, or diet with the child.
- Caregivers must not attempt to influence the child to distrust child welfare staff, foster caregivers, medical providers, or the treatment team.
- Supervisors must not provide reassurance, medical opinions, or feedback regarding the child's health or progress; neutral redirection is required.

Physical Contact and Gifts

- Physical contact must be developmentally appropriate. It may be restricted based on case-specific risks.
- If allowed at all, gifts and cards must be developmentally appropriate, limited to one per visit, and carefully searched by staff prior to delivery.

Documentation and Coordination

- Visitation plans and structure must be developed and coordinated with medical, mental health, and child welfare professionals.
- Supervisors should document visits objectively and in detail, including:
    - Exact statements (quoted) and observable behaviors
    - Timing, frequency, and patterns across visits
    - The child's behavior and symptoms before, during, and after contact
- Documentation informs ongoing assessment of caregiver behavior, family dynamics, and treatment response.

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Authority to Intervene

• Case-specific visitation conditions based on caregiver behavior should be established in advance. • Supervisors must have clear authority to pause or terminate visits immediately if safety concerns arise. • If the child experiences a trauma reaction or medical event during or shortly after a visit, visits should be suspended while the situation is evaluated to determine what changes in the plan are indicated. • Ongoing assessments and adjustments, which might require court orders, might be needed to address specific threats (e.g., the use of a fragrance that triggers an allergic reaction, subversive messages found in pens or embedded in prayers, or other attempts to harm or control the child.)

References

American Professional Society on the Abuse of Children Taskforce (APSAC, 2018). APSAC Practice Guidelines: Munchausen by proxy: Clinical and Case Management Guidance. The APSAC Advisor. March; 30(1): 8-31.

Bursch, B**.** (2018). Child Protective Services Management of Cases of Suspected Child Abuse and Neglect due to Factitious Disorder Imposed on Another. The APSAC Advisor. March; 30(1): 76-82.

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