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COMMITTEE CHARGE
The CPAC Child Abuse Medical Response Committee shall, no later than January 1, 2016 issue a report to the Child Protection Accountability Commission which sets forth recommendations for statewide protocols and policies pertaining to the medical response to suspected victims of sexual and physical child abuse.

At a minimum the recommendations shall include:

1.) A methodology for identifying, training, supporting and sustaining a statewide network of medical professionals who have received specialized training in the evaluation and treatment of child abuse, who meet national standards and who are engaged in on-going quality improvement activities to remain current in the field.

2.) Statewide, cross-discipline, child abuse medical evaluation screening and referral protocols and policies which:

   a.) provide for the timely assessment of all suspected child abuse victims to determine the need for a medical evaluation,

   b.) provide education, tools and guidelines to help multi-disciplinary team members understand why, where and how to refer children and their caregivers to specially trained medical professionals for timely and appropriate medical care.

Committee membership shall be representative of all MDT disciplines.
COMMITTEE MEMBERSHIP
## Child Protection Accountability Commission
### Child Abuse Medical Response Committee

### Members

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<td>A.I.duPont Hospital for Children</td>
<td>Dr. Allan DeJong (Co-Chair)</td>
</tr>
<tr>
<td>Children’s Advocacy Center</td>
<td>Randy Williams (Co-Chair)</td>
</tr>
<tr>
<td>Department of Justice</td>
<td>Deputy Attorney General Josette Manning</td>
</tr>
<tr>
<td>Department of Services For Children Youth And Their Families</td>
<td>Jennifer Donahue</td>
</tr>
<tr>
<td>Family Court</td>
<td>Judge Joelle Hitch</td>
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<td>Law Enforcement</td>
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<tr>
<td>• State Police</td>
<td>Colonel Nathaniel McQueen</td>
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<tr>
<td>• New Castle County Police</td>
<td>TBD</td>
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<tr>
<td>• Chiefs of Police Appointee</td>
<td>Chief Laura Giles</td>
</tr>
<tr>
<td>Child Protection Accountability Commission</td>
<td>Mike Cochran</td>
</tr>
<tr>
<td>Office of The Child Advocate</td>
<td>Tania Culley</td>
</tr>
<tr>
<td>Nemours Health and Prevention Services</td>
<td>Erin Carroll</td>
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<td>10am-12pm</td>
<td>A.I. duPont Hospital for Children Room 2C, 55/56 (2nd Floor) 1600 Rockland Road Wilmington, DE</td>
</tr>
<tr>
<td>Friday, October 16, 2015</td>
<td>10am-12pm</td>
<td>Dept. of Services for Children Youth And Their Families Administration Building #2 Room 198 1825 Faulkland Road Wilmington, DE</td>
</tr>
<tr>
<td>Friday, November 20, 2015</td>
<td>10am-12pm</td>
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<tr>
<td>Friday, December 18, 2015</td>
<td>10am-12pm</td>
<td>Dept. of Services for Children Youth And Their Families Administration Building #2 Room 201 1825 Faulkland Road Wilmington, DE</td>
</tr>
<tr>
<td>Friday, January 22, 2016</td>
<td>10am-12pm</td>
<td>Dept. of Services for Children Youth And Their Families Administration Building #2 Room 198 1825 Faulkland Road Wilmington, DE</td>
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MEETING AGENDAS
Child Protection Accountability Commission
Child Abuse Medical Response Committee Meeting

Friday, October 16, 2015
10:00am – 12:00pm
Dept. of Services for Children
Youth And Their Families
Administration Building #2
Room 198
1825 Faulkland Road
Wilmington, Delaware

Agenda

Welcome Dr. DeJong
Randy Williams

Report on Status of Additional Medical Resources Dr. DeJong
at A. I. Hospital

Report on Possible VOCA Funding for Medical Resources Randy Williams

Existing Delaware Medical Response Protocols Randy Williams

Model Medical Response Protocols Randy Williams

Next Steps Dr. DeJong
Randy Williams

Future Meeting Schedule

- Friday, November 20, 2015 10am-12pm
- Friday, December 18, 2015 10am-12pm
- Friday, January 22, 2016 10am-12pm
Child Protection Accountability Commission
Child Abuse Medical Response Committee Meeting

Friday, September 18, 2015
10:00am – 12:00pm
Room 2C, 55/56 (2nd Floor)
A.I. DuPont Hospital for Children
1600 Rockland Road
Wilmington, Delaware

Agenda

Welcome and Introductions       Dr. Allan DeJong
                                      Randy Williams

The Importance of the Medical Response Component in Cases of Child Abuse
                                      Dr. Karen Farst

The Committee’s Charge       Dr. Allan DeJong
                                      Randy Williams

Next Steps       Dr. Allan DeJong
                                      Randy Williams

Future Meeting Schedule

- Friday, October 16, 2015       10am-12pm
- Friday, November 20, 2015      10am-12pm
- Friday, December 18, 2015      10am-12pm
- Friday, January 22, 2016       10am-12pm
COMMITTEE RECOMMENDATIONS
EXISTING DELAWARE PROTOCOLS
Medical Protocol for Acute Child Physical Abuse and Sexual Abuse Cases

I. PURPOSE

The purpose of this protocol is to improve the efficiency and effectiveness of medical intervention into child abuse cases, to minimize the stress created for the child during an examination and investigation, and ultimately improve outcomes for children. It is recognized that in more than 90% of child sexual abuse cases, no specific medical findings will exist. This is in contrast to physical abuse cases where a physical injury will always be present. However, the examination may provide reassurance to the victim and the family regarding the child's well-being.

Information leading to a reasonable suspicion of acute physical abuse or sexual abuse may be provided by the child, their parent, or a third party. An acute medical examination is warranted for a child that is thought to be a victim of child abuse and has any of the following:

- History of genital or rectal bleeding, pain or discharge in the setting of possible sexual abuse.
- Child sexual abuse is suspected and the abuse occurred within the previous 72 hours.
- Active bleeding; deformity; moderate or severe pain; altered mental status; difficulty breathing in the setting of possible acute physical abuse.
- Any time a DFS worker, police officer, or other provider is concerned for the acute, physical well-being of the child and feels that any delay in medical treatment would put the child at risk in any way.

II. ROLE AND RESPONSIBILITIES

A. The role of the Attending Emergency Department physician or Forensic Nurse Examiner (FNE) is to provide a comprehensive medical evaluation which, when appropriate, includes an in-depth medical examination of the child, in which the examiner has experience and training in child sexual assault, physical abuse and neglect.

B. The role of a physician, such as Emergency, Family practice or Pediatrician, is to provide a screening evaluation for abuse, knowing that comprehensive medical care is available. Comprehensive medical care is available at Emergency Departments with forensic nurse programs as well as the Child Advocacy Center (CAC).

It is the responsibility of each Emergency Department conducting such exams to have personnel that are properly trained in pediatric forensics and evidence collection and have experience with child sexual and physical abuse examinations. It is also the responsibility of each Emergency Department to acknowledge that comprehensive medical care is available for victims of sexual assault. If experienced staff is not available at a facility the
child may need to be sent to another facility to have a comprehensive medical exam.

C. A physician may take a child that is suspected of being in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect into temporary emergency protective custody for up to 4 hours and shall immediately notify the child’s custodian and DFS (16 Del. C. §907)

III. REPORTING ALLEGATIONS OF ABUSE

A. The term child abuse and neglect includes the physical injury by other than accidental means, negligent treatment, sexual abuse, maltreatment, mistreatment, torture, emotional abuse, exploitation, or abandonment of a child under the age of 18. (This does not include infants left under the Safe Arms for Babies statute.16 Del. C. §907 A.)

B. All reports of suspected child abuse or neglect must be made to the Delaware Division of Family Services Report line (800-292-9582).

C. Complete Mandated Report Form. (See attached)

IV. PROCEDURAL GUIDELINES FOR MEDICAL EVALUATIONS

A. A comprehensive medical evaluation should be performed if there is a physical injury or one is suspected.

If child sexual abuse is suspected and the abuse occurred within the previous 72 hours, an examination should be done immediately. If beyond the 72 hours, consideration should be given to scheduling a medical evaluation at the CAC.

B. Participating hospitals will provide priority treatment to sexual abuse or serious physical abuse victims in the Emergency Department and privacy will be established for the victim as quickly as possible.

C. The medical examination should be performed by a specially trained and experienced examiner. Hospitals should develop guidelines how to access these individuals in the event they are not on duty.

D. Hospitals will notify the Division of Family Services of possible sexual abuse or physical abuse when medical personnel have reason to suspect or identify abuse.

E. Prior to the medical evaluation of the child, the examiner should gather history from the caretaker, the DFS Caseworker, and or the Investigating Officer. Minimal questioning should occur with the child under 12 and should be limited to that which is needed to care for the patient. Specific questions regarding abuse and whether or not contact occurred should not be asked at this point. Spontaneous statements made by the patient should be recorded in direct quotes. Those present during the evaluation should also be
noted in the medical record.

F. The examination should follow guidelines established by the American Academy of Pediatrics, the American College of Emergency Physicians and the International Association of Forensic Nurses. Examinations should be properly documented to include descriptions and photographs of injuries when possible.

G. Hospitals will provide a copy of the Emergency Department record in sexual abuse cases and physical abuse cases upon written request from one of the participating agencies, if the appropriate release information has been provided.
Investigation Protocol

1. The Division conducts civil investigations in which the standard of proof is a preponderance of the evidence.

2. Reports assigned a Priority 1 response will have an investigation initiated within 24 hours.

3. Reports assigned a Priority 2 response will have an investigation initiated within 72 hours.

4. Reports assigned a Priority 3 response will have an investigation initiated within 10 calendar days.

5. A DELJIS search must be conducted before the caseworker responds to assess whether there are potential safety issues for the caseworker who will contact the family and to identify potential risk to the child.

6. Federal law (CAPTA) requires that the Division notify every individual who is the subject of a child abuse and neglect investigation (the alleged perpetrator) of the allegations against him or her. In addition, the individual who is the subject of an investigation shall be given a copy of the Parent Handbook.

7. All children in the home who are verbal are to be interviewed or observed if they are non-verbal to evaluate their condition.

8. All adults residing in the household with caretaking responsibilities for the children must be interviewed and individuality assessed for risk to the child(ren).

9. A parent not residing in the household who has routine contact with the alleged victimized child(ren) must also be interviewed.

10. An adult caretaker (e.g., paramour, relative) not residing in the household who is alleged as a perpetrator in a report under investigation must be interviewed.

11. A Safety Assessment will be conducted for each new report accepted for investigation.

12. The investigation shall include a review of available historical information on FACTS, CYCIS, and DELJIS.
13. All reports assigned for investigation must include a minimum of two collateral contacts. It is
the responsibility of the caseworker to determine and select the appropriate collateral contacts,
alone or in consultation with the supervisor, based on the allegations in the report and other
factors learned about the family during the investigation. Collateral contacts are to be made
during the course of an investigation (not at the conclusion of the investigation) to verify
information obtained from the family and to obtain additional information to assist the
caseworker in the decision-making process.

When the investigation involves a case active in Treatment, the investigating caseworker will
focus on collateral contacts relevant only to the child victim(s), unless it becomes necessary to
interview collaterals relevant to all of the children. Also, the Treatment caseworker may be
viewed as a collateral provided the caseworker has had routine contact with the child victim(s)
and family.

14. The Division of Family Services will request that appropriate consent forms be signed by the
parent, custodian, guardian, or by the child over age 12 years for every case. These include
the Consent to Obtain/Release Information Form, the Interagency Consent for Release of
Information Form (for all children removed from the home).

15. A-14. The three primary reasons for obtaining a medical examination/screening are to:

   a. Determine the child's immediate medical needs.
   b. Determine if there are any previous injuries consistent with physical abuse.
   c. Determine and document current injuries.

   d. Division staff shall obtain a medical examination or medical screening of a child based
      on the Medical Examination Protocol in the Investigation User Manual. Medical
      examinations shall be conducted by qualified medical staff (e.g., doctor). The protocol
      does not preclude Division staff from obtaining a medical examination for children over
      8 if warranted. In addition, a supervisor has the option at any time to require that a
      child, regardless of the source or content of the report, be examined prior to the
      completion of an investigation.

   e. Per 16 Del.C. § 906(b)(5), parental consent is not required provided the case is
      classified as an investigation and the Division Director or designee gives prior
      authorization for such examination to protect the health and safety of the child. In
      addition, consideration should be given to a dental examination for injuries involving the
      mouth or teeth.

16. Regardless of whether or not substance abuse or domestic violence is mentioned in the
Hotline report, the investigation caseworker will assess the use of substances and the
existence of domestic violence during their interviews and in completing the investigation
safety and risk assessments.

17. The Division shall contact the appropriate law enforcement agency and the Department of
Justice for all reports, which if true, would constitute a criminal violation against a child by a
person responsible for their care, custody, and control. Care, custody, and control are not
required for alleged sexual abuse violations.
### Medical Examination Protocol

<table>
<thead>
<tr>
<th>AGE OF CHILD</th>
<th>PHYSICAL</th>
<th>ABUSE</th>
<th>PHYSICAL</th>
<th>NEGLECT</th>
<th>MEDICAL</th>
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<tr>
<td><strong>BIRTH TO 8 YEARS</strong></td>
<td>Any infant or child who is the alleged victim of a physical abuse report must receive a medical examination by a pediatrician or family practitioner as soon as possible. A Supervisor may waive the examination when there are no visible injuries, significant bruises, and the infant or child does not appear to be in physical pain. In New Castle County, all children will be examined at the A.I. duPont Hospital for Children unless otherwise directed by law enforcement. If necessary, the appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding.</td>
<td>Any infant or child who is the alleged victim of sexual abuse which involves external contact, fondling, penetration, intercourse, or when injury is alleged or suspected must receive a medical examination by a trained pediatrician or physician as soon as possible. All children statewide will be interviewed at one of the Children's Advocacy Centers of Delaware and, in New Castle County, all children will be examined at the Children's Advocacy Center unless otherwise directed by law enforcement. The appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding.</td>
<td>Any infant or child who is the alleged victim of neglect that may be life threatening (e.g., Non-organic Failure to Thrive, malnutrition) must be examined by a pediatrician or family practitioner as soon as possible. In New Castle County, all children will be examined at the A.I. duPont Hospital for Children unless otherwise directed by law enforcement. If necessary, the appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding. Also, a referral must be made to Part C (birth to age 3).</td>
<td><strong>Any infant or child who is the alleged victim of a medical neglect report that may be life threatening (e.g., failure to administer prescribed medication, failure to use an apnea monitor, untreated asthma) must receive a medical examination by a pediatrician or family practitioner as soon as possible. In New Castle County, all children will be examined at the A.I. duPont Hospital for Children unless otherwise directed by law enforcement. A referral should also be made to the Division of Public Health. If necessary, the appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>9 to 18 YEARS</strong></td>
<td>A child who is the alleged victim of a physical abuse report with observable injuries must be screened, at minimum, by a registered nurse or a physician's assistant to determine if more in-depth medical care is needed. A Supervisor may waive the screening if there is minor bruising and the child does not indicate they are in physical pain. The child may be screened by a school nurse, a school-based well-child clinic, a state service center clinic, or Managed Care Organization. This location decision will be made on a case by case basis. If necessary, the appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding.</td>
<td>Any child who is the alleged victim of sexual abuse which involves external contact or fondling and injury is not alleged or suspected, must be screened, at minimum, by a registered nurse or physician's assistant to determine if more in-depth medical care is needed. (Refer to physical abuse for screening locations). A child who is the alleged victim of sexual abuse which involves penetration, intercourse, or where injury is alleged or suspected must be examined by a trained pediatrician or as soon as possible. All children statewide will be interviewed at one of the Children's Advocacy Centers of Delaware and, in New Castle County, children will be examined at the Children's Advocacy Center unless otherwise directed. The appropriate Police Department and the Department of Justice will be contacted per the Memorandum of Understanding.</td>
<td>A child who is the alleged victim of a report of physical neglect that may be life threatening must be examined by a pediatrician or family practitioner as soon as possible. In New Castle County, all children will be examined at the A.I. duPont Hospital for Children. If necessary, parental neglect will be reported to the appropriate Police Department and the Department of Justice per the Memorandum of Understanding.</td>
<td><strong>Refer to Medical Neglect (Birth to 8 years)</strong></td>
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Child Abuse/Death Investigation Checklist

Patrol:

- Observe and preserve scene, take photographs when appropriate
- Note position of child if still on scene. In the majority of death investigations, children will be transported to the hospital
- Note area where child was found, if infant is believed to be deceased, note area where child had been laying, note crib, bed, blankets, stuffed toys etc.
- Obtain basic story from persons at the scene
  - If an injury is present ask about the mechanism
  - Take notes this may be the most accurate account of events and also may help with inconsistencies later provided
  - Make sure notes are detailed in your report.
- Parents don’t ride in ambulance with child
- One officer follows ambulance or rides inside
- If parents/witnesses respond to hospital, officer should stay with them to prevent them from talking about specifics
- Do not allow parents to hold a deceased child (hospital will agree to this at police request)
- Neighborhood canvass
- Submit a copy of notes to CIO in detectives, originals should be filed in records or logged into evidence per departmental policy

Supervisor:

- Send evidence detective and one regular detective to scene
- Any other witnesses/kids?
- Send family services detective to hospital
- Respond to hospital, then scene

Detective:

- Obtain information received from patrol officers
- Complete data runs
- Contact DFS, report incident and check for history
- Contact AG’s office
- Speak with EMS, Medics and attending physician
- Consult with Dr DeJong when appropriate
- Cursory check of child, mandatory in death investigations (before interview with parents)
  - Special attention to the eyes, area behind the ears, and frenulums
  - Note any fingertip size bruising or other evidence of grabbing which are indicative of shaken baby
- Consent? (both parents or caregiver)
  - Reminder in death investigations if a crime has not been identified consent is appropriate, must be consent from all parties involved and an officers must be present with them so they can withdraw their consent if desired
- Speak to parents separately (SUIDI checklist)
- Respond to scene (can be done first if possible)
- Blood for drugs/alcohol?
- Scene re-enactment with doll
- Get CAD print out and 911 call
- Autopsy

**Specific Case Related Information:**

- **Physical abuse**
  - Use of CAC
  - If a minor case where patrol will keep and no CAC is conducted, remember to ask child
    - Why did the injury happen
    - If instrument use, how was it held
    - How many times were they struck
    - Where on the body were they struck
    - What made perpetrator stop
    - Has this happened before
    - Other siblings/ anyone else injured
  - Photographs with scale (especially important with bite and pattern marks)
  - Search warrant versus consent for belt or instrument
    - Consent must be voluntary with perpetrator present to end search if they so desire

- **Burns**
  - Mechanism information is most important
  - Reenactment with doll
  - Time/length of exposure
  - Temperature of water
  - Photographs of scene
  - Important to photograph measurements of child's reach and height of table, stove etc. in cases where it is alleged that the child grabbed hot materials off of same
- Fractures
  - Reenactments
  - If alleged to have occurred from a fall, height of area from which child fell
  - Note type of flooring child fell onto
  - Photographs
  - Be very suspicious of spiral fractures which are indicative of a twisting motion

A call must be made to the AG's office in all major cases. Intakes for all child abuse arrests are mandatory.
RECOGNIZING WHEN A CHILD’S INJURY OR ILLNESS IS CAUSED BY ABUSE
Recognizing When a Child’s Injury or Illness Is Caused by Abuse
The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance; the Bureau of Justice Statistics; the National Institute of Justice; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking.
Recognizing When a Child’s Injury or Illness Is Caused by Abuse
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Recognizing When a Child’s Injury or Illness Is Caused by Abuse

The investigation of child abuse is a critical and sensitive issue that affects the safety and well-being of children nationwide. It is estimated that law enforcement agencies in the United States investigate more than 3.3 million cases of child maltreatment each year and that as many as 2,000 children die as a result of this maltreatment. Law enforcement personnel are responsible for protecting children and often have the difficult task of determining if a child’s injury is accidental or deliberately inflicted.

Careful investigation is required to determine whether a child’s injuries are accidental or intentional. This guide, first developed in 1996, provides information about the many indicators of child maltreatment and abuse to help first responders and investigators differentiate between physical abuse and accidental injury. Over the years, advancements in medicine have helped further distinguish between accidental and abusive injuries. This fourth edition of the guide reflects the most current literature on how to distinguish between types of injuries and includes the questions that investigating officers must ask.

Could This Be Child Abuse?

Child physical abuse is not a constant or daily occurrence; instead, it is a pattern of violent behavior that is usually concealed along with its resulting injuries. When responding to reports of abuse, law enforcement should be aware of the risk factors for abuse, the most common injuries or “red flags” in abusive situations, and the ways in which caretakers may conceal an abusive injury.

Although physical abuse and neglect occur in all kinds of families, an increased risk of abuse is often associated with the following:

- Intimate partner violence, criminal activity, mental illness, substance abuse, inappropriate expectations of children, and punitive childrearing habits.
- Premature babies and children with physical, developmental, or behavioral difficulties.
- Incidents that may be triggers for abuse, such as a crying infant, a toilet training accident, or a child’s misbehavior.
When responding to a call for suspected abuse, law enforcement should investigate all injuries. Some characteristics of injuries are considered red flags and warrant further scrutiny:

- Injuries on children who are not mobile, especially infants.
- Injuries on protected surfaces of the body, such as the back and buttocks, ears, inside the mouth, genitalia and inner thighs, the neck, arms or legs, and underarms.
- Multiple injuries in various stages of healing (i.e., skin injuries, lesions of varying ages, bruises).
- Patterned trauma, even if the object used to commit the abuse cannot be determined.
- Injuries that routine, age-appropriate supervision of the child should have prevented.
- Significant injury with either no explanation or an explanation that is not plausible.

A statement from the parent or guardian and any witnesses regarding how the child sustained the injury will help determine whether the injury is accidental or abusive. A statement from the parent or guardian explaining why he or she delayed in seeking medical treatment is important to the investigation because caretakers often postpone medical treatment or fail to provide treatment for an injured child to hide physical abuse. The abusing parent or caregiver may also put a child in oversized clothing or keep the child inside a residence for extended periods of time in an attempt to conceal the child’s injuries.

Investigators must determine whether the explanation of how an injury occurred and the reason for delay in seeking treatment are plausible. If a discrepancy exists between the history provided and the injuries noted during a medical examination, law enforcement should investigate further. Exhibit 1 contains a list of questions investigators should ask, both at the scene of the incident and with medical personnel when they examine the child.

**Caretaker Assessment**

Whenever suspected physical abuse or neglect of a child is reported, an investigator must complete a caretaker assessment, which is a report on the caretaker’s explanation of the injury. In many cases of neglect and in some cases of physical abuse, a caretaker’s actions or lack of appropriate actions can be attributed to a simple lack of resources or parenting skills. It is incorrect to assume that every parent has innate parenting abilities and instinctively knows how to care for a child. The investigator must determine whether the caretaker’s intent was to injure a child or if the caretaker knew that his or her actions would cause injury.

The caretaker should be questioned in a nonintrusive and nonthreatening manner. The best way to begin questioning a caretaker suspected of physical abuse is to ask him or her to explain how the child’s injury happened; for example, “I understand there was an accident and your child was injured. Tell me about that.” Caretakers are more likely to answer these
EXHIBIT 1. INVESTIGATOR’S CHECKLIST

If performed correctly, the investigation process will ultimately provide sufficient information to determine if a child’s injuries were caused by abuse.

Investigators must first answer these questions to determine if the child is safe:

- Is the child safe in this environment?
- Does the child need immediate medical attention?
- Does the child need long-term protection?

Additional questions to be asked and issues to be considered when investigating a suspected case of child abuse include the following:

At the Scene

- How could the child’s behavior or the caretaker’s stress have contributed to these events?
- Is the child developmentally able to do what the caretaker told you he or she did?
- Is the child a “target” child (that is, a child perceived by the parent as having negative characteristics), or are other target children present?
- What are the locations, configurations, and distribution of any skin injuries, such as bruises, welts, bites, lacerations, abrasions, or burns? Does the child have multiple injuries in various stages of healing?
- Does it appear that someone’s hands or an instrument caused the injuries? Can you determine what instrument might have been used? Are there control or ligature marks on the wrists, forearms, legs, or neck?
- Can you determine the positions of the offender and the child during the incident? Is there any evidence of attempts to hold the child in a certain position or at a certain angle during the incident?
- Does the child have any injuries that are highly specific for abuse? Are there alternative nonabusive explanations that are consistent with these injuries?
- Does the child have any injuries on difficult-to-reach places or on the sides of the body?

At the Medical Examination

- What is the child’s medical history (including all medications) and the family’s medical history? Is there substance abuse or are there other environmental factors in the home? What is the parents’ marital status, employment history, and expectations of the child? Are the parents’ expectations reasonable for what a child of that age should be able to do?
- Was there any delay in treatment or was hospital “shopping” involved? Is there any evidence of prior injury, malnutrition, or lack of medical attention? Does the child have multiple injuries in various stages of healing?
- Were the child’s head, mouth, ears, nose, anus, and genitals examined carefully for injuries?
- What other specific injuries have been identified? Have head injuries, eye injuries, fractures, or abdominal injuries been identified? Are blood tests or medical imaging planned? Are specialists, such as social workers and child abuse pediatricians, being consulted?
- Have pictures of the injuries been taken or has medical imaging been ordered?
- Are the injuries life threatening or severe? Does the child need to be admitted to a hospital? If not, what are the safety plans, need for medications, and followup appointments?
- What is the prognosis for recovery? Should residual disabilities be expected?
types of questions—which contain no threats or accusations—than those that refer to an incident as abuse or suggest in any way that the caretaker caused the child’s injuries.

A credible explanation of how an injury occurred should be (1) reasonable and supported by fact and (2) consistent with the type, location, and severity of the child’s injury. The absence of details, failure to mention the injury, and/or presence of any contradictory or unconvincing explanations may provide clues about whether an injury was accidental or the result of abuse or neglect. Investigators should thoroughly report and investigate any explanations that seem contrary to the injury observed.

**Injury Assessment**

Following a report of abuse, a licensed medical professional should examine the child. The investigator should use the report from this examination to conduct an injury assessment, which focuses on three important questions:

- Is the injury natural or caused by a medical condition?
- Is the injury accidental?
- Is the injury inflicted?

It is important to remember that children’s statements to healthcare providers during the medical evaluation may be admissible in court as exceptions to the hearsay rule. Also, a lack of medical corroboration does not necessarily mean that a child was not abused or that an offense cannot be proved in court. Some types of abuse do not result in physical injury that a medical examination can identify and, depending on the child, some injuries can heal rapidly. Law enforcement should review the specific injuries with medical staff, assess the potential that the injuries were accidental or caused by a medical condition, determine whether there are likely alternative explanations, and confirm with the child protective services caseworker that the child is safe.

**Ruling Out a Natural Phenomenon or Medical Conditions**

Investigators should confer with a pediatrician or child abuse specialist to determine if the child’s condition is a natural phenomenon or an injury. A medical examination is critical to ruling out medical conditions that may appear to be a result of abuse or neglect. For example:

- Mongolian spots and some birthmarks that occur in dark-skinned individuals can be mistaken for bruises.
- Impetigo can imitate cigarette burns.
- Excessive bruising, or petechiae, may result from low platelet counts or clotting disorders, such as hemophilia or Von Willebrand disease.
• Some infections, such as Fifth Disease, can cause rashes that may appear to be slap marks on the face.

• Rarely, a young infant may have an abnormality of bone or collagen (e.g., osteogenesis imperfecta) that causes bone fractures.

Obtaining a medical history from the child’s pediatrician or family practitioner can help determine if the child has any medical conditions with symptoms that may look like injuries and if abuse can be ruled out.

**Distinguishing Between Accidental and Abusive Injuries**

Accidental injuries usually occur along areas commonly known as bony prominences (elbows, knees, hands, nose, chin, and forehead). They generally involve less force than nonaccidental injuries, except in some well-described circumstances such as falls or motor vehicle collisions.

Nonaccidental injuries are typically found in an area called the primary target zone (an area for inflicted injury, such as corporal punishment, that extends from the back of a child’s neck to the area behind his or her knees). Injuries in the primary target zone should be viewed with suspicion and should be investigated to determine whether the force of punishment was criminal. It is important to be aware of your state’s laws on corporal punishment during the investigation.

A triggering mechanism is a crisis or other event that precedes and precipitates an incident of physical abuse. It is a single event that causes a parent or caretaker to feel suddenly angry, out of control, or overwhelmed and leads him or her to react with abuse.

Child abuse investigators should try to determine both the timing and the triggering mechanism in all cases of abuse. Asking a simple question such as “What were you doing just prior to the incident?” may provide valuable clues as to what was happening and the caretaker’s behavior during that time. This question may also lead you to identify the object that was used to inflict the injury.

Investigators can help determine when the child was last exhibiting normal behavior with a question such as “When did you see that the child was last well?” as evidenced by normal awake behaviors. Medical professionals may be able to estimate the timing of the injuries, but investigators should always attempt to determine the timing of the event through interviews with the caretaker rather than relying solely on the medical examination.

**Constructing a Timeline**

It is crucial that you obtain a detailed, precise timeline of events surrounding the incident. The more detailed the history, the more likely the assessment of the injury will be accurate. Document the caregiver’s words in quotes. Whenever possible, do not paraphrase. Clarify
vague references to times, places, or observers. Following are some key questions to ask when constructing a timeline of events:

- When was the child last known to be well or acting normally, without injury?
- What is the child’s age and developmental status (on target or delayed)?
- Is there a history of chronic illness or other medical conditions? What are the child’s medications, if any?
- When did a medical professional, such as a family doctor, pediatrician, or emergency physician, last see the child?
- When did the caregiver first notice there was a problem? How did it come to his or her attention?
- Where and when did the incident occur?
- Who witnessed the incident? Were there any other objective observers in the vicinity who might have seen or heard something?
- How did the child respond after the incident?
- What did the caregiver do after the incident? Were any treatments administered?
- How did the symptoms of the injury progress over time?
- When and how was the decision made to seek medical care?

**Skin Injuries**

The most common forms of child abuse involve skin lesions (such as bruises and burns) and bone fractures; they are also the most common accidental injuries. Because of variations in the appearance of bruises and burns and in the time it takes for healing to occur, it can be difficult to determine whether the injury was caused by accident or abuse and when it occurred. (See sidebar, “Common Skin Injuries,” for a description of the medical terms used for various types of skin injuries.)

**Contusions (Bruises)**

Contusions are the result of trauma to the skin, which causes ruptures in underlying blood vessels that leak blood into the surrounding tissues. The appearance of the bruise depends on many factors:

- The amount of blood leaked into tissues.
- The distance of the blood from the skin’s surface (deeper contusions may take longer to appear as bruises).
COMMON SKIN INJURIES

**Abrasion:** Removal of superficial layers of skin due to friction (e.g., scrapes, “road rash”).

**Petechiae:** Minute hemorrhages into the skin resulting from pressure, friction, or both. Common locations include the eye, scalp, and neck.

**Contusions:** Hemorrhage into the skin and underlying tissues after blunt trauma (i.e., bruises).

**Lacerations:** Tears of the skin due to shearing or crushing forces.

**Burns:** Destruction of tissue by heat, chemical agents, or radiation.

- The number of blood vessels in the particular area of the body.
- The skin’s thickness.
- The amount of underlying fat, muscle, or bone.
- The velocity of the striking force (more damage occurs as the velocity increases).
- The surface area over which force is applied (the same force concentrated in a small area will create more damage than when it is distributed over a larger surface area).

**How Old Is This Bruise?**

No one can precisely assess the age of bruises based on their color. Even physicians do not agree on how to determine the age of a bruise by its color, and their predictions of age are no more accurate than chance because the color changes that occur as a bruise heals are not as predictable as once thought and may not provide an accurate timeline of injury. In fact, color changes are quite variable. The earliest color (yellow) is seen about 18 hours after onset; red, blue, purple, and black can be seen any time from onset to resolution. Bruises sustained at the same time on different parts of a person’s body may also change color at different rates. Thus, the investigation should not rely on opinions that assign an age to bruises.

**Distinguishing Between Accidental and Abusive Bruises**

**Child’s age and development.** One of the most important factors to consider in infants and very young children is their mobility. The prevalence, number, and location of bruises on
Recognizing When a Child's Injury or Illness Is Caused by Abuse

babies are linked to their motor abilities. Infants who are not mobile rarely have bruises. Once they are ambulating, however, babies’ bruises occur mainly on the legs, shins, and forehead. Bruises on the head, face, and ears of a young infant are very suspicious for abusive head trauma and should prompt medical examination and a CT scan of the child’s head. (See sidebar, “Common Medical Imaging Technologies,” for a list of tests commonly performed as part of a medical evaluation.)

Location. Falls are the most common cause of childhood injury, and the corresponding bruises occur where bones are closest to the skin and on the front of the body (e.g., knees, shins, forearms, chin, and the forehead in toddlers). Bruises on the soft parts of the body (e.g., cheeks, neck, buttocks, thighs, calves) are uncommon in accidental injury. Investigators should obtain a detailed history of the child’s previous injuries and a description of the fall because they are essential for distinguishing between accidental and inflicted trauma.

Distribution. Bruises that are symmetric, located on both sides of the body, or located on multiple body surface planes suggest that abuse occurred. Groups or clusters of bruises often seen on the upper arms, on the outside of the thighs, and on the trunk and adjacent extremity should be considered suspicious.

Size and number. Accidental bruises are characteristically few in number and small in size (1 to 2 cm). Abusive bruises are typically greater in number (averaging 5 to 10) and larger in size (>10 cm).

Patterned bruises. Patterned bruises often indicate abuse and may show the imprint of an object. For example, common patterned bruises include a handprint caused by slapping; linear marks caused by blows with belts, cords, or sticks; imprints caused by a household item, such as a wooden spoon or flyswatter; bite marks; ligature marks from ropes, cords, or other bindings; and fingertip bruises caused by forceful grabbing or squeezing.

See sidebar, “Bruises Suggesting Abuse.”

COMMON MEDICAL IMAGING TECHNOLOGIES

CT: Computed tomography.
MRI: Magnetic resonance imaging.
US: Ultrasound.

Endoscope: An instrument with magnification capabilities for visualizing the interior of a hollow organ, such as the stomach, colon, or rectum.

Endoscope: An instrument with magnification capabilities for visualizing the interior of a hollow organ, such as the stomach, colon, or rectum.
BRUISES SUGGESTING ABUSE

• Any bruise on an infant younger than about 9 months old or a noncruising child.
• Bruises in areas other than bony prominences.
• Bruises on the ears, face, abdomen, buttocks, back, arms, thighs, hands, and feet.
• Multiple bruises in clusters or large bruises.
• Patterned, symmetric, or bilaterally located bruises.

Other Factors To Consider

The medical provider must take into account any conditions or disorders that could cause or worsen bruising in a child, such as bleeding disorders, connective tissue diseases, and medications that predispose children to bleeding or bruising. Although it may be more difficult to see bruises in people with darker complexions, there is no evidence that babies or very fair children bruise more easily than others. Multiple contusions in the same area may blend together and obscure patterns of the object used.

Burns

Burns are classified as superficial (redness, no blisters), partial thickness (painful, form blisters, vary in depth), and full thickness (not painful, appear white or dry, scars with healing). An older system uses the categories of first-, second-, and third-degree burns. Currently, the three most common burns in young children are thermal burns, contact burns, and scalds. An overview of burn types is helpful in determining how this type of injury may have occurred and whether it was accidental or abusive.

Thermal Burns

Thermal (or heat) burns account for almost all burn injuries in children. Children younger than age 6 (especially 2- to 4-year-olds) are the most frequent victims of abusive burns. Scalds with hot liquids, contact with a hot object, exposure to flame, or radiation injury may cause thermal burns. The severity of a thermal burn depends on six factors:

• Thickness of the skin (varies with age, gender, and location on the body).
• Temperature of the agent.
• Length of time the agent is in contact with the skin.
• Heat-dissipating capacity of the skin (amount of blood flow).
• Amount and type of clothing worn.
• Type of liquid.

**Contact Burns**

Prolonged contact with a hot object causes contact burns, which reflect the size and shape of the part of the object that contacted the skin. Accidental contact burns usually have indistinct or smeared edges because the child quickly pulls away from the hot object.

Contact burns involve prolonged exposure to heat and produce more uniformity of depth, sharply demarcated edges, and distinct patterns. They are unlikely to occur on clothed parts of the body. “Running into a cigarette” produces an indistinct, superficial burn that is oval or comet shaped; this is in contrast to an inflicted cigarette burn, which is typically a deep partial thickness, round to oval-shaped lesion with well-defined edges.

Objects commonly used in abusive burns include clothes irons, cigarettes, curling irons, stovetop burners, cigarette lighters, and heated kitchen implements.

**Scalds**

Burns caused by hot liquids are some of the most difficult cases to assess. Most scald burns in children result from household accidents involving spills or splashes by hot coffee, soup, or cooking oil. Typically, accidental burns have indistinct margins, are usually located on one side of the body, exhibit a trailing-off pattern (the hot liquid cools as it runs down the body), and have areas that are spared or relatively spared because of the presence of clothing.

Most abusive scald burns are caused by hot tap water, typically by immersing the child in standing hot water (e.g., in a sink or bathtub) or by holding the child under running hot water. When feet and hands are submerged, the scald creates a “stocking or glove distribution” pattern. Characteristics of forced-immersion scalding include:

• Burns that are of uniform depth and sharply demarcated (indicating the child was restrained).
• Bilateral, symmetric burns.
• Sparing of the flexion creases, indicating the position of the body at the time of the injury (drawing up the arms and legs will minimize burning in the area behind the knees and where the thighs touch the abdomen).
• Areas of relative sparing where the body is in contact with a cooler surface (e.g., soles of the feet pressing against the bottom of the bathtub).

With scald burns, investigators must act quickly to preserve the integrity of the scene and obtain accurate measurements. The depth of the bathtub or sink, setting of the hot water
heater, and temperature of the water at varying time intervals should be documented immediately.

See sidebar, “General Indicators of Abusive Skin Injuries.”

**Fractures**

Accidental fractures can occur in children who are mobile and active. Household accidents and falls produce the most common accidental fractures: linear skull, clavicle, forearm, and lower leg “toddler’s” fractures. Most abusive fractures occur in infants and young toddlers. Similar to bruises, accidental fractures are rare in infants because they do not have the strength or mobility to cause them. In fact, infants’ bones, which are more flexible than those of older children and adults, can bend significantly before breaking.

When assessing the likelihood of abuse, the most critical component is a detailed history of how the injury occurred. The history should include the child’s age and developmental abilities (e.g., some babies are learning to stand at 12 months, while others are running) as well as the presence of possible contributing medical conditions (e.g., vitamin D deficiency or osteogenesis imperfecta, also known as “brittle bones”). The timeline of events from the initial injury to the time when the caregiver sought medical treatment should also be determined.

Investigators should obtain as much information as possible about the position and motion of the child just before, during, and immediately after the injury. Questions asked and the investigation at the scene should focus on details of the surroundings, including the height of the fall, location of nearby objects, and type of landing surface (e.g., carpet or tile). Confirm whether the child was alone when he or she fell, if the child was dropped, or if the child was being held and fell with another person. Injuries can be more severe when a baby falls while being carried; the adult’s mass falling along with the child creates significantly more force than when a baby falls alone from the same height. Ask how the

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**GENERAL INDICATORS OF ABUSIVE SKIN INJURIES**

- Many injuries are present.
- Injuries occur in unusual locations.
- Injuries cover a large area.
- Medical care is delayed.
- Injuries are inconsistent with family history and the child’s developmental abilities.
- Injuries show a pattern.
child acted and behaved immediately after the injury and later during daily activities (such as diaper changes).

When a fracture is suspected, children younger than age 2 should have x rays of all bones to look for older healing fractures from previously undetected injury or abuse. A complete survey of the skeleton (full body scan) should be conducted; this includes separate exposures of each of the long bones, spine, head, hands, and feet.

**Types of Fractures and Mechanisms of Injury**

<table>
<thead>
<tr>
<th>Location</th>
<th>Type of Fracture</th>
<th>Type of Force</th>
<th>Examples of Accidental Injury</th>
<th>Examples of Abusive Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaft of long bone (e.g., femur, humerus)</td>
<td>Spiral, oblique</td>
<td>Twisting (rotating)</td>
<td>Child falls while running, twists leg</td>
<td>Caregiver grabs or twists an arm</td>
</tr>
<tr>
<td>Shaft of long bone (e.g., femur, humerus)</td>
<td>Transverse</td>
<td>Direct blow, bending</td>
<td>Child runs into edge of coffee table</td>
<td>Femur is struck with baseball bat</td>
</tr>
<tr>
<td>Shaft of long bone (e.g., femur, humerus)</td>
<td>Buckle, impaction</td>
<td>Compression</td>
<td>Child falls onto outstretched arm</td>
<td>Child is slammed onto knees on a table</td>
</tr>
<tr>
<td>Shaft of long bone (e.g., femur, humerus)</td>
<td>Greenstick</td>
<td>Bending</td>
<td>Child’s arm hits edge of step with a fall</td>
<td>Child’s arm is grabbed and yanked upward</td>
</tr>
<tr>
<td>Metaphysis of long bone (near growth plate)</td>
<td>Metaphyseal “corner” fractures (classic metaphyseal lesions)</td>
<td>Tension, shearing</td>
<td>Traction on limb during physical therapy (unusual)</td>
<td>Violent shaking of infant</td>
</tr>
<tr>
<td>Skull</td>
<td>Simple, linear</td>
<td>Direct blow</td>
<td>Infant rolls off the changing table onto the floor</td>
<td>Caretaker throws infant onto the floor</td>
</tr>
<tr>
<td>Skull</td>
<td>Complex, depressed</td>
<td>Direct blow</td>
<td>Child falls off bunk bed, hitting head on corner of wooden toybox</td>
<td>Child is hit in the head with a hammer</td>
</tr>
<tr>
<td>Ribs</td>
<td>Transverse</td>
<td>Bending during compression of chest; direct blow (uncommon)</td>
<td>Infant is resuscitated by two-handed CPR</td>
<td>Infant’s chest is squeezed during violent shaking</td>
</tr>
</tbody>
</table>
How Old Is This Fracture?

The opinion of a radiologist experienced in child abuse cases is essential because it is often difficult to determine the exact age of a fracture by x ray. Also, because injuries in children heal faster than those in many adults, the age of fractures as determined through x rays can be given only in broad timeframes. In abused children, this process can be interrupted if the bone is not immobilized (causing repeated movement of the fractured ends) or if other episodes of trauma are inflicted on the same area.

Follow-up x rays for suspected fractures are key to determining when the injury occurred and whether it is supported by the caregiver’s explanation. A very new fracture without a lot of inflammation or that is not widely separated, especially in very small bones (such as those in infants) may be difficult to see on an x ray in the first few days. Fractures become more visible when they begin to heal because of the presence of callus, a healing bone tissue that forms to bridge the break in the bone to make it stable again. During this stage of healing, medical professionals are able to better identify fractures that may have been missed during the initial x ray. This follow-up skeletal survey is part of the investigation, and ensuring its completion is vital to the assessment of injuries.

Features Strongly Suggesting Abuse

Following are some common features suggesting that fractures are a result of abuse:

- Fractures in infants who are not independently mobile.
- Unexplained fractures.
- Inconsistency between the movement necessary to cause a fracture and the description of how the injury occurred.
- Severity of the injury out of proportion to the event described.
- Fracture accompanied by other evidence of abuse or neglect.
- Significant delay in seeking medical care.
- Multiple fractures of different ages.
- Metaphyseal fractures (classic metaphyseal lesions).
- Rib fractures.
- Complex, depressed skull fractures.
Head and Eye Injuries

The most common signs of head injury are vomiting, seizures, stupor, and coma. However, sometimes the signs and symptoms of abusive head trauma are nonspecific, such as irritability, lethargy, or poor appetite.

Investigators should determine whether a head injury is consistent with the reported injury and whether the events surrounding the incident explain the severity. Severe or life-threatening injuries generally do not occur from short falls, falls down stairs, or minor accidents when children are playing. These types of injuries usually require more force, such as a high-speed auto collision or a fall from several stories in height. An evaluation of a serious head injury usually requires blood tests and imaging, and it may involve surgeons, neurologists, neurosurgeons, and other specialists.

Distinguishing Between Accidental and Abusive Head Injuries

Most fatalities from child abuse involve serious head injuries. The depth of the injury within the skull has been correlated to the amount of force used (i.e., deeper injury means more force). Bruising to the face, ears, eyes, and neck is often associated with abuse in children who are not walking or who are younger than age 3.

Following are some common types of head injuries:

- Hair loss or baldness (alopecia) or bleeding into the scalp or eyes may be caused by hair pulling as a means of discipline.

- A subdural, subarachnoid, or epidural hemorrhage under a skull fracture is caused by direct impact to the head and often features overlying bruising or swelling of the scalp. These hemorrhages may be associated with an intentional blow to the head, such as when a child is struck or thrown against a hard object, or with an accidental injury.

- Subdural hematomas without external injury correlate with whiplash or shaking.

- Abusive head trauma may present as retinal hemorrhages or trauma to the eye and its surrounding structures. Abuse should always be considered in children younger than age 3 who have these symptoms without an adequate history of accidental injury.

It is also important to observe the child’s living situation for cues of abuse. For example, increased rates of abusive head trauma have been associated with a crying infant who lives in a home with adults who are not related to each other.

Distinguishing Between Accidental and Abusive Eye Injuries

Isolated external eye injuries are so common in children that they seldom show clear evidence of abuse. Investigators should use their best judgment based on the caregiver’s explanation and the nature of the injury. For example, two black eyes seldom occur together accidentally unless the nose is broken. Also, internal eye injuries (such as retinal
hemorrhages in multiple layers of the retina that are diffuse and numerous) strongly suggest whiplash or shaking as the means of injury. An ophthalmologist should examine the child to determine if internal eye injuries, such as retinal hemorrhages, have occurred.

**Abdominal Injuries**

Abdominal trauma is second only to head trauma as the most common cause of death in child abuse. Pain and poor appetite may be the only symptoms of abdominal trauma because there is often no external bruising. Severe symptoms resulting from damage to internal organs (liver, spleen, pancreas, stomach, and intestines) can be delayed; this, in conjunction with a false or misleading history, often causes delayed recognition and treatment, leading to high rates of serious complications (internal bleeding, organ death, infection) and death.

Accidental abdominal injuries are usually caused by a long fall to a flat surface or a motor vehicle accident. In rare circumstances, a contact sport or bicycle accident may cause an abdominal injury in an older child. These patients usually seek medical attention immediately. Abusive abdominal injuries occur more often in younger children with a delayed presentation for medical care. Punching, kicking, and striking with objects can cause internal organ damage. Sometimes an external bruise can help to identify the means of injury.

**A Note on Investigating Injuries**

Once a suspicious injury has been reported, it is critical that law enforcement conduct an immediate assessment of the situation, ensure that the child receives medical care, identify witnesses, and collect evidence from the scene of the incident. In documenting evidence, investigators should obtain high-quality photos (including a scale) to document all injuries and their changes over time, to enhance testimony, to solicit second opinions from other professionals, and to supplement case reviews.

**Working With the Medical Community**

The most effective way to investigate child maltreatment is through interagency coordination and planning, also known as a multidisciplinary team approach. Physicians and other healthcare providers are key participants in cases involving child abuse alongside social workers, therapists, victim/witness service providers, prosecutors, judges, and law enforcement officers.

Law enforcement should work with healthcare providers to ensure that all suspicious injuries are reported to the proper authorities. Physicians, nurses, sexual assault nurse examiners, and other medical professionals play a vital role in the investigative process by objectively
evaluating occurrences of child maltreatment, recognizing and documenting suspicious injuries, interviewing children, and referring children for additional treatment.

The medical community has four basic responsibilities in the identification and treatment of injuries:

- Identify, diagnose, interpret, and document injuries.
- Treat and make appropriate referrals for conditions and injuries.
- Report suspected incidents of abuse to the appropriate authorities.
- Provide evidence for subsequent legal proceedings.

Before obtaining medical care from a provider, investigators should confirm that the provider has been trained and is experienced in the special needs, diagnoses, and treatment of child abuse victims. The provider should also be willing and able to appear as an expert witness and present his or her findings in court.

**Obtaining a Medical Examination**

A medical evaluation should be performed as soon as possible on all children suspected of having been abused; preferably, the evaluation should be conducted by a medical professional who has been trained in and is experienced with examining abused children. Immediate medical exams can prevent further injury to the child or complications from the injury and help to avoid accusations that a child’s injuries occurred after removal from the home. See sidebar, “How To Obtain a Medical Examination.”

Medical emergencies (such as severe pain, bleeding, fracture, head trauma, internal injuries, or acute sexual assault) require immediate evaluation in a hospital emergency room where specialized resuscitation, surgery, and testing are available. Law enforcement should remain at the hospital with the child and family. Officers play a vital role by providing critical details of events, collecting evidence, and helping hospital medical and social work staff contact and interact with family members.

In nonemergency situations, medical evaluations can be performed at less specialized facilities, depending on the resources available in the community. The timing for these exams is less critical, but they should be scheduled within 1 to 3 days to increase the potential for evidence collection. Many medical services are provided at Children’s Advocacy Centers (CACs). If your agency does not already coordinate with the local CAC, you may want to include CAC staff on your multidisciplinary team or establish a relationship with them for future investigations. The accrediting body for CACs is the National Children’s Alliance, which has a list of CACs in each state (www.nationalchildrensalliance.org).

A secondary but nevertheless vital purpose of a medical examination is to determine the presence of and properly collect any corroborating evidence of acute or chronic
Preparing and Presenting Medical Evidence for Trial

Preparation for trial begins with good practice and documentation the moment a child presents for medical care with an abusive injury or illness. Child abuse cases rely heavily on medical evidence, and complicated information must be presented in a clear, concise manner that all jurors can understand. For this to occur, investigators and prosecutors must be in frequent contact with the physician assisting them. The entire team should be fully aware of what can and cannot be proved, what statements have been given, and whether the evidence corroborates the crimes charged. Exhibit 2 on page 18 presents a list of tasks and questions to consider when preparing for trial.

The ultimate goal of medical testimony is to teach. The judge or jury’s decision is only as good as their understanding of the evidence. The value of visual aids (including x rays, photographs, or models of objects) cannot be overemphasized—they can help juries...
EXHIBIT 2. PREPARING MEDICAL EVIDENCE FOR TRIAL

Organizing the Team

• Obtain and review all medical records, including past primary care and hospital records, which often contain clues to previous abuse or neglect. These records may include films or a disk containing diagnostic images.
• Review (in a face-to-face meeting) the salient features of the medical evidence, ask questions, clarify details, view x rays and scans, and ensure that everyone has the same understanding of the facts.
• Determine the expertise and experience of the physician involved and whether additional medical experts are needed.

Collecting the Medical Evidence

• What is the nature and extent of the child’s injury or illness?
• What is the mechanism of injury? What type and amount of force are required to produce the injury?
• Does the history the caregiver provided explain (in whole or in part) the child’s injury?
• Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
• Could the injury be consistent with an accident?
• Can the timing of the injury be estimated? To what degree of certainty?
• Have all injuries been assessed in light of any exculpatory statements?
• What treatments were necessary to treat the injury or illness?
• What are the child’s potential risks from the abusive event?
• What are the long-term medical consequences and residual effects of the abuse?
• Have all reports by medical experts retained by the defense been obtained and reviewed? What are the similarities and differences between the reports?

Preparing for Trial

A thorough understanding of all medical evidence is helpful only if this information can be communicated effectively to the trier of fact. Prepare to answer questions about the following:

• How the child’s and family’s medical and social history can assist in arriving at a diagnosis.
• Basic anatomical and physiological principles.
• Symptoms anticipated with the abusive injury.
• The basis for the medical diagnosis and widely accepted scientific research about the particular diagnosis.
• Limitations of what medicine can and cannot prove definitively.

understand object relationships and unfamiliar concepts. Video reenactments and computer-generated graphics can also be helpful. Resources have been created to educate medical and lay audiences about the most common abusive injuries (see “Resources for Educating Others About Abusive Injuries”).
Conclusion

An injury by itself does not indicate abuse. The history of how the injury occurred is vital when determining if abuse occurred. A comprehensive assessment by a team of knowledgeable professionals is the best approach to reaching an accurate conclusion.

Supplemental Reading


Resources for Educating Others About Abusive Injuries


Organizations

**American Academy of Pediatrics**
Section on Child Abuse and Neglect
141 Northwest Point Boulevard
Elk Grove Village, IL 60007–1098
847–434–4000
childabuse@aap.org
www2.aap.org/sections/childabuseneglect

**American Professional Society on the Abuse of Children**
350 Poplar Avenue
Elmhurst, IL 60126
877–402–7722
apsac@apsac.org
www.apsac.org
NCA-EMPOWERING LOCAL COMMUNITIES TO SERVE VICTIMS OF CHILD ABUSE
The National Children’s Alliance: Empowering Local Communities to Serve Victims of Child Abuse

Karen Farst, MD, MPH

The National Children’s Alliance (NCA) is a nonprofit membership organization whose mission is to empower local communities to serve victims of child abuse (NCA, About NCA, 2011). Former Congressman Bud Cramer (Alabama) developed the NCA in 1987. His goal was to bring organization and coordination to the community-level children’s advocacy centers (CACs) that were developing across the country. The NCA mission is accomplished by empowering the work of local CACs, such as providing training, grants for development and sustainability, and technical assistance. Membership is through an accreditation process that exists to strengthen best practices both within the CAC and the community being served.

While the NCA’s mission is to empower work at the community level through individual CACs, this work would not be possible without the partnerships of the state chapters of CACs and the regional CACs (see Figure 1). There are four centers with regional designation across the country that serve as keystones to the training and technical assistance provided at the local level. These are located in Huntsville, Alabama (Southern), St. Paul, Minnesota (Midwest), Philadelphia, Pennsylvania (Northeast), and Colorado Springs, Colorado (Western). These centers provide such resources as “bootcamps” to prepare for submitting an application for accreditation, online and onsite learning opportunities, teledicine-based reviews for medical–mental health–forensic interview services, and online library assistance for professionally-based articles (see Table 1).

Although no two CACs will look or function exactly alike (Walsh, Jones, & Cross, 2003), research has shown that collaborative investigative efforts employing best-practice techniques (in an environment in which the child is able to feel at ease) lead to better coordinated investigations, more satisfaction from the caregiver of the child in the investigative process, and better referral rates for mental health and medical services (Walsh et al., 2007; Cross et al., 2008). For this reason, the NCA holds the multidisciplinary team (MDT) as central to the effectiveness of child abuse work at the local level. A CAC cannot be effective in its local community without the partnership and participation of the MDT.

A Trauma-Based Approach

Child sexual abuse makes up 65% of the cases seen in CACs across the country; physical abuse, neglect, witnessing violence, and drug endangerment comprise the other cases (NCA Annual Report, 2011). The original standards focused on issues related to child sexual abuse, but the most recent revision included information from the evidence-based literature about the need to use a trauma-based approach to any form of child abuse/neglect. This was done due to CACs being utilized by their local MDTs to assist with interviewing and service delivery for all forms of abuse/neglect and the growing understanding of the long-term issues encountered by child victims. The current standards remain focused on issues related to child sexual abuse but incorporate information in the evidence-based literature about the need to use a trauma-based approach to address the long-term issues associated with any form of child abuse or neglect.

The evidence base for the short- and long-term negative consequences of child abuse is robust and growing. One of the largest scale projects on the subject is the Adverse Childhood Experiences (ACE) study. After analysis of adult’s self-reports of traumatizing events during childhood, the study group has...

Figure 1: Organizational Structure of National Children’s Alliance
The cumulative adverse effects that childhood trauma has on adult health and well-being, including premature death, increases in chronic disease conditions, higher rates of attempting suicide, and more engagement in high-risk sexual activity and substance misuse (Felitti et al., 1998; Centers for Disease Control and Prevention, 2013). Physical abuse, sexual abuse, and neglect were each categorized as ACEs in the study. Other researchers have looked specifically at victims of child sexual abuse and also shown long-term negative consequences to both physical and emotional health (Trickett, Noll, & Putnam, 2011).

This trauma-based understanding of the potential for negative consequences for victims of child abuse is central to the CAC approach. Advocating for and facilitating a coordinated approach to an investigation can not only lead to better case outcomes (U.S. Department of Justice, 2008) but may also minimize the trauma experienced by children and their family members through the process (Jones et al., 2007; Bonach, Mabry, & Potts-Henry, 2010). Ensuring that the professionals providing services to the child are properly trained and remain current in their field through continuing education and participation in peer review is another important role of the CAC in minimizing trauma a child may experience as part of the investigation itself.

For example, many victims, family members, and even professionals may believe that the medical evaluation for possible sexual abuse is a painful and negative experience for a child. On the contrary, when someone with knowledge and experience in the field of child abuse performs an examination, most children do not rate the exam negatively (Palusci & Cyrus, 2001; Marks, Lamb, & Tzioumi, 2009; Hornor et al., 2009). It is important for the CAC not only to ensure access to qualified providers in the community but also to help educate MDT members and other local partner agencies. In this way, a misconception of one component of the investigation does not interfere with needed services being offered to a child and the family. Studies are underway that evaluate rates of referrals for trauma-focused cognitive-behavioral therapy to children served by CACs as this is a modality that has proved beneficial to child abuse victims by reducing some of the long-term negative effects (Mannarino et al., 2012; U.S. Department of Health and Human Services, 2012). This specialized service requires initial and ongoing training with expert oversight, which is outlined in the NCA’s mental health standard.

### Medical Standards

The NCA developed the first set of practice standards in 1996 aimed at building CAC services that use methods with evidence-based foundations. Since that time, the standards have been revised according to emerging information in the evidence-based literature. Currently, ten standards (see Table 2) that describe minimum best-practice components must be met for a CAC to qualify as an accredited center (NCA Standards, 2011). While centers are working toward meeting the standards for accreditation, they can still be part of the NCA for training and other areas of support at the level of associate, affiliate, or satellite member. Accredited and associate members submit a report to the NCA every 6 months. Once accredited, a CAC’s membership status must be renewed every 5 years in a process that includes a detailed written report on adherence to accreditation standards and an in-person site visit.
Table 2. National Children’s Alliance Standards for Accredited Members

Program Components

1. Multidisciplinary Team
2. Cultural Competency and Diversity
3. Forensic Interviews
4. Victim Support and Advocacy
5. Medical Evaluation
6. Mental Health
7. Case Review
8. Case Tracking
9. Organizational Capacity
10. Child-Focused Setting


Table 3. National Children’s Alliance Standards for Accredited Members: Medical Evaluation

Standard = specialized medical evaluation and treatment services that are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

1. Medical providers (physicians, nurse practitioners, nurses, or physician assistants) must meet at least ONE minimum training standard.
   a. Child abuse pediatrics sub-board eligible or certified.
   c. Documentation of 16 hours of formal medical training in child sexual abuse evaluation.
2. Specialized medical evaluations are made available onsite or through linkage agreements with appropriate providers.
3. Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.
4. The CAC must have written documents to include:
   a. Screening criteria to be used to determine the timing of the medical evaluation.
   b. How the medical evaluation will be made available, including how emergency situations are addressed.
   c. How multiple medical evaluations are limited.
   d. How medical care is documented (medical history, physical and diagnostic-quality photographic documentation).
   e. How the medical evaluation is coordinated with the MDT to avoid duplication of interviewing of the child.
   f. How medical evaluations for physical abuse will occur.
5. CAC and/or MDT provide opportunities for those who conduct medical evaluations to participate in ongoing training and peer review.
   a. Minimum of 3 hours every 2 years of CEU/CME credits in the field of child sexual abuse must be completed.
   b. Photodocumented examinations are reviewed with advanced medical consultants. Review of ALL exams with positive findings is strongly encouraged. (Advanced medical consultant = physician or advanced practice nurse who has considerable experience in the medical evaluation and photodocumentation of children suspected of being abused, and who is involved in scholarly pursuits, such as conducting research studies, publishing on the topic, and speaking at regional or national conferences the topic of child abuse.)
6. MDT members and CAC staff are trained about the nature and purpose of a medical evaluation so they can competently respond to common questions, concerns, and misconceptions.
7. Findings of the medical evaluation are shared with the MDT in a routine and timely manner.

referred for a medical evaluation if there is a perception that it would not yield forensic evidence for the investigation. Therefore, the CACs again need to help educate the MDT and their community that the benefits of an exam go far beyond the collection of evidence, and that the absence of physical findings of trauma in the anogenital area in no way discounts a valid disclosure of sexual abuse (Heger et al., 2002).

Within the medical standard, regardless of the education of the provider (registered nurse, advanced practice nurse, physician assistant, or physician), a minimum amount of initial and continuing education specific to child abuse is designated. This was established because research has shown that, regardless of the degree of the provider, experience within the field of child sexual abuse is a major determining factor when it comes to accuracy in interpreting examination findings (Adams et al., 2012; Campbell et al., 2010; Makoroff et al., 2002). The other factor that has been linked to accuracy in interpreting examination findings is participation in expert peer review (Adams et al., 2012). This is especially true for providers who do not perform exams on a regular basis (fewer than five exams per month). To participate in expert review of examination findings, a provider must be able to obtain diagnostic quality photodocumentation of the anogenital findings. Although this does require access to specialized equipment that is cost-prohibitive to some centers, it is possible to assemble the needed components for diagnostic-quality images for just a few thousand dollars compared with spending over tens of thousands of dollars on a medical-grade colposcope and recording system.

Support for Medical Providers
Access to someone qualified to provide expert peer review of examination findings may be difficult for some centers as well, especially if they are not located in close proximity to an academic medical resource. In response to this need, the Midwest Regional CAC established an online, de-identified expert case review system, called myCaseReview (formerly known as Telehealth Institute for Child Maltreatment). More information about this program can be found on the Web site for the Midwest Regional CAC's Medical Academy through the link provided in Table 1.

A recent review of CAC services appeared to indicate that progress is being made toward meeting best-practice standards in the field. Specifically, the survey showed that forensic interviewers and medical providers were receiving increased training, peer-review participating was increasing, and the percentage of children receiving a medical evaluation was increasing (Stephens, Martinez, & Braun, 2012).

The process of applying to the NCA for initial or re-accreditation by a CAC is rigorous. While accreditation in and of itself signifies adherence to quality standards and brings an inherent level of validation, there are other benefits to membership beyond funding support. The NCA manages a members-only e-mail listserve for networking and customizable public awareness campaigns. In addition, it has testified at Senate and House hearings about the importance of both the intervention and prevention of child abuse, thereby raising national awareness of the importance of CACs.

Improving Outcomes at CACs
As a nonprofit entity that receives federal funding and individual donations, the NCA is committed to good stewardship with its resources. The annual report, including fiscal information, is available in open forum online (NCA Annual Report, 2011). Over 90% of the revenue received from sources such as the federally based Victims of Child Abuse Act is disbursed to the local CACs and state chapters for growth and development (NCA Annual Report, 2011). The NCA and its member organizations also participated with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the U.S. Department of Justice for an evaluation of the CAC’s response to child abuse. OJJDP (Cross et al., 2008) funded a comparative review by an external research group between four communities with CACs and four communities of similar composition that did not have CACs.
In this evaluation, communities with CACs had greater involvement of law enforcement in sexual abuse evaluations, more evidence of coordinated investigations, and higher rates of referrals for medical and mental health services. Children served by a CAC had a medical evaluation in 48% of the cases, which was significantly higher than those served in comparison communities (21%). Caregiver satisfaction was higher in cases served by CACs. In addition, the CACs in this particular study were identified as providing other services to their communities, including training and consultation. The MDT partners in the communities with CACs regarded the CAC staff as leaders and experts in the field of child abuse for their area.

Despite the NCA’s struggles to maintain long-term effectiveness and viability as a nonprofit entity, the number of CACs available to MDTs and children across the country has more than doubled since the year 2000. Two thirds of counties in the United States now have access to a CAC. Accordingly, the number of children served by the CAC model has increased by 175% since 2000 (see Figure 2)(NCA, 2013). The news from child welfare data sources that rates of child sexual abuse continue to decline is encouraging (Finkelhor & Jones, 2012). However, there are still thousands of children affected by this issue each year, indicating the need to keep intervention and prevention efforts moving forward. As the service areas of CACs continue to grow, the NCA will continue to evaluate ways to assist its membership with training, advocacy, and support. This has already included partnering with agencies dealing with victimization by child pornography. Other issues, such as addressing the needs of children who have been trafficked for sex and other crimes, may benefit from inclusion in CAC services when they clearly fall within the mission of the NCA.

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National Children's Alliance (NCA). (2013, June). *Number of children served by CACs in the United States by year*. Presented by Teresa Huizer, Executive Director, at the Leadership Conference of the National Children's Alliance, Washington, D.C.


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CHILD ABUSE MEDICAL EVALUATIONS IN TEXAS:
CURRENT PRACTICES AND CHALLENGES
Child Abuse Medical Evaluations in Texas: Current Practices & Challenges

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EXECUTIVE SUMMARY

When an allegation of child abuse is reported, it is important that children receive medical evaluations for both medical and forensic purposes (National Children’s Alliance, 2012; Texas Children’s Justice Act Task Force, 2012). A 2011 report by the Midwest Regional Children’s Advocacy Center stated that nationally, 34% of children referred to a non-profit children’s advocacy center (CAC) receive a medical evaluation. However, Children’s Advocacy Centers™ of Texas (CACTX) has found that, in Texas, only 21% of children with alleged abuse receive medical evaluations, with even lower rates in smaller communities and rural areas. As a result, CACTX identified a need to research existing policies about and barriers to children receiving medical evaluations so that recommendations and strategies can be developed to increase the rates of evaluations in Texas. CACTX contracted with the Child and Family Research Institute (CFRI) at The University of Texas at Austin School of Social Work to conduct this research.

CFRI researchers conducted a mixed methods study in two parts. The first part of the study consisted of 60 focus group interviews of multidisciplinary team (MDT) members in twelve CAC service areas. The service areas were chosen using two criteria: (1) community size (e.g. small/rural, mid-sized, and large/urban centers); and (2) rates of medical evaluations in the service area (either higher or lower than service areas of similar sizes). Researchers used the focus group interviews to explore existing practices for medical evaluations in alleged child abuse cases, barriers to evaluations, and possible strategies to increase evaluation rates. In the second part of this study, researchers used the initial focus group findings to develop and distribute an online survey statewide to all MDT members. Over 300 MDT members completed the survey. The research was conducted between October 2012 and June 2013.

Results suggest that multiple barriers prevent child abuse victims from receiving proper medical evaluations. The findings document the processes of obtaining medical evaluations for children, factors that impact whether or not a medical evaluation is conducted, and the functioning of MDTs. Complex issues related to children obtaining evaluations include a lack of medical professionals with child maltreatment specializations; complicated reimbursement structures; factors related to a child’s outcry, the child and the child’s family; and community factors such as the proximity to specialized services. Finally, MDT functioning, collaboration and understanding between team members impacts the processes of referrals for medical evaluations.

Based on these findings, primary recommendations for improving rates of medical evaluations include: 1) changing the funding structure to help streamline the billing process; 2) highlighting and reinforcing hospital support; 3) developing statewide guidelines for medical evaluations; 4) including policies and procedures for improving rates of physical abuse and neglect evaluations;
5) expanding access to MEDCARES; 6) providing cross-training to improve understanding of medical evaluations among MDT members; and 7) engaging in broader discussions about forensic medical services, particularly in rural areas.
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BACKGROUND

The following section reviews current literature and research on topics pertinent to this study, which examined the rates of medical evaluations for suspected child abuse victims. Included are discussions on child maltreatment prevalence and consequences, descriptions of children’s advocacy centers (CACs) and the multidisciplinary teams (MDTs) they coordinate, and the exploration of several key issues related to medical evaluations in child abuse cases. More specifically, medical evaluation rate, medical models and best practices for child abuse evaluation, medical evaluation importance, barriers limiting access to medical evaluations, and statewide efforts to coordinate medical evaluation programs are discussed. This review concludes with an overview of the need for additional research on this topic.

CHILD MALTREATMENT PREVALENCE AND CONSEQUENCES

Impact of child abuse. Child abuse can have a wide-ranging impact in both the short- and long-term for a child’s physical health, mental/emotional health, and behavior (Administration for Children and Families, ACF, 2012; ChildHelp, 2012; Irish, Kobayashi, & Delahanty, 2009; van Roode, Dickson, Herbison, & Paul, 2009). For example, when compared to non-abused counterparts, child sexual abuse victims are at increased risk for multiple problems later in life, including revictimization, criminal justice involvement, substance abuse and mental health difficulties, social and sexual problems, and physical health problems (Golding, Wilsnack, & Cooper, 2002; Haven, 2001; Howard & Wang, 2005; Irish et al., 2009; van Roode et al., 2009; White & Smith, 2001; Widom, 1995; Widom & Kuhns, 1996; Widom, Marmorstein, & White, 2006).

Child abuse also has a significant impact on society as a whole through direct costs to victims and families (e.g., medical or psychological care), as well as direct and indirect costs to systems and organizations (e.g., child welfare, law enforcement, judicial, juvenile and adult criminal justice health, and mental health systems) (ACF, 2012). Some researchers have estimated that, in the United States, the annual cost associated with child abuse and neglect is approximately $103.8 billion (Wang & Holton, 2007).

Prevalence of child abuse. Child abuse can include physical abuse, sexual abuse, emotional abuse, and/or neglect. Legal definitions of child abuse in Texas are detailed in Section 261.001 of the Texas Family Code and Chapter 481 of the Texas Health and Safety Code. Although it is likely most child abuse incidents are not reported to authorities, significant numbers of alleged child abuse cases are reported each year. The National Child Abuse and Neglect Data System (NCANDS) reported that Child Protective Services (CPS) agencies across the nation received reports of approximately 3.3 million cases of child abuse (U.S. Department of Health and Human Services, U.S. DHHS, 2010). Of these, there were nearly 700,000 substantiated incidents of abuse and more than 1,500 known fatalities due to child abuse (U.S. DHHS, 2010).

Data regarding child maltreatment is generally cited from state child protection agencies and national level sources that summarize data across states. In Texas, there are two main sources
for annual child maltreatment data: Child Protective Services (CPS) and Children’s Advocacy Centers™ of Texas, Inc. (CACTX). In examining this data, it is important to recognize that these organizations function differently and have different mandates for the populations they serve. Administered by the Texas Department of Family and Protective Services, CPS releases statewide data annually; however, much of CPS data relies on information from cases served directly by CPS. CACTX is the statewide membership organization for the 68 children's advocacy centers (CACs) in Texas. Each CAC coordinates a local multidisciplinary team (MDT) to respond to child abuse allegations from the time of the report. CACTX data shows a different distribution of cases than those served by CPS because of the CACs’ central role in coordinating the criminal investigation and prosecution of child abuse cases. While CPS serves children whose primary caregivers have either perpetrated abuse or failed to protect them from abuse, CACs serve children whose perpetrators may or may not be family members. Thus, not all CAC children are involved in CPS cases and vice versa. In discussing the prevalence of abuse in Texas, this section utilizes national data and state data from CPS and CACTX.

CPS data shows that in Texas during 2011, out of a total child population of 6,663,942, there were 297,971 alleged victims of child abuse, 98,435 children whose alleged abuse was confirmed by CPS investigation, and 17,108 children removed from their homes to keep them safe (Texas Department of Family and Protective Services, TX DFPS, 2011). In 2010, Texas also had a total of 222 child fatalities due to child abuse, a rate of 3.22 deaths per 100,000 children (Texas Department of State Health Services, TX DSHS, 2010).

As shown in Figure 1 above, most of the confirmed CPS cases of abuse in Texas were neglect cases (82.5%), followed by 21% that were physical abuse cases, 9.3% that were sexual abuse cases, and 1.5% that were medical neglect cases (TX DSHS, 2010). However, children referred to CACs tend to be mostly victims of alleged sexual and/or physical abuse, which more often
involves criminal offenses that are better prosecuted through a multidisciplinary approach. Figure 2 below summarizes CACTX’s most recent statistics (2012) about abuse type for CACTX clients. Specifically, CACTX statistics show that for primary clients referred, the majority were referred for alleged sexual abuse only (69.48%), with another 10.97% referred for physical abuse only, and 1.79% referred for both sexual and physical abuse (CACTX, 2012).

**Demographics of child abuse victims.** In Texas, most child victims of any form of maltreatment are between one and three years old (34%), a rate of 20.6 per 1,000 children in the population of the same age (TX DSHS, 2010). In 2011, approximately 60% of children in CPS cases of confirmed child maltreatment in Texas were six years old or under (TX DFPS, 2011). The high rates of abuse among young children reflects the fact that the majority of CPS cases are related to neglect, rather than the more overt forms of abuse (physical and sexual) experienced by children served at CACs. In addition, clients of Texas CACs have a different age distribution than those associated with CPS cases. Nearly half of the children served by CACs in FY 2012 were between the ages of six and 12 years (48.2%), approximately one-quarter were ages five or younger (26.3%), another quarter were between the ages of 13 and 17 years (25.1%), and the remaining 0.4% were 18 years or older.

Though Texas CPS reports a nearly even gender split of child maltreatment victims (TX DFPS, 2011), CACs tend to serve more females than males. Sixty-seven percent of CAC clients were female and only 33% were male (CACTX, 2012). The gender difference is likely due to a higher prevalence of reported sexual abuse of girls compared to boys and the fact that CACs serve a higher proportion of sexual abuse victims.
In addition, the racial demographics of the clients served by CPS and CACs also differ. Of the children reported to TX DFPS for suspected child maltreatment, 31.4% were White, 16.5% were African American, and 46.1% identified ethnically as Hispanic (TX DSHS, 2010). Texas CAC data more closely matched U. S. Census estimates. Of those children served by CACs, 40.1% were Hispanic, 39% were Caucasian, 14.3% were African American, 5.3% were multi-racial and 1.3% were Asian, Native American, other or an unknown ethnicity (CACTX, 2012).

**MEDICAL EVALUATIONS IN CHILD ABUSE CASES**

One function of CACs and their respective MDTs is to determine the need for and facilitate medical evaluations for alleged victims of child abuse. Medical evaluations are often considered a best practice in cases of child physical abuse and neglect, and especially in cases of child sexual abuse. In fact, the National Children’s Alliance (NCA) (2011) formally recommends as best practice that all children who are suspected victims of any form of child abuse be assessed to determine the need for a medical evaluation, and that all children involved in sexual assault cases receive medical evaluations. It also recommends that medical evaluations should be required based on specific screening criteria developed by skilled medical providers or by local multidisciplinary teams that include qualified medical representation (National Children’s Alliance, NCA, 2011). To facilitate peer review, continuous quality improvement and consultation, NCA guidelines promote photographic documentation of evaluation findings as the standard of care. Photo-documentation may also obviate the need for a repeat evaluation of the child. This section addresses the importance of medical evaluations, rates of medical evaluations in alleged child abuse cases, resources for medical evaluation and challenges to obtaining medical evaluations.

**Importance of medical evaluations.** Medical evaluations are a critical piece of both the therapeutic and criminal justice responses to alleged child abuse. A medical evaluation assesses the child’s emotional and physical health, while also providing crucial forensic findings to support prosecution of the alleged offender. Specifically, the purpose of these evaluations is “to identify injuries that require treatment, to screen for or to diagnose sexually transmitted infections, to evaluate and if possible to reduce the risk of pregnancy, and to document findings of potential forensic value” (Atabaki & Paradise, 1999, p. 178).

**Medical importance.** Obtaining medical evaluations in alleged child abuse cases serves an important medical role by ensuring the overall health and safety of the child. During an evaluation, a trained physician or medical professional has the ability to check, treat, and document injuries that are not readily apparent (Pence & Wilson, 1992), while also providing answers and reassurance about the child’s health, bodily integrity and other concerns (Adams et al., 2007). Additionally, the medical professional has the ability to “assist in the assessment of the match between the injuries noted and the explanation offered” (Pence & Wilson, 1992, pg. 19).
Although further research is needed to verify the impact of professionals with specialized training conducting child abuse medical evaluations (Jones, Cross, Walsh, & Simone, 2005), the research to date suggests that professionals trained in conducting child abuse evaluations provide valuable medical services for children and their families. For example, Crandall and Herlitzer (2003) found that when a Sexual Abuse Nurse Examiner (SANE) participated in the services a victim received at a hospital, the victims received more comprehensive care that included treatment for sexually transmitted diseases (STDs), pregnancy testing and referrals to victim services. Similarly, research shows that for sexual abuse cases in pediatric emergency departments, SANEs increased prophylaxis treatment and the number of mental health referrals, and provided more documentation of the physical evaluation (Bechtel, Ryan, & Gallagher, 2008; Patterson, Campbell, & Townsend, 2006). A study by Ericksen, et al. (2002) found that SANEs were a therapeutic part of the medical evaluation, with victims feeling respected, safe, and reassured. Other studies suggest that SANEs may be effective in reducing posttraumatic stress symptoms (Little, 2001; Patterson et al., 2006). Increased feelings of comfort during a medical evaluation may increase the likelihood of sexual abuse victims disclosing additional information to a SANE. Finally, Sievers, Murphy, and Miller (2003) found that evaluations done by SANEs were completed with higher fidelity to protocols and more accuracy than those done by physicians and nurses not certified in child sexual abuse evaluations.

**Forensic importance.** Aside from the medical importance, evaluations serve a crucial forensic purpose as well. Research suggests that medical evaluations aid in the substantiation and prosecution of child abuse cases. Evidence from the medical evaluation may assist in determining the strength of the case and the severity of the offense (Besharov, 1987), and may also assist in CPS investigations of alleged child abuse (Anderst, Kellogg, & Jung, 2009). For example, Palusci, Cox, Cyrus, Heartwell, Vandervort, and Pott (1999) conducted a retrospective review of child sexual abuse cases to examine predictors of legal outcomes. The authors found that when a medical evaluation had positive physical findings the case was 2.5 times more likely to result in a prosecution with a guilty verdict.

One reason medical evaluations may assist in the prosecution and conviction of cases is the nature of children’s interactions with medical professionals. Children often disclose information to medical professionals because they see doctors and nurses as safe and trusted allies, and such disclosures can often provide vital information for prosecution of child abuse cases (NCA, 2011). The Federal Rules of Evidence Rule 803 stipulates that “statements made for medical diagnosis or treatment are not excluded by the rule against hearsay” (2012). Since the medical history is taken as a part of the medical evaluation, it may be protected under this exception and children’s disclosures to medical professionals may be able to be introduced at trial. Because medical evaluation findings can often be inconclusive, the history collected from the child by the medical provider is often the most important part of the overall evaluation (Adams et al, 2007; Heger, Ticson, Velasquez, & Bernier, 2002).

Without evaluations by practitioners who are trained in both forensics and empathetic forensic interviewing of children, convictions may be harder to obtain in sexual assault cases (National Network to End Domestic Violence, 2010). Though existing research on this topic is primarily
focused on adult victims, the research is generalizable to child abuse convictions. For example, Crandall and Herlitzer (2003) found that in cases in which victims were seen by SANEs and later pressed charges against their assailants, there were, on average, higher conviction rates and longer sentences compared to cases in which the victims were not seen by SANEs. In Wasarhaley, Simcic, and Golding et al.’s 2012 study of jury perceptions of medical professional testimony, the researchers found a higher rate of guilty verdicts when a SANE testified than when an RN testified. Mock jurors in the study attributed higher credibility to the SANE, and the jurors reported more positive perceptions of the victim when a SANE testified (Wasarhaley, Simcic, & Golding, 2012). Though it is not known whether medical evaluations in general impact conviction rates, these findings suggest that at least with adult victims, it is possible that a medical evaluation by a SANE may increase convictions. However, it is important to note that research regarding SANE programs with child victims is lacking and child cases are managed differently than adult cases.

Technological advances, including photo-documentation and telemedicine, increasingly enhance the value of forensic evidence collected during medical evaluations (Kellogg, 2001). Telemedicine is a cost effective, timely method of consultation and peer review, and is particularly useful in remote areas that lack experienced, trained medical providers (Kellogg, 2001). While photo-documentation for peer review and consultation is considered a standard of care (NCA, 2011), most of the literature on the role of these technologies in the field of child abuse evaluations is descriptive. While indicators point to improvements in the quality of the investigations, empirical evidence about the effects on outcomes is limited.

**Rates of medical evaluations.** In a review of court files, Campbell, Patterson, Dworkin and Diegel (2010) found that only 22 to 44% of child sexual abuse survivors receive medical evaluations. The Midwest Regional Children’s Advocacy Center (MRCAC) reports that nationally, 34% of alleged child abuse cases referred to non-profit CACs receive medical evaluations (2011). In comparison, CACTX reports that the rates of medical evaluations for Texas CACs are:

- Small/Rural CACs – 8%
- Mid-sized CACs – 14%
- Large/Urban CACs – 25%

These rates of medical evaluations in Texas are substantially lower than national rates, particularly in mid-sized and rural communities.

**Medical resources for child abuse evaluation.** Medical evaluations for alleged child abuse cases can occur in a variety of contexts (e.g., CACs, hospitals, emergency rooms, clinics, doctor’s offices) and can be performed by a range of medical professionals (e.g., nurses, physicians, or physician assistants). The following is a discussion of the roles of specialized nurses and CAC-MDTs, as well as the resources available through Texas state programs for child abuse medical evaluations.

**Specialized nurses.** To improve their evaluation of abuse cases, nurses may receive advanced, specialized training as either Sexual Assault Nurse Examiners (SANEs) or Forensic Nurse
Examiners (FNEs). The FNE title is a broader term referring to nurses in a wider range of forensic contexts. In some contexts, FNE does not refer to a certification, but to a job title for a nurse who works in a forensic context. However, various FNE certifications are available, each with somewhat different requirements. According to the International Association of Forensic Nurses (IAFN) (2006), the board certification offered for SANEs, “is different than state credentialing or earning a ‘certificate’ at the end of an educational course. Although board certification is not a requirement to practice in most areas, getting certified signifies that a nurse is committed to professionalism and has the expert knowledge necessary to meet the highest standards of forensic nursing.” To earn SANE certification, registered nurses must take a Sexual Assault Examiner Class comprised of 40 hours of classroom training, followed by an average of 40 hours of clinical training. IAFN has Educational Guidelines that recommend this training as a minimum starting point for SANEs (IAFN, 2006).

Although the SANE certification focuses on sexual abuse evaluations, it also requires substantial knowledge of physical abuse assessment. The SANE certification can be specific to only adults or only children, though in Texas most SANEs receive both certifications. Because puberty defines when a SANE evaluation is considered adult or pediatric, it is important to note that nurses need both certifications to provide SANE evaluations to both pre- and post-pubertal children. Physicians may complete a clinical subspecialty qualification in child abuse pediatrics (CAP), offered by the American Board of Pediatrics (n.d.). However, most medical professionals do not receive specialized training in child abuse evaluation and treatment.

**Children’s Advocacy Centers and the multidisciplinary team.** CACTX was founded in 1994 with a membership of 13 local centers. In fiscal year 2013, that membership had grown significantly to include 68 developing and established centers located in all types of communities ranging from large urban cities to small rural areas. CACTX describes the CAC’s mission as “(to) provide a safe, child-friendly environment where law enforcement, child protective services, prosecution, and medical and mental health professionals may share information and develop effective, coordinated strategies sensitive to the needs of each unique case and child. It is a core belief of all CACs that the best interests of the child and non-offending family members should be protected as the case proceeds through the investigation and prosecution stages and beyond.”

According to current CAC standards, the local MDTs are required to include CAC staff, law enforcement officers, prosecutors, and CPS investigators. New MDT standards for 2014 will also require inclusion of medical and mental health professionals, as well as victim advocates. Representatives from other organizations and disciplines may also serve on MDTs according to client and community needs. The MDT has two main goals: (1) to reduce trauma to the child by coordinating intervention while also allowing each MDT member to pursue their respective mandates; and (2) to improve forensic processes by gathering evidentiary information and improving investigation efficiency (Ells, 2000; Lindberg, Lindsell, & Shapiro, 2008; Wolfteich & Loggins, 2007).

The MDT model has numerous benefits in responding to alleged child abuse cases. These include: collaborative review of cases of alleged child abuse; less service fragmentation resulting in less
service duplication; and more successful resolution of cases (Lalayants & Epstein, 2005). Research
also suggests that the CAC approach leads to improved outcomes for children (Newman & Pendleton, 2005) and improved experiences of caregivers as they accompany their children though sexual abuse investigations (Jones, Cross, Walsh, & Simone, 2007).

**State Programs in Texas.** To improve the medical response to child abuse, the Texas Legislature mandated the creation of the Medical Child Abuse Resources and Education System (MEDCARES), which, by way of the TX DSHS, provides grants to improve medical evaluations of child abuse. MEDCARES grantees are located in major children’s hospitals throughout the state that have been identified as centers of excellence in child abuse and neglect evaluation. These centers combine an array of integrated services that may be needed by a child victim, including specialized equipment needed for evaluations, on-site mental and behavioral health services (e.g., mental health services, domestic violence screening and referral, and substance abuse screening/ treatment referral), forensic photo-documentation, and sometimes even follow-up care. Medical professionals at MEDCARES sites have specialized training in child abuse evaluation and can provide consultation, case review, and other technical assistance to medical professionals around the state. They also provide training to other members of the MDTs such as law enforcement, prosecutors, and CPS caseworkers. Such trainings may cover a range of topics including how to identify and document abuse, reporting requirements, and the importance of medical evaluations (Texas DSHS, 2012).

Another resource to aid the medical evaluation of child abuse cases is the Forensic Assessment Center Network (FACN), which was developed by Texas DFPS and the University of Texas Health Science Center – Houston (UTHSC-Houston). FACN and MEDCARES collaborate closely, and the Child Abuse Resource and Education (CARE) Center at UTHSC-Houston serves as FACN’s hub. FACN was established in response to state legislation passed in 2005. According to its website, as of December 2008 FACN physicians had served 4,000 children from 158 counties. The network consists of physicians from six medical schools in Texas who are available to provide consultation and recommendations to CPS workers, nurses and administrators in cases of suspected abuse through a 24-hour toll free number and a web-based system. In addition to written consultations for reviewed cases, the program also provides in-person and remote training for CPS workers. To ensure coverage of underserved areas of the state, Texas’s 254 counties were grouped into regions, each designated to one of the six participating medical centers.

**Barriers to medical evaluations.** Multiple barriers may contribute to low rates of medical evaluations in Texas. Detailed below, such barriers include a lack of trained medical providers, a lack of positive findings, cost and administrative burden, a lack of understanding about the importance of medical evaluations, and in the broader context, a lack of statewide coordination of a medical evaluation program.

**Lack of trained medical providers.** Many communities in Texas lack sufficient medical care facilities and professionals. For example, the Texas Children’s Justice Act Task Force (2012) reports that in 2009, 74% of Texas’ 254 counties lacked a sufficient number of primary care doctors and 54% were without a pediatrician. In addition, Texas also has a significant lack of
medical professionals with specialized training in child abuse and sexual abuse evaluations (Busch-Armendariz & Vohra-Gupta, 2011). This is significant because although most medical professionals will encounter child abuse at some point in their careers, specialized training is needed to accurately assess and treat child abuse cases. Without specialized training it can be difficult to differentiate between normal and suspicious findings, and to know how best to assess and intervene with child victims (Kellogg, 2005). A 2009 study by Anderst et al. found that when evaluating the same cases, there were significant discrepancies between physicians with and without specialized training in child abuse pediatrics. Additionally, several studies have found that without specialized training, many doctors are unprepared to identify normal and abnormal genitalia (Dubow, Giardino, Christian, & Johnson, 2005; Lentsch & Johnson, 2000; Makoroff, Brauley, Brander, Myers, & Shapiro, 2002).

A related issue involves a lack of understanding about appropriate procedures for documenting medical evaluations among medical providers who complete them and the law enforcement officers, district attorneys, CPS workers, etc. who review them. The absence of standardized protocols, including standardized terminology for anatomic and clinical findings, assessment and conclusions may hinder the transfer of clear, concise information (Lahoti & Kellogg, 2001), thus minimizing the impact of medical evaluations. Because the medical record is a legal document, appropriate documentation is essential for the best legal outcome for the child. Although research on this topic is limited, two articles generated from a study on physician knowledge of child sexual abuse demonstrate how physicians’ lack of understanding of protocols for medical evaluations weakens the strength of the reporting. The first investigation found significant variations in physicians’ documentation of relevant historical and physical findings and gaps in clinical knowledge (Socolar, 1996). The second concluded that standardization of protocols in reporting and documentation would improve the accuracy, and thereby the strength of medical evaluations (Socolar, Raines, Chen-Mok, Runyan, Green, & Paterno, 1998). A number of states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence (NCA, 2011); however, similar state protocols for physical abuse and neglect cases appear to be lacking.

A number of studies have examined the importance of training not only for the quality of the evaluation, but also in building physicians’ willingness to handle child abuse cases. This research focuses heavily on the physicians’ comfort, experience and competence associated with child abuse evaluation. An investigation by Lane and Dubowitz (2009) analyzed survey data for 147 randomly selected American Academy of Pediatrics members to determine how frequently they performed child abuse evaluations and their level of access to consultations with child abuse pediatricians. They were also asked to rate their knowledge, comfort level and competence in managing these cases. Results revealed that respondents had very little experience with child abuse evaluation and reporting, and that they expressed a strong desire for increased expert consultation. While respondents often felt competent in conducting exams for suspected cases of child maltreatment, they expressed less competence in rendering definitive opinions and did not generally feel competent about testifying in court. A similar study by Heilser, Starling, Edwards & Paulson (2009) focused on child abuse training, comfort and knowledge among emergency medicine, family medicine and pediatric residents, finding major gaps in the residency
training in child abuse. A 25-item survey was distributed to 274 residents at two medical schools in Virginia and Texas. Results showed that family medicine residents performed significantly worse on both clinical and overall knowledge, and that knowledge of genital anatomy and comfort with sexual abuse evaluations was poor among all specialties. The authors concluded that improvements in and a more systematic approach to residency training in child abuse were requisite.

Another study that examined reluctance by physicians to engage in child abuse evaluations concluded that interventions that enhance interdisciplinary/interagency communication and training might facilitate higher physician involvement and improved accuracy in case reporting (Socolar & Reives, 2002). This was based on survey findings in which physicians identified time, scheduling and problems interacting with legal, judicial and social services systems as impediments to greater involvement in child abuse cases. Physicians also signaled that more medical information, training and follow-up about the disposition of cases would motivate them to engage more in child abuse medical evaluations.

Nurses may also conduct medical evaluations in child abuse cases. However, similarly to physicians, specialized training (e.g., SANE training) is needed to be able to perform these evaluations accurately. Due to a number of factors (e.g., funding, distance, training needs, etc.), it can be difficult to implement and maintain a SANE program, particularly in smaller communities. The cost and administrative burden of SANE programs is discussed further below.

For remote areas lacking trained clinicians, photo-documentation and telemedicine have created cost effective and time efficient avenues for consultation; however, implementation of telemedicine networks face various challenges associated with training medical staff (Kellogg, 2001). These include the need for ongoing training and technical support; secure, confidential storage and transmission of patient electronic records; ensuring patient consent; medical license reciprocity for interstate consultations; liability issues; and limited reimbursement for consultations.

**Cost and Administrative Burden.** Another possible barrier to the completion of medical evaluations relates to cost, legal protocol, and complex administrative procedures, especially reimbursement. For example, health care facilities must conduct a sexual assault evaluation if the victim has not reported the assault to law enforcement and arrives at the facility within 96 hours of the assault. If, however, a child sexual abuse victim first reports the assault to law enforcement and it is within the 96-hour timeframe, law enforcement must still request an evaluation for child. Beyond the 96-hour time limit for sexual abuse cases, law enforcement has discretion about whether or not to request an evaluation. Additionally, for child victims of physical abuse, neglect, or failure to thrive, medical evaluations are not legally mandated.

The source most frequently discussed in relation to medical evaluations for child sexual abuse victims is Crime Victims Compensation (CVC), which is administered through the Office of the Attorney General. The Texas Legislature passed the Crime Victims Compensation Act in 1979 creating the CVC program (Abbott, 2011). CVC provides financial assistance to victims of crimes
to cover financial costs incurred due to their victimization. CVC is funded through multiple sources, including court fees paid by persons convicted of crimes, federal grants, restitution paid by offenders, donations and subrogation of civil awards paid to victims.

In Texas, CVC has clear payment policies in place for the costs of medical evaluations for child sexual assault cases. The sexual assault forensic (evidence collection) exam is billed directly to the local law enforcement agency; neither the hospital nor the victim is responsible for this portion of the costs (Office of the Attorney General of Texas, OAG TX, 2010). However, since medical assessment and treatment are not considered evidence collection, victims usually incur costs related to these procedures (OAG TX, 2010). Conversely, if eligible, the victim may be able to receive funds from the CVC program for reimbursement of the medical assessment and treatment related to the abuse if they do not have other resources to cover those expenses (OAG TX, 2010). Victims must also cooperate with law enforcement investigations in order to qualify for CVC. There are no such clear payment policies for child physical abuse or child neglect medical evaluations, though it may be possible for victims to recoup some costs through CVC, which may pay up to a total of $50,000 for approved benefits (OAG TX, 2009).

In order to receive reimbursement for sexual assault evaluations, law enforcement must first cover the cost of the evaluation as billed by the medical provider. Law enforcement then must complete a Sexual Assault Examination Reimbursement form. Submission of this form to the OAG must include all relevant bills and detailed charges related to the evaluations from the medical providers. CVC reimburses law enforcement for expenses related to sexual assault evaluations that are reasonable and do not exceed $700 (OAG TX, 2011). In 2011, CVC received almost 4,387 applications for child victims of sexual abuse. The average reimbursement rate for these evaluations was $474.

Although CVC reimburses for evaluations, there is evidence to suggest that even with reimbursement, the medical providers of these evaluations incur unpaid expenses. In conducting a needs assessment of sexual assault services in Texas, Busch-Armendariz and Vohra-Gupta (2011) found that hospitals often incurred unreimbursed expenses related to running SANE programs and SANEs not employed by hospitals incurred personal costs. For example, training re-certification and on-call time are estimated to cost $3,000 to $4,500 annually per SANE. Additionally, Busch-Armendariz and Vohra-Gupta’s findings (2011) suggest the real cost of a SANE exam ranges from $900 to $1200 in comparison to the $700 that is reimbursed by CVC (OAG TX, 2011). Thus, the financial security of SANE programs coupled with extensive training and re-certification requirements are a primary concern to the continuation of the SANE programs despite compensation from CVC (Maier, 2012).

Lack of understanding about medical evaluations. Lack of understanding among caregivers, law enforcement and MDT members about medical evaluation procedures can also pose barriers to child abuse victims receiving evaluations. For example, some adults might worry that a medical evaluation would be painful or compound trauma to a child. It is possible that some professionals assume medical evaluations are similar to “well woman” evaluations, which is not generally so. Most child abuse cases are non-acute and do not require internal genital evaluations (CACTX,
Waibel-Duncan (2001) found that the majority of parents or guardians reported a relatively high level of concern about the evaluation and its potential painfulness. Similarly, Scribano, Hornor, Rhoda, Curran, and Stevens (2010) examined anxiety levels among child/parent dyads where the child was receiving a medical evaluation due to alleged sexual abuse. These authors found that anxiety tended to decrease after the evaluation for both child and parent. This research suggests that medical evaluations may actually reduce anxiety for many children and their parents and that initial anxiety on behalf of professionals, parents and children can be alleviated by educating them on the process. A recent investigation (Rheingold, Danielson, Davidson, Self-Brown, & Resnick, 2012) examined the effect of a brief, cost-effective video intervention for child and caregiver distress related to the child sexual abuse medical evaluation. The developmentally appropriate, psychoeducational video designed to instruct children and caregivers about the evaluation procedures and coping strategies to be used during the evaluation was found to be well received by families. It helped to increase caregiver knowledge and decrease stress during the evaluation.

Another misunderstanding may relate to the necessity and value of non-acute evaluations. MDT members may think a medical evaluation is not needed if the abusive incident exceeds the 96-hour acute time period because the possibility of obtaining evidence, which was already minimal, is further reduced. This belief can be a significant barrier to obtaining evaluations, particularly in child sexual abuse cases, since reporting often happens long after the incident occurred. Studies by Kellogg and Huston (1995) and Kellogg and Menard (2003) suggest that most children do not disclose abuse within 96 hours and thus, most cases are non-acute. In their studies, the average time from an abusive incident to disclosure was 2.3 years. However, even in non-acute cases, medical evaluations may be indicated because such assessments assure that the child has been examined for infections and other injuries, and because the evaluation may collect other forensically important information from the child that may be admissible in court (Heger et al., 2002; Adams et al., 2007). Additionally, as discussed above, children and families may find medical evaluations affirming because they are reassured that their bodies are “normal” and healthy despite the abuse they have experienced (Adams, et al., 2007).

Lack of positive findings. Even when medical evaluations are completed, most are inconclusive for child sexual abuse and this lack of evidence may decrease motivation to request an evaluation. For example, Heger et al. (2002) found positive physical findings confirming abuse in only 4% of the 2,384 children referred for evaluation in their study. Further, when there is a delay in conducting the medical evaluation, rates of positive findings may decrease significantly (Johnson, 2009). Low rates of positive findings may be due to factors such as how quickly the body begins to heal and evidence being lost over time. For example, if a victim does not receive a medical evaluation within 96 hours of the assault (the time period required by Texas statute) evidence may disintegrate as the victim may bathe, change clothes, or in some other way unknowingly compromise evidence (Johnson, 2009; Texas Department of Criminal Justice, online; VAWOR, 2010). It is important to note that a lack of physical findings in no way indicates abuse did not occur. For example, Kellogg, Menard, & Santos (2004) found that most pregnant teenagers and most females with sexually-transmitted diseases have a normal exam despite the fact that vaginal penetration had obviously occurred.
Weak statewide systems for medical evaluation in child abuse. Academic research is limited on statewide systems for medical evaluations in child abuse cases; however, the few investigations focused on this topic demonstrate the benefits of having such systems in place, and expose the weaknesses associated with their absence. For example, an investigation of Missouri’s Sexual Assault Forensic Examination (SAFE) Network compared outcomes of children evaluated by SAFE Network providers with children seen with other providers (Kivlahan, Kruse & Furnell, 1992). It found that substantiation of child abuse neglect by CPS was higher among children seen by SAFE Network providers even in the absence of physical evidence. Investigators concluded the network had a more reliable standard of care in comparison to non-SAFE network providers, attributing the advantage to mandatory training, standard data form and protocol utilization, uniform reimbursement, and continuing education.

A related case study by Socolar et al. (2001) cites evidence that suggests that states without coordinated statewide medical programs have significantly lower substantiation rates of reported child abuse by CPS compared to similar states with statewide programs. The authors make the case that, although such programs are rare, coordinated statewide programs for the medical diagnosis of child abuse result in better outcomes. While further research is needed on the influence of statewide programs on child abuse outcomes, in light of the other barriers outlined in this report (lack of trained medical providers, lack of positive findings, cost and administrative burden, lack of understanding about medical evaluations), these studies make a compelling case that comprehensive statewide medical programs are uniquely positioned to address these limitations.

**STATE INVOLVEMENT IN PROMOTING BEST PRACTICE**

As described above, states play an important role in guiding the medical response in child abuse investigations. To be eligible for federal funding, states are required to comply with the requirements of certain federal programs; however, the primary responsibility for child welfare services rests with the states (Child Welfare Information Gateway, 2012). An examination by Kolbo and Strong (1997) of state participation in MDTs provides a valuable framework for assessing state-level involvement, which can be difficult to analyze because no two states’ structures and approaches are alike. Kolbo and Strong found that establishing state statutes to accomplish participation in MDTs was common. Statutes were used to mandate statewide participation, or at least to permit or encourage the development of teams and the sharing of information under specific conditions. Alternatives to the state statute approach could include voluntary, community-level recognition and/or departmental regulation or directive. Outside of legislation, states also developed manuals, handbooks or protocols to guide local MDTs in areas such as treatment, case oversight, and investigation, including guidelines for interviewing children and conducting forensic evaluations. Some states offered planning and provision of initial and ongoing training. In the absence of a statewide initiative for training, Kolbo and Strong found that MDTs took it upon themselves to provide training to one another, locally and informally.
Also in their study, Kolbo and Strong (1997) documented a dramatic expansion of state legislation mandating or permitting MDT use between 1987 and 1997. They attributed the growth to two major pieces of federal legislation, the Victims of Crime Act of 1984 and the Children’s Assistance Act of 1986, which authorized Children’s Justice Grants. These grants established state-level task forces, which helped lead the development of MDTs. Most were carried out on the local level, but in some cases, task force recommendations resulted in mandates to form statewide MDT programs.

Kolbo and Strong (1997) concluded that legislation legitimizes the work and roles of MDT members, shapes team composition, and, to a large extent, determines the activities taken on by MDTs. A 2005 survey conducted by Newman and Pendleton that queried law enforcement and CPS investigators about their use of CACs also found that state directives played a central role. Whether administrative or legislative, state mandates and protocols for multidisciplinary approaches were identified by CPS and law enforcement investigators as the primary reason for using CACs for investigations of suspected child abuse (Newman & Pendleton, 2005). Described below, three state initiatives in Oregon, Missouri and Pennsylvania highlight different ways that statewide programs are currently influencing medical response to child abuse.

**The State of Oregon.** The Oregon State Legislature allocated funds in 1997 to the Child Abuse Multidisciplinary Intervention (CAMI) Program to establish regional centers and expand community child abuse assessment services throughout the state (Reichert, Keltner, Reilly & Skinner, 2004). This legislation expanded Oregon’s child abuse assessment services in an effort to ensure that “every child reasonably suspected of having been physically or sexually abused has access to a skilled, complete, and therapeutic child abuse medical assessment.” As a result, efforts were strengthened to develop and support the operation of community-based child abuse intervention centers (CAICs). Since that time, CAICs have been created in most counties in Oregon. In addition, Oregon legislation includes the requirement that the District Attorney in each county is responsible for developing an MDT, which consists of both mandated and non-mandated members. The “Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents” (2005) also was developed in response to the 1997 legislation. Published by the State Office of Services to Children and Families, the 232 page document presents a comprehensive “user-friendly handbook of information, resources and references to guide medical providers in the evaluation of child sexual abuse.” First published in 1999, the most recent 2004 edition, maintains the mission statement of the original version, but was revised to reflect advancements in the field. The extensive document includes examples of standard forms for collecting the child’s history, scripts for addressing both children and caregivers before and during the medical exam, illustrations and diagrams of anatomy, detailed medical diagnosis information, information on the health care providers’ role in court proceedings, and more.

**The State of Missouri.** Missouri’s Sexual Assault Forensic Examination Child Abuse Resource and Education program, (SAFE-CARE) was established in 1989 and is administered by the state’s Department of Health and Senior Services (Missouri Department of Health and Senior Services, n.d.). The primary objective of the SAFE-CARE program is to provide comprehensive, state-of-
the-art medical evaluations to alleged child victims in their own communities. SAFE-CARE provides statewide training to physicians and nurse practitioners in the medical evaluation of alleged victims of child sexual abuse, physical abuse, and neglect. To enhance sustainability, these trained physicians and nurse practitioners provide community and professional education regarding child maltreatment on behalf of the SAFE-CARE Network. The program requires training for network providers and, in order to ensure peer review and consultation, each member must have a collaborating physician who is a SAFE-CARE provider. To assure appropriate peer consultation and review in the case of nurse practitioners, the collaborating physician must have at least as much SAFE-CARE training and experience as the nurse practitioners. As illustrated in Missouri’s Child Welfare Manual, the SAFE-CARE program also features standardized reporting forms and protocol for medical evaluation and treatment, as well as a standard procedure for reimbursement (Missouri Department of Health and Senior Services, 2013). State agency personnel are “strongly encouraged to use a SAFE-CARE Network provider, whenever possible, for sexual abuse, physical abuse or neglect evaluations;” however, they are not mandated to do so.

**The State of Pennsylvania.** In the wake of the Jerry Sandusky child sexual abuse case in 2011, Pennsylvania created the State Task Force on Child Protection that has since led a bipartisan proposal to overhaul that state’s child protection laws (Office of Senator Kim Ward, 2013). Included is Senate Bill 25, which improves the exchange of information among medical practitioners and county agencies (Pennsylvania General Assembly, 2013). It requires county agencies to provide medical practitioners 1) information regarding the abused child’s condition and well-being; 2) protective services records of the child and any other child in the household if it relates to the case; and 3) the identity of other licensed medical practitioners providing medical care to the child so that medical records can be shared. When an assessment, investigation or the provision of services is initiated by a county agency, that agency must notify the child's primary care provider and any other licensed medical practitioner who is providing ongoing care to the child. The information that is required to be exchanged includes 1) the purpose of the investigation or provision of protective services to the child, and 2) a service plan developed for the child and the child's family. Final passage of the bill is pending, and is will be determined by the close of the 2013-2014 session.
**Best Practice for Statewide Programs.** Little empirical research exists on statewide medical programs for child abuse; however, a case study by Socolar et al. (2001), which compared five case studies of established or fledgling state programs, found that coordinated state programs result in better outcomes. States included in the study were Kansas, Florida, Oklahoma, North Carolina and Louisiana. The study showed that while each state took a unique approach, those that were successful in establishing and maintaining comprehensive programs shared commonalities involving funding, services and training. The authors highlighted lessons learned
for initiating and sustaining effective statewide medical programs, which could be applied in any state (see Figure 3 on the previous page).

**NEED FOR ADDITIONAL RESEARCH**

Despite the numbers of child abuse victims annually, there are many gaps in research about the importance of and access to medical evaluations in child abuse cases. First and foremost, more empirical research is needed to demonstrate the importance of medical evaluations on outcomes for child abuse victims. Even with the low rates of positive findings with medical evaluations, experts in the field suggest these evaluations can be critical to the child’s emotional well-being and to substantiation and prosecution of alleged child abuse.

A second gap in the extant research literature relates to the completion of medical evaluations by medical professionals and how they are related to the outcomes for child abuse victims. Most research in this area is focused on the importance of using SANE nurses to conduct medical evaluations. More information about the effectiveness of specially trained pediatricians or other medical professionals is needed. While a number of studies have surveyed physicians and pediatricians about their level of engagement and competence with child abuse medical evaluations, empirical research on the outcomes of the child abuse cases they handle is lacking.

Additionally, there is little information about medical evaluations for child abuse victims of crimes other than sexual assault. The bulk of the literature focuses on sexual assault evaluations. Therefore, the importance and impact of evaluations for children who have experienced physical abuse and/or neglect is not explored. These forms of abuse do present with more obvious signs of abuse, but the impact of evaluations on the child’s emotional well-being and case prosecution may still be relevant.

There is little information available to understand the process by which some children receive evaluations and others do not. Therefore, identifying specific barriers to children receiving medical evaluations requires additional investigation.

Finally, there is limited up-to-date research on the effects of coordinated statewide medical programs for child abuse on outcomes pertaining to the welfare of children and families, the quality of investigations, and the rates of substantiation and prosecution. It is evident that a number of states are moving toward strengthening coordination of statewide programs, with CACs and MDTs playing a central role. Due to the lack of published research on the topic, however, assessment is currently limited to a state-by-state review of legislative statutes and procedures. More research is needed to synthesize these developments and determine which efforts result in positive outcomes (Jones et al., 2005).
The purpose of this study was twofold: (1) to examine current practices across Texas for obtaining medical evaluations in alleged child abuse cases; and (2) to explore strategies to improve access to medical evaluations. More specifically, the study sought to answer the following research questions:

1. What are current practices for obtaining child abuse medical evaluations across Texas?
2. How do these practices vary by community size and other community characteristics?
3. What factors increase or decrease the likelihood a child will receive a medical evaluation in an alleged child abuse case?
4. What can be done to improve practices for obtaining child abuse medical evaluations in Texas?

The research team used a mixed-methods approach to answer these research questions. The qualitative portion of the study consisted of focus groups and/or interviews of CAC multidisciplinary team members from 12 CAC areas in Texas. The quantitative portion consisted of an online survey distributed to all multidisciplinary team members in all Texas CACs.

**Qualitative Study**

**Sample.** The sample for the qualitative study was a purposive sample of multidisciplinary team members (MDT) from twelve CACs, chosen by CACTX to be representative by community size (small/rural, mid-sized, and large/urban) and rates of medical evaluations (higher or lower rates of medical evaluations). Rates of medical evaluations were based on the rates reported in the CACTX Quarterly Statistical Report (2011).

For each community size, CACTX staff chose the two CACs with the highest medical evaluation rates and the two CACs with the lowest medical evaluation rates for inclusion in the sample, resulting in a sample of twelve CACs. (Note: To reduce the potential for bias or preconceived ideas about each MDT, research team staff members were not informed of each community’s medical evaluation rates until after data collection was complete.) One of the selected sites elected not to participate, so CACTX staff selected an alternate community with similar characteristics. Once the sample was chosen, CACTX staff contacted the executive director of each CAC to explain the study and request their participation. The final sample of communities included: Abilene, Bonham, Cleburne, Dallas, Houston, Kerrville, Laredo, Livingston, Paris, San Antonio, San Marcos, and Sweetwater. Research team staff then worked with CAC staff to arrange site visits.

The researchers conducted a total of 60 in-depth focus groups and individual interviews. (Note: For ease of reading, “focus groups” will refer to both the groups and the individual interviews.) To begin the project, the research Principal Investigators (PIs) held two focus groups with representative CAC executive directors from around the state. Then, in each of the 12
communities, the researchers sought to conduct in-depth focus groups with representatives of the five core MDT membership organizations: CACs, law enforcement (LE), prosecutors, CPS, and medical. However, not all groups were held in all locations because in three cases, there was overlap in service providers between sample communities, resulting in shared prosecutors, medical personnel, or CPS units. To avoid redundancy, these shared providers were interviewed only once. Additionally, in one community, not all key CAC staff could attend the focus group, so an additional interview was done. The total number of focus group participants was 205. Groups had 1-15 participants with an average of 3-4 participants. Table 1 below shows the number of participants for each focus group.

Table 1: Number of focus group participants by community type and discipline.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Small/Rural</th>
<th>Mid-size</th>
<th>Large/Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Advocacy Center staff</td>
<td>17</td>
<td>18</td>
<td>9</td>
<td>63</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>31</td>
<td>10</td>
<td>7</td>
<td>48</td>
</tr>
<tr>
<td>Child Protective Services staff</td>
<td>33</td>
<td>15</td>
<td>7</td>
<td>55</td>
</tr>
<tr>
<td>Medical Providers</td>
<td>8</td>
<td>8</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Prosecutors</td>
<td>13</td>
<td>6</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Totals</td>
<td><strong>102</strong></td>
<td><strong>57</strong></td>
<td><strong>30</strong></td>
<td><strong>208</strong></td>
</tr>
</tbody>
</table>

**Procedures**

**Interview guide.** The research team developed an interview guide based on the review of relevant literature and input from CACTX staff, CAC executive directors, doctors specializing in child abuse evaluation, and other stakeholders. The interview guide was piloted and subsequently revised after completing two focus groups with CAC executive directors (see Appendix A). After the research team completed focus groups in five communities, further revisions were made in order to add more in-depth and discipline-specific questions.

**Data collection.** Focus groups were conducted between November 2012 and March 2013. Two research team members were present for each focus group, one to lead the group discussion and one to write field notes and provide backup. Whenever possible, one of the project’s PIs led the groups, though this was not always feasible due to scheduling and timeframe constraints. Prior to beginning focus group discussions, the research team explained the purpose of the study and obtained informed consent for both study participation and audio-taping. Most focus groups took approximately an hour, though timeframes ranged from about .75 - 1.5 hours.

**Transcription and coding.** All focus group audio-tapes were transcribed by an external contractor. Dedoose qualitative software was used for coding transcripts, maintaining a focus group descriptors file, and performing reliability and content analyses.
Research team members coded all transcripts for concepts relevant to the project’s research questions. A number of strategies were used to ensure team members were coding in a way that was both rigorous and reliable. First, prior to beginning coding, a project PI provided training on qualitative analysis and coding to all research assistants and project staff. Second, a reliability procedure was implemented that included the following steps:

1. The PI initially coded a transcript and then had an expert in qualitative analysis verify and/or critique the coding.
2. Each trained team member then coded part of the same transcript so that discrepancies in coding could be identified and addressed.
3. Once actual coding began, coders initially worked in teams to assure similar understandings of codes and how to apply them.
4. The PI reviewed each coding team’s work and provided feedback when necessary. After each team had coded at least one transcript together, coders began to work independently and the PI continued to monitor code application.
5. After the team had coded all transcripts, someone other than the original coder reviewed, verified, and, if necessary, supplemented the coding.

Data analysis. Analysis of the transcripts began with a group “brainstorming” session. This session included nearly all the research team members who had either conducted interviews or participated in coding transcripts. Through this discussion, the team was able to identify overarching, preliminary trends in the data. Next, several members of the team each analyzed the data for a particular MDT group (CAC, LE, prosecutors, CPS, or medical) and compiled this information in a spreadsheet format. Finally, a project PI read through all of the transcripts and, using all of the above resources (transcripts, group discussion results, spreadsheets, etc.), began to conduct the final analysis by checking all provisional findings against original text. As a final check on researcher subjectivity, other research team members conducted detailed reviews of the results to ensure consensus. This analysis process resulted in the findings presented in this paper.

**Quantitative study**

Information from the qualitative study was used to inform a quantitative study designed to verify themes found from focus groups and hone in on the most important issues raised in focus groups.

**Sample.** The sample for the quantitative study included all MDT members in Texas. However, there was no sampling frame for this study because a comprehensive list identifying all MDT members in Texas does not exist. Thus, a convenience sample was obtained by soliciting assistance from each of the 66 CACs throughout the state.
Data collection. As stated above, the researchers developed an online survey based on findings from the qualitative study. This survey had three main parts. The first part gathered data about the respondents and their professional backgrounds. The second part addressed the study’s primary research questions and delved deeper into issues and potential solutions suggested in the qualitative study. Questions asked respondents for information about where and by whom medical evaluations were conducted in the community, the barriers to obtaining medical evaluations, and ways the rates of medical evaluations could be improved. The final part of the survey asked for general information related to MDT functioning, since MDT functioning and relationships among MDT members were noted in the qualitative component as issues limiting the use of medical evaluations. The survey was developed with consultation from CACTX and research team members who coded and conducted focus groups.

The survey was administered online via Qualtrics. CACTX sent an introductory email and link to the survey to each of its 66 centers. CAC directors were asked to forward the survey to all their MDT members. Participants were given two weeks to respond to the survey and in an effort increase response rates, were sent multiple reminders from CACTX. In order to encourage participation, CACs were entered into a raffle for each MDT member who completed the survey from their MDT. One CAC was chosen from each of the community size categories (small/rural, mid-sized and large/urban) to receive a $400 gift card to Target or Walmart.

Data analysis. Quantitative data were descriptively analyzed using SPSS. Tables, charts and graphs were developed utilizing the data.

Human subjects protections.
Prior to beginning data collection, the researchers received approval of the study protocol by The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects (UT IRB # 2012-11-0003). IRB oversight of the project continued through study completion and reporting. Using forms and processes approved by the IRB, informed consent was obtained from all participants both to participate in the study and to have the focus groups audio-taped. All research team members had current human subjects training certification and the study complied with relevant institutional standards and applicable laws for the protection of human research subjects, including HIPAA and HHS regulation 45 CFR part 46. Participants were promised confidentiality; therefore, all results from the study are presented in aggregate only.
FOCUS GROUP FINDINGS

Findings from the focus groups are presented in three main topic areas: current practices for obtaining child abuse medical evaluations in Texas, factors impacting medical evaluation in Texas, and multi-disciplinary team (MDT) functioning and needs. Each topic area is discussed in detail below.

CURRENT PRACTICES FOR OBTAINING CHILD ABUSE MEDICAL EVALUATIONS IN TEXAS

The general CAC model. Children with alleged or suspected abuse can enter the CAC/MDT service system if a CPS and/or law enforcement case has been opened. Generally, cases referred to the CAC/MDT have the potential to become criminal cases, necessitating law enforcement involvement. Additionally, if a family member or other caretaker is the alleged perpetrator, CPS will also be involved early in the case investigation. When a case is reported to CPS, CPS staff members assign a priority level that determines how quickly CPS must begin investigating the allegation. Though some MDTs in the study reported more disjointed case coordination, most MDTs who participated in the qualitative study reported some method of coordinating case investigation from the outset. Usually this occurs when the organization receiving the initial report contacts the local CAC to facilitate joint investigation of the allegation. This joint investigation may include forensic interviewing, evidence collection, documentation of any injuries, witness interviews, and medical evaluations.

After an allegation enters the CAC system, the CAC coordinates regular case reviews with all MDT members to assure the smoothest case processing possible. Once CPS investigation is complete, CPS staff members either close the case, open the case for services, or remove the child from the home. When law enforcement completes its investigations, the cases are presented to the local prosecutor, who then either charges the suspect or refuses the case. The degree to which other MDT members participate in either CPS or law enforcement investigations varied considerably across communities, with more participation noted in highly-cohesive MDTs.

General medical evaluation procedures. MDT procedures for obtaining medical evaluations had some commonalities across communities, but there were also significant differences noted. Findings about procedures included:

1. When a child needs urgent medical attention, the agency receiving the initial outcry prioritizes medical care prior to contacting others in the MDT.

2. When a medical evaluation is requested for a child who has been sexually abused, most often that evaluation is conducted by either a nurse with specialized training or possibly by a doctor with specialization in child abuse, if the community is close to a Medical Child Abuse Resources and Education System (MEDCARES) site.

3. Law enforcement pays for medical evaluations in sexual abuse cases and is then compensated by CVC. Other MDT organizations can request sexual abuse medical evaluations, but can only receive CVC compensation by way of law enforcement. Physical
abuse and neglect medical evaluations are not routinely compensated by CVC, though families may be eligible to apply for CVC funds in some cases.

4. Many law enforcement officers who participated in the study stated that they referred only acute sexual abuse cases for medical evaluation. Chronic sexual abuse cases were much more likely to be referred to pediatricians for medical services, though some law enforcement saw benefit to referring chronic cases for SANE exams also. *(Note: Acute cases are those in which the alleged abuse occurred within 96 hours of the report. Chronic cases are those that occurred more than 96 hours after the report of alleged abuse.)*

5. Physical abuse and neglect medical evaluations were often handled differently based on community factors such as proximity to a MEDCARES site. Communities closer to MEDCARES sites had readier access to medical professionals with the expertise to conduct evaluations of alleged physical abuse and neglect. Conversely, in communities further from MEDCARES sites, pediatricians (non-acute) or emergency room (ER) physicians (acute) were more likely to complete medical evaluations of physical abuse or neglect. Since pediatricians and ER physicians rarely have specialized training in both forensics and child abuse assessment and treatment, evaluations by these physicians may result in less accurate conclusions about whether child abuse occurred.

6. Finally, in most communities medical evaluation results were shared with MDT members in case review meetings and other forums.

**Medical providers conducting evaluations.** Medical professionals completing evaluations of alleged child abuse may or may not have specialized training or certification in assessing and treating child abuse. Of those professionals with specialized training and certification, the most common are Sexual Assault Nurse Examiners (SANEs) and Child Abuse Pediatricians (CAPs). SANEs are nurses with specialized training in assessing and treating sexual assault. Registered nurses can earn SANE certifications for adult (CA-SANE or SANE-A) or child (CP-SANE or SANE-P) evaluations, or both (CACP-SANE or SANE-A). SANEs can be certified either by the Texas Office of the Attorney General (TXOAG) or by the International Association of Forensic Nurses (IAFN). CAPs are physicians with a sub-specialty in child abuse assessment and treatment, granted through the American Academy of Pediatrics.

Some study participants also held other specialized certifications such as Certified Forensic Nurse (CFN) or Certified Medical Investigator (CMI), but these certifications were less common. In addition to certifications, some medical professionals in the study used job titles referencing their work with victims of violence. Such titles included Forensic Nurse Examiner (FNE) for nurses and Sexual Assault Forensic Examiner (SAFE) for doctors or physicians assistants. Professionals who use these titles may or may not have specialized training and certification in child abuse evaluation.

Finally, Emergency Room (ER) staff or pediatricians evaluate some allegations of abuse, particularly physical abuse and neglect. Generally, these professionals do not have specialized training child abuse and study participants reported that these professionals were often reluctant to participate in either law enforcement or CPS investigations, or in any court proceedings. This
greatly limited the utility of these evaluations to the MDT. Study participants also frequently noted concerns about these professionals’ abilities to accurately assess whether child abuse occurred, a concern that is supported by existing empirical studies (Andrest, Kellogg, & Jung, 2009; Dubow et al., 2005; Kellogg, 2005; Lentsch & Johnson, 2000; Makoroff et al., 2002).

Three factors predicted what type of medical professional will most likely conduct the evaluation: type of abuse, time since the alleged abuse incident, and proximity to a MEDCARES site. In sexual abuse cases, particularly if the incident was recent, SANEs most often conducted medical evaluations in small/rural and mid-sized communities, although access was a problem for certain communities. In large/urban areas, both SANEs and CAPs conducted medical evaluations. Most SANE and CAP evaluations were conducted in a hospital or clinic setting, though some CACs have medical evaluation rooms set up specifically for child sexual assault evaluations. ER physicians and pediatricians generally conducted physical abuse and neglect evaluations unless the community had access to specialized physical abuse and neglect services (e.g., through a MEDCARES site) or the child’s injuries were severe enough to warrant transport to a site with specialized services.

Some Texas communities, particularly more rural communities, lack sufficient medical services, including access to medical professionals with specialized training in child abuse. This could pose a significant barrier to obtaining medical evaluations. In these communities, MDT members tended to weigh the need for an evaluation based on potential benefits (forensic, medical, emotional, etc.) and costs (e.g., resources, personnel, transportation, funding, time), and this calculus tended to be based on the type of abuse and its severity.

**Payment for medical evaluations.** Payment for medical evaluations differed depending on the type of abuse. In acute sexual abuse cases, law enforcement typically paid for the forensic medical evaluation and was later reimbursed through the CVC program. However, sexual abuse cases reported after the 96-hour timeframe were often referred to pediatricians for medical services and were more likely to be billed directly to insurance. Physical abuse and neglect cases are not routinely covered by the CVC and are also more likely to be billed to insurance. In all instances where insurance is billed, families can seek compensation through CVC.

The CVC compensates up to $700 for sexual assault evaluations, an amount that has held steady since 1999 despite rising healthcare costs. Often the medical provider’s bill for the evaluation may exceed the CVC compensation amount significantly. In these cases, either the law enforcement agency requesting the evaluation or the medical provider has to absorb the excess costs. Because of this situation and because there is no standardization of medical evaluation fees across the state, a few study participants suggested that sometimes law enforcement may “SANE shop” to try to get the lowest fees possible. Occasionally this may create other difficulties such as longer wait times for victims when the cheapest services are not the closest.

Another issue in CVC compensation for forensic sexual abuse evaluations is that law enforcement must pay for the evaluation up-front and wait to be compensated at a later time. Most law enforcement study participants did not have direct knowledge of this process, but those who did
noted some concerns. First, some officers stated that it could be burdensome for smaller law enforcement departments to carry the costs of evaluations on their budgets while waiting for compensation. Other officers noted that while payment for the evaluations came out of the department’s budget, compensation often was made into a city or county general fund and may or may not be put back into the law enforcement budget.

**Forensic Assessment Center Network (FACN).** In communities without ready access to a MEDCARES site, the FACN often provides consultation services to CPS workers. The FACN is a group of physicians from six Texas medical schools who have specialized training in child abuse and who provide consultation and recommendations to CPS workers about child abuse assessment and treatment. CPS in some study communities accessed FACN services quite frequently, while CPS units in other communities reported rarely using the service. Those who used the service generally found it very useful. As one respondent stated:

“[FACN is] quality. They’re well-known, very respected, renowned doctors in the child abuse field. ...they can tell you. We get reports where it says, ‘This is child abuse.’ They even will go as far as [saying] we recommend this child be removed from the home or from the family. [The feedback] gets detailed.”

**FACTORS IMPACTING MEDICAL EVALUATION IN AN ALLEGED CHILD ABUSE CASE**

Focus group data showed that a wide range of factors impact both medical evaluation protocols and the likelihood a child will receive a medical evaluation in an alleged child abuse case. These data can be roughly grouped into factors related to the outcry, child, or family; the community; and the dynamics of the MDT and its members. Each of these is discussed in detail below.

**Factors related to the outcry, the child, or family.** Characteristics of the outcry, the alleged victim, or the family often impacted if and how a child would receive a medical evaluation. The organization receiving the initial outcry and characteristics of the reported incident, including abuse type, severity, time since the incident, and context of abuse all were factors. Each is discussed in more detail below.

**Organization receiving the initial outcry.** Any MDT member organization might be the first to whom abuse is reported and sometimes this led to differences in how cases were initially processed. For example, when a child with alleged abuse was brought to a hospital, medical services were usually provided first. However, if LE or CPS brought the child to the CAC, the forensic interview might take precedence over the medical evaluation unless there was a pressing medical need.

**Abuse type.** The type of abuse was strongly predictive of variations in medical evaluation protocols because, as stated above, CVC will compensate law enforcement for evaluations of reported sexual abuse/assault, but not for evaluations of physical abuse or neglect. Therefore, law enforcement seemed to coordinate obtaining medical evaluations for sexual abuse cases in most communities, often with assistance from the CAC or other MDT members. However, with
physical abuse and neglect cases, the organization that received the initial outcry often coordinated obtaining the medical evaluation.

**Abuse severity.** The severity of the alleged abuse predicted the likelihood that a medical evaluation would be obtained. The cases most likely to be referred for medical evaluation were the more severe physical abuse or neglect cases and those acute sexual abuse cases with an outcry of penetration. Forensic medical evaluations were rarely obtained for physical abuse and neglect cases, as most of these cases were seen in an emergency department or physician’s office. A few MDTs referred most sexual abuse cases for medical evaluation, usually because the MDT members in those communities believed that medical evaluations could provide more information for case investigation and/or provide other supports to the victim (i.e., reassurance that their bodies were okay). In one community, the prosecutors reported that they requested medical evaluations in every sexual abuse case because even if there were no physical findings, many victims “cycled” back through the system and the first evaluation provided a “baseline” against which future findings could be compared.

**Time since incident.** Whether the abuse had occurred recently or in the past (what participants commonly referred to as acute or chronic) was strongly predictive of whether a medical evaluation would be requested. Most law enforcement agencies had a period of time after the incident during which they were more likely to request an evaluation. For sexual abuse cases, these time periods were generally based on Texas statute guidelines, which state that hospitals must provide a medical evaluation for sexual abuse cases reported within 96 hours of the incident. However, many law enforcement officers were not aware of current guidelines and as a result, were using 72, 48, or even 24 hour time periods as their cutoff points for requesting an evaluation. For physical abuse cases, victims with acute injuries were much more likely to receive medical evaluations than victims who reported an incident in the more distant past.

**Victim and family characteristics.** Victim and family characteristics also impacted both medical evaluation protocols and the likelihood that an evaluation would be requested.

**Age.** Age impacted medical evaluation referrals in a number of ways. Pre-verbal children or those who are young might be more likely to be referred for evaluation because the evaluation might be able to find information that the child could not convey directly. For example, one CAC member said:

“If you’ve got a fairly young child, who has out cried to like penetration type stuff over a period of years that would be something where we definitely would probably get an exam if we could, no matter how long it’s been.”

However, some MDT members, particularly law enforcement, did not understand the scope of a medical evaluation and thought it would be similar to a well-woman exam. These individuals were often less likely to refer young children for a medical evaluation, assuming it would be particularly re-traumatizing for them. Age could also impact sexual abuse cases with older youth. Often, teens who were sexually active were much less likely to be referred for a medical
evaluation. In these cases, law enforcement investigators were hesitant to use resources to obtain an evaluation with likely ambiguous physical findings.

**Citizenship / Documentation.** Family or victim citizenship sometimes led to alterations in medical evaluation protocols. For example, if any family members are undocumented, victims may fear coming to the attention of authorities out of fear of deportation. Additionally, if victims or family members are undocumented, it is more difficult to transport them to medical services for several reasons. First, it is illegal for most MDT members to provide transportation to undocumented individuals within the U. S. Second, if the medical provider is on the other side of a border control station, the undocumented individual runs the risk of being identified as undocumented. As a result, in cases such as this, the MDT might utilize alternative medical services that are not as specialized to ensure medical care is received without placing the individual at risk of deportation.

**Insurance.** The Type of medical insurance or lack thereof may impact the likelihood of getting a medical evaluation, particularly in the case of physical abuse or neglect cases where private insurance is billed. For example, some providers will not accept Medicaid:

> “I’ll be honest, [doctor’s name] doesn’t wanna work with Medicaid, and no other doctors will do [these exams]. I’ve gotten it done once or twice with private insurance.”

**Custody conflicts.** When a parent involved in a custody conflict alleged abuse and there was no other evidence to support the allegation, MDT members reported they sometimes suspected the report was fallacious. In these instances, MDT members might be more reluctant to have the child medically evaluated.

**Siblings.** In some cases when one child in a family had alleged or substantiated abuse, MDT members might have wanted to obtain a medical evaluation of other siblings in the family.

**Victim and family preferences.** Medical evaluations are more likely to happen in cases where both the alleged victim and the family want the evaluation. Sometimes medical evaluations can be reassuring to victims by providing information about the impact of the abuse, reassuring them about their bodies, giving them a safe person to ask questions, and other such benefits. However, sometimes the alleged victim or family does not want to obtain a medical evaluation for the child. Typically in these cases, the MDT members would explain the process to the child and family in an attempt to allay fears. Should the child or family remain adamant about not wanting the evaluation, then most MDTs had policies not to force the issue. However, participants in one community reported that law enforcement would obtain evaluations if the parents wanted it, even if the victim adamantly did not. Another issue that might make victims and families reluctant to obtain evaluations was if the community was a very small one because this made privacy and confidentiality much harder to maintain. As one participant said, just sitting in triage waiting to get services could “out” a victim:

> “Well, even if they didn’t have to go through triage, if [they could use] ..... that office just like any of the other doctor’s offices. It’s down the hall by itself. It has its own entrance.
If they could go straight to that back entrance into the SANE suite instead of having to sit through triage-

**Community factors.** Community factors have significant impact on both formal and informal protocols for obtaining medical evaluations, as well as on the likelihood that alleged victims will receive medical evaluations. In most communities, at least some respondents stated some variation of “Anyone who needs a medical evaluation gets one.” Yet, significant differences were noted in criteria used to assess the need for medical evaluations. As one participant stated:

“You know, the reason that law enforcement in [name of community] might be reluctant to pursue medical examinations could very well be different than the same exact problem that you’d run into in [another community]. They do it for different reasons. You run into that, even though you might find the same thing occurs in three or four areas that you’re targeting to service. The reason that they do it may vary from place to place.”

Without an accepted operationalization of “need” and case-level research examining the match, it is not possible to assess whether those who need medical evaluations actually get them.

**Coordinating the MDT.** Coordination between MDT members can be complicated and community factors may exacerbate difficulties in coordination. For example, some rural CACs cover several counties and smaller towns over a wide geographic region. This results in MDT members needing to coordinate with many law enforcement agencies, prosecutors, and even CPS units. As one respondent said:

“Then there’s another issue we hit on earlier, about the [multiple] counties and the [numerous] different [law enforcement] agencies. It’s one thing if you’re dealing with a big city where you’ve got one [CPS] organization, and you’ve got two different law enforcement agencies. [Here if you get] one place that’s workable, you have to figure out ways to duplicate that workability in all these other areas with other groups. When you’re dealing with eclectic, diverse groups like we are, that’s a tough sell when you have to go from place to place.”

**Proximity to specialized services.** Unless they close to a MEDCARES facility, most communities found it difficult to obtain a medical evaluation from a trained forensic practitioner. These communities often reported having access to an insufficient number of providers, difficulties in accessing a facility to conduct the evaluation, and excessive time requirements to drive long distances to obtain services. As one respondent said, “We don’t do very many SANE exams. I think part of that might be because we’re an hour away [from where we can get those].” Having ready access to SANE services seemed to increase referral for medical evaluation.

Communities closer to MEDCARES facilities seemed to make more medical evaluation referrals. This is likely due to a number of factors, including: 1) Staff from the MEDCARES sites seem to be relatively committed to participating actively on their local MDTs and providing consultation to its members; 2) MEDCARES staff seem to have the knowledge and commitment to participate in the criminal justice process and this makes evaluations more useful to law enforcement, CPS, and
prosecutors; 3) MEDCARES sites have more staffing and resources, resulting in shorter wait times; 4) MEDCARES sites may have funding available to cover gaps in hospital bills and CVC compensation, saving law enforcement from having to cover the gap. One respondent explained how they lost the ability to easily gather forensic evidence when they lost their local SANE nurse:

“About a year ago, we had a nurse who, this is what she did. She didn’t have any other job. Actually, she was here probably every day, actually in the building, doing research, and networking and things like that. Whenever we would have a case that a child had severe bruising, they would just ask her, “Hey, do you mind taking pictures?” She’s here, the kid is here, and so she would. Now, since, of course, she now left, and has a real job now, whenever we have kids that have serious physical findings, I’m guessing they just refer them to their pediatrician or to a doctor, or, if it’s bad enough, go to Children’s Hospital.”

Having a trained medical professional with which to consult. MDTs that had stronger relationships with a child abuse pediatrician were more likely to seek medical consultation and seemed to make more referrals for medical evaluations. Generally, the strongest relationships between medical providers and the rest of the MDT occurred in communities where a physician or SANE nurse actively participated in the MDT. However, in at least one community that lacked a SANE or trained physician on their MDT, the FACN played this role. Even when the case was not necessarily a CPS case, CPS workers would serve as an intermediary between the agency with the case and the FACN physician to obtain advice.

Facility in which to conduct the evaluation: The MDT needs to have good relationship with a hospital or clinic where evaluations can be done. As one respondent stated:

“…. if we didn’t have [access to a MEDCARES site], I don’t know what we would do. [This local hospital] doesn’t wanna do it. [That local hospital] doesn’t wanna do it. Then the closest other children’s hospital is [far from here].”

However, hospitals or clinics may have several barriers to providing medical evaluations in child abuse cases. First, the facility may have increased liability from granting privileges to SANEs or CAPs. Second, the hospital may be reluctant to provide the infrastructure needed to conduct medical evaluations (e.g., dedicated space, expensive medical equipment such as colposcopes or SDFI cameras, etc.). Third, even when CVC compensates law enforcement for exams, CVC compensation rates are often less than the full cost of medical evaluations. As a result, the facility may have to absorb some of the costs for medical evaluations, which creates a difficult situation for them. Several communities were struggling with this issue and trying to find other ways to “compensate” hospitals. The one strategy that seemed somewhat effective and did not require excessive additional funds was to assure public recognition of the facility’s commitment to child victims. Some MDTs focused on getting good press for their local hospitals. Another community suggested that some sort of state-level recognition might support their local hospital in participating.
It is also worth noting that even when local hospitals support a SANE or related program, the MDT members and medical providers may “hospital shop,” choosing a hospital based on cost, access, attitudes towards victims, policy strictness, reporting policies, and other factors. For example, one SANE nurse reported:

“We do adults over there because in [the other community] the patient is charged for the morning-after pill on their insurance. A lot of the times it is students, so the information goes to parents’ insurance, and then they want to know why you were treated with these. Why are we getting this bill? Why didn’t our insurance get the bill for these drugs? It’s just more of a confidentiality thing, because in [this community] the hospital donates the medications.”

Another SANE nurse reported that she was uncomfortable with how loose confidentiality was in one hospital, so tended to refer her patients to another hospital:

“In [this community] their name is on our board in the ER. It says SANE next to it. You know, so everybody in there knows that we have a patient there for a SANE exam. It’s on the tracking board. ... In [this other community] I don’t even give them the patient’s name. They don’t even have an ER record. They just have—I give them date of birth, and social security number, and I give ‘em the law that’s gonna pay for the exam. They don’t have to be registered as an ER patient.”

Finally, when SANE nurses are so poorly compensated to begin with, it can be hard for them not to hospital shop based on which facility provides better support or compensation. For example:

“I get paid more on call for being in [that community], too. I mean, that’s not my biggest deciding factor, but I do get paid more for call pay [there], and I take more call there, and if I get a call from a detective here and I’m on call over there, then I’ll take the patient over there and do the exam.”

Because there is no set fee for SANE services and no standardized forms or procedures, MDT members may “SANE shop” for the provider who charges least or has the simplest reporting/procedures. For example, one community had no local SANE program, so law enforcement had to travel to other communities to obtain medical evaluations for children. However, evaluation fees varied wildly across those providers, so officers would often be told to take the victim to the hospital with the cheapest rates, rather than the one that was closest.

Recruiting and retaining SANEs. SANEs are the most common providers of sexual assault medical evaluations in Texas, yet recruiting and retaining SANEs can be both expensive and difficult. There is significant burden on SANEs for a number of reasons and all of these may impact retention. First, SANEs spend a lot of money out of pocket for training, recertification, travel, and even medical supplies. Some SANE study participants reported spending thousands of dollars on these costs. Second, SANE training and recertification both require clinical hours and these can be difficult to obtain in rural areas where there tend to be fewer reported sexual assault cases. Thus, SANEs have to travel to large/urban areas in hopes of meeting clinical requirements. Third, SANEs often have to juggle demanding on-call schedules and extra work hours. Many employers
will not allow SANEs to count the time spent doing medical evaluations, attending court, or attending MDT meetings as part of their regular work week. In fact, SANEs may even be penalized by their employers if they miss time from their regular jobs in order to attend court. Fourth, the fees paid to SANEs usually cover only the time spent on the exam, and do not cover time spent coordinating with the MDT or attending court. Finally, many SANEs may enter the field because they want to help victims, but may not anticipate the burden of gathering forensic evidence and attending court. As one respondent put it:

"Nurses are good at seeing patients. That's who they are. Court is a huge burden for many nurses. ... The emotional and psychological toll it takes has high burnout. No other field of nursing feels that weight of court. It requires a precision of practice. There is no margin for error. ... It's like being in a pressure cooker while under a microscope."

As a result of these many challenges, MDTs may need more focus on strategies to support SANEs. One CAC director explained her motivation to facilitate payment between the SANE and law enforcement, as follows:

“They send me the bills for the SANE nurse. I pay her immediately so we keep her happy; we only have one SANE nurse. Good Lord, we don’t want her upset. We keep her very—as happy as possible, and we pay her directly. Then I bill all of the law enforcement entities and get paid.”

Some effective strategies to support SANEs as reported by study participants included:

- Providing them a small stipend for transportation, liability insurance, attending court, attending MDT meetings, and obtaining training.
- Advocating with their employers so they get comp time for SANE hours worked.
- Advocating with local hospitals to ensure SANEs get hospital privileges.
- Providing a safe place for them to debrief their cases (e.g., with a social worker from the local victim advocacy organization).
- Providing social events for the SANEs to support self-care.
- Assuring they have a medical director who is both a good advocate for them and qualified to supervise forensic nurses.
- Sending SANEs to conferences where they can be with others doing similar work.

These are preliminary ideas only and further research should be done about how best to support SANEs, given resources available. Ideally, this might be done on the local level since different communities have varying resources to offer and each SANE may have different ideas about what they would find supportive.

Providing physical abuse and neglect medical evaluations: As discussed above, physical abuse and neglect cases are often treated either in an ER or through a primary care pediatrician. This results in several problems.
1. These physicians rarely have specialized training in child abuse and this can lead to inaccurate conclusions about whether abuse occurred.

2. The physicians rarely have training in gathering forensic evidence, so any evidence may be lost.

3. ERs are generally ill-equipped to follow-up with child abuse cases, meaning physically abused or neglected children may not get ongoing care.

4. ER physicians and pediatricians are usually reluctant to participate in the criminal justice process. This may be due to both lack of knowledge and lack of compensation for court attendance and other criminal justice activities.

Other resources needed to obtain medical evaluations: In addition to funding for medical evaluations, SANE programs, and the other needs addressed above, many MDT members mentioned a lack of other resources that could impact the likelihood of a child receiving a medical evaluation. Foremost among these were transportation and personnel, particularly in rural areas where distances to medical facilities may be substantial and travel time might be excessive. If the LE department is small, it can be quite difficult for them to free up an officer and a vehicle to provide transportation and stay through the evaluation so that the chain of evidence is maintained.

**Factors related to MDT members.** Characteristics of the MDT and its members often predicted the likelihood that a child would receive a medical evaluation. The primary factors in this category included: having an advocate for medical evaluations on the MDT, level of motivation to obtain medical evaluations, knowledge, and the relationships between MDT members.

**Advocate for medical evaluations on the MDT:** Ideally, all members of the MDT would see the value of medical evaluations and ensure that evaluations are obtained when needed. However, this is not always the case. The study found that when someone in a position of power pushes for more consistent medical evaluations, they are much more likely to occur. It did not seem to be as important who advocated for medical evaluations, only that someone in power did. In some communities, this person was a prosecutor, while in other communities, the person was a doctor, a sheriff, or a CAC executive director. When the local prosecutor advocated strongly for evaluations, it did seem to increase law enforcement investment in medical evaluations. Medical MDT members seemed to be most effective advocating for medical evaluations when they spent time building the relationships with other team members and when they were effective at explaining the need for medical evaluations, particularly with cases where the need for an evaluation was less obvious.

**Motivation:** Obtaining medical evaluations requires time, effort, and other resources, so MDT members need to be motivated to pursue them. Different MDT groups had different motivations to pursue medical evaluations.

For example, law enforcement was generally most interested in obtaining medical evaluations to help in case investigation and prosecution. Because positive findings are rare in an evaluation,
their motivation to obtain evaluations seemed to increase when they saw the evaluations providing other evidence, such as additional outcry details and/or medical histories that are an exception to the hearsay rule. One participant described old protocols for deciding which cases received medical evaluations:

“Protocol was, especially in the sexual assault cases, you got an exam. In the years past it was only if it was penetration, because there was a decision to be made by law enforcement, who's paying for those exams, which ones they were going to pay for and which not. The ones that were more probable to have evidence were the ones you focused on.”

Another law enforcement officer described why they now request medical evaluations in a wider range of situations:

“It's also not only just to check their innards. It's also for evidence cuz they [medical professionals] play a separate role with what they can testify to in court than we can. It's additional corroboration for evidence for us cuz if they make that same outcry to them, then that corroboration—their outcry is more credible. As well as [that] medical personnel can testify to things that we can't testify to in court, say things that we're not allowed to say.”

His colleague in the same community goes on to say:

“That's the biggest benefit for—obviously, for the safety of the kid to have medical personnel look at them. That's a huge benefit, but in terms of prosecuting someone, [the medical] team can get in there and ask the leading questions and then testify to a court and it's all admissible, whereas if we mess up and ask something leading in our forensic interview, then we're damaging the case. That's the biggest part there.”

In short, motivation to seek medical evaluations increased when doing so helped MDT members in their jobs.

**Knowledge.** Medical providers who have the knowledge to explain, evaluate, and document child abuse cases in a way that assists law enforcement, CPS, and prosecutors in case investigation and prosecution were able to help increase the effectiveness of the overall MDT in conducting medical evaluations, particularly when the medical professionals were willing to testify. Mentoring by a more seasoned medical MDT member can be invaluable in developing this skill set. Additionally, prosecutors may need to provide training to medical professionals on how to testify as an expert witness, present information in court, and manage difficult questions from the defense.

**What medical evaluation involves.** When MDT members were asked what would make them hesitate to get a medical evaluation, one of the most common answers was fear of re-victimizing the child. Some participants even talked about how the evaluations “violate” the child. This suggests a lack of knowledge about what actually does and does not happen during a medical evaluation. Such misunderstandings were fairly common among law enforcement, prosecutors,
and CPS workers, and occurred most often in communities without a strong medical presence on the MDT. Fears about the medical evaluation potentially re-victimizing children were often compounded by uncertainty about how to talk to victims and families about the medical evaluation and how to help the victims and families feel safe during the evaluation process.

Managing medical evidence at trial. Several aspects of presenting medical evaluations can pose difficulties for prosecutors. First, few medical evaluations result in positive physical findings and this needs to be explained to the jury. Medical professionals can help with this. As one law enforcement officer talked about cases of his that have been presented with no physical findings:

“A lot of times ... there’s no medical findings, but they can explain to the jury where there’s no medical findings, which is very good. I thought that was very beneficial for me, so I can only imagine as a jury how important that is, why there's no medical findings.”

Second, it is likely that children may tell the story of the abuse incident somewhat differently at different times and defense lawyers may try to suggest this is due to “not being able to keep their story straight.” So prosecutors need to explain how trauma and developmental stage may impact how children recount incidents of abuse. Third, not all medical providers can be certified as expert witnesses. Therefore, prosecutors need to be able to frame questions to them to avoid expert opinions, but still get in all relevant facts. Finally, many prosecutors talked about “the CSI effect,” including how television crime shows have shaped jury members’ ideas about how evidence is gathered, the amount of scientific resources that should be devoted to a case, how cases will proceed, how likely it is to have positive findings, etc. So prosecutors need to be able to address this issue effectively and explain discrepancies between television and the real case before the jury. On the other hand, several prosecutors also said that the CSI effect made them more likely to want a medical evaluation because juries expect that evaluations will be done and, when they are not, juries may see that as a significant gap in the case investigation.

The billing “black box.” Several study participants expressed confusion about CVC procedures. The system of paying for medical evaluations and getting compensated can be confusing in several ways:

1. CVC is unavailable for physical abuse and neglect cases, so few MDT members knew how to obtain medical services for those cases.

2. There is significant variation in compensation based on the particular hospital’s rates, the SANE’s or CAP’s rates, types of services provided, etc. This variation in rates made it difficult for MDT members to plan or budget for medical evaluations.

3. There is often disconnect between those who request the medical evaluation, those who handle the money and those who request services. One law enforcement officer told about getting “pressure from above” to limit the number of medical evaluations and not understanding this was because the department was paying significantly more for the evaluations than CVC compensates. Such a disconnect may be inevitable, particularly in larger systems, but it may limit the actions of those MDT members who do not have decision-making authority regarding medical evaluations.
Relationships between the MDT members. MDTs with stronger relationships between members seemed to be more effective at assessing the need for a medical evaluation and then obtaining one if needed. In these situations, several factors existed, including:

1. MDT members had good strategies for working through differences of opinion about when a medical evaluation was needed.
2. MDT members knew where to go to advocate for an evaluation.
3. Those MDT members who had decision-making authority about evaluations were open to input from others, including CPS or CAC staff who may be left out of this decision-making process.
4. MDT members shared the burden of getting evaluations completed (e.g., sometimes CPS would transport for LE when LE could not free up an officer).

When asked about how MDT functioning could pose barriers to obtaining medical evaluations, one CPS worker stated:

“It’s just hard to see it from our perspective, simply because we do work very well together. I know I can call the DA that’s sitting outside. We’ve brought cases to the DA here at the MDT, which is not something commonly that CPS actually does. It’s usually from criminal. But we’ve come forward where there’s criminal cases, but we feel like these need to be brought to the forefront, whatever, and we can bring 'em. That kind of relationship, it’s hard to build, I think, but once you have it, it makes a very, very big difference.”

MDT functioning and needs

MDT functioning and needs have a direct impact on how medical evaluations are obtained in a community. Thus, the study also asked a number of questions about the MDT itself. Out of these discussions, participants spent the most time discussing two overarching themes: 1) building a team/culture for collaboration; and 2) training needs.

Building a team/culture for collaboration. MDT member organizations have different organizational cultures and work contexts that can create significant challenges to building an effective collaboration. Study participants addressed a number of issues that directly impact the effectiveness and cohesiveness of the team. The primary themes addressed included: MDT leadership, getting everyone “to the table,” developing protocols and making sure all members understand them, developing communication networks, building respect and understanding between members, developing accountability, and having a strategy to address staff turnover.

CAC leadership. Several CAC staff members discussed the challenges of trying to coordinate the MDT while having no official administration over the other MDT members. Yet, despite this, many CACs were able to foster effective, well-functioning teams. Those CACs that struggle with building the collaboration could possibly benefit from mentoring relationships with a CAC in a similar type of community.
Getting everyone “to the table”. Fundamental to an effective MDT is the team’s willingness to participate in collaboration. Study participants identified the following tasks critical to this effort, which are discussed below:

- Building relationships between individuals across organizations,
- Building motivation to collaborate,
- Engaging the reluctant organization or individual,
- Addressing tension between organizations,
- Keeping the mission forefront, and
- In some cases, co-locating services.

Building relationships between individuals across organizations. MDT members need to work with each other regularly for the MDT to function as effectively as possible. Many study participants noted that monthly case review meetings are insufficient to create an efficient collaboration and that it is important for individual relationships to be developed across organizations. Several participants also noted that while the collaboration requires individual-level relationships across organizations, continued collaboration needs to also be supported by agency-level agreements so that when there is staff turnover, the collaboration does not falter. In short, although relationship-building is an individual-level process, effective collaboration requires that relationships between organizations not be dependent on particular individuals.

Building motivation to collaborate. MDT participation takes time and effort and thus requires a certain level of organizational and personal commitment. In some cases, though, this could put significant demands on MDT members. For example, in a small community with few personnel in a particular job, one participant reported that “an unreal level of commitment” was required to be as accessible as the MDT needed. However, there are also ways the MDT can actually reduce burdens on its members by sharing responsibility for tasks. For example, CAC and CPS staff often reported that they would transport alleged victims for medical evaluations even when law enforcement had requested the evaluation. Additionally, several participants noted that motivation to collaborate was often greatly increased as member organizations and individuals saw participation in the MDT process improving the response to victims, assisting with case investigation and prosecution, and achieving other important outcomes. For example, one CAC staff member talked about building the MDT in a community:

“You have to prove yourself and prove your value to them. When you’ve done that, then you get some real loyal support.”

Engaging the reluctant organization or person. Often MDTs encountered either an organization or person who was key to achieving MDT goals, but who was reluctant to fully participate or support MDT activities. Engaging these individuals can be difficult and CACs must find effective ways to involve all partners.
Addressing tension between organizations. Tension was often noted between various MDT member organizations, and this can impede MDT functioning. The most common source of tension was between LE and CPS. These two organizations both conduct investigations, but have very different investigation timeframes and levels of evidence required. Several participants noted that these differences often led to misunderstandings and that high turnover at each organization can compound difficulties in coordinating between the two organizations.

Some communities had found effective ways to meld the needs of the both LE and CPS. For example, in one community, CPS became aware that LE worried that if CPS interviewed the perpetrator first, this might alert the person that they were being investigated and lead to them fleeing or giving a biased account. In response, CPS set up a system where such interviews were done jointly with representatives from both organizations present. Another factor that seemed useful in addressing CPS/LE tension was that a fair number of CPS study participants were formerly with LE. These individuals often served as natural bridges between the two organizations. A final strategy some participants used to address CPS/LE tension was doing a great deal of cross-training. Once individuals understood the differences between organizational timelines, requirements, etc. and the reasons for such differences, the individuals often found the differences easier to respect.

Building a shared mission and keeping that mission forefront. Collaboration can be difficult and personalities can get in the way. Many participants made some statement about how keeping a focus on the MDT mission to help children often diffused tensions when they arose. For example, a CPS worker discussed how their MDT handled it when CPS saw a need for a medical evaluation and LE did not:

“That’s where your partners help out, because a lot of times it’ll be like, okay, maybe they don’t see it, but if we feel that it’s urgent or critical need, that’s where the team works together. You can definitely get things done. Obviously, it’s in the best interest of the children.”

Co-locating services. To facilitate collaboration, some MDTs had co-located some member organizations. In some cases, participants saw this as useful in that it often streamlined services and created tighter connections between organizations. However, other communities reported difficulties with this because it could diffuse appropriate boundaries between organizations.

The role of food. As something of an aside note, it was interesting how frequently food was mentioned as integral to effective collaboration. For example, one CPS unit reported the following about healing a strained relationship with law enforcement,

“CPS has to be consistent and flexible, but God, I guess the bottom line is that you really frigging have to work at [building the relationships]. I mean you really do. You have to know what your detective’s favorite flavor of ice cream is, or if chili cheese fries are his favorite thing to eat.”
Developing protocols and being sure everyone understands them: Participants frequently reported an evolution in MDT protocols as team members tried different approaches to determine what worked best. They also reported a need to regularly review protocols to ensure protocols match current needs, particularly for communities experiencing significant growth. Some participants suggested that it can be helpful for MDTs to have a mechanism to regularly review procedures to assess the match between protocols and the needs of the MDT and community.

Developing both formal and informal communication networks: Participants frequently discussed the evolution of MDT communication networks as both formal (as established by protocols) and informal. Participants often reported improved collaboration when communications did not always have to go through formal networks (e.g., the CPS hotline), and when members could informally brainstorm about cases, ask for help, get advice about how to proceed on a case. One participant described it as:

“Communication, talking to them. Know who they are. Present yourself. Build alliances, build teamwork in the field. It doesn't matter, if you only meet once a week, and that's the only time you're communicating—like if a detective and I work with CPS, and the only time I talk to him about the case is on Thursday, then there's no point. You gotta build that relationship. You gotta have phone numbers. You gotta call them. You gotta trust each other. They're gonna call you. You gotta do things. Obviously, nothing, I'm not talking about anything that's away from policy. I'm saying, you gotta scratch each other's back. ‘Regarding this, have you talked to them?’ ‘No.’ ‘Well, look, I'm gonna talk to them. Is that okay?’ ‘Yes.’ ‘Alright, well what I get, I'll give you the information.’ That kind of open communication. That's what I feel that we have here, and that's why I think we're successful. Again, are we perfect? Absolutely not. I think we're very successful, because people are able to talk. I have the DA's number and I've called her at two in the morning, and she doesn't get mad.”

Building respect and understanding between team members: This topic came up frequently in the focus groups. Participants offered a number of strategies that may help in developing respect and understanding between MDT members. Included in these were the overarching themes of:

1. Understanding the roles, limitations, restrictions, and job expectations specific to each job or organization.
2. Developing strategies to resolve conflicts and find solutions despite differing agendas.
3. Ensuring all members on the MDT participate actively, have a voice, and no one person or organization dominates the group.
4. Addressing, and hopefully minimizing, power differentials between organizations or individuals.

On the latter point, a couple of sub-themes emerged. One was that “power equals purse strings,” a topic which arose most often when discussing how LE generally controls requests for medical evaluations because LE is the only entity that can be compensated for them. In most cases, when
a CAC, CPS, or medical person thought an evaluation was needed, but law enforcement disagreed, the evaluation would not be done. For example, one CAC staff member said:

“Well, really it’s not our choice. It’s law enforcement’s decision, so even if we say, ‘Well, I think a medical exam would be a good idea, it’s up to them whether or not that happens.”

Another sub-theme arose around power differentials between LE and CPS in that some CPS workers reported feeling like they needed to do what LE told them to. One CPS worker explained how this complicated her doing her job:

“Yeah, we’ll call [law enforcement] if it’s a severe case or sexual abuse. They’ll tell us from the beginning, ‘Don’t interview anybody until we get involved, until we talk to everybody.’ We have to hold off. Then they’ll go and interview everybody and not tell us. Then we end up needing to get a disc of the interview. It’s just a lot of extra stuff that we could avoid if we just did it jointly.”

When MDT members felt like they had unequal power on the MDT, this sometimes seemed to cause other problems. Specifically, participants reported outcomes such as feeling less motivated to participate fully in the MDT process, feeling like they did not have the ability to truly advocate for victim needs, or believing they had to compromise their agency’s policies to facilitate or appease another organization.

Developing accountability: Several participants reported that it was critical to effective MDT functioning for members to hold each other accountable for doing their jobs as best as possible, but to do this in a way that was not, as one participant put it, “blaming or shaming.” At the same time, participants also focused on a need to approach problems with a case as opportunities for team problem-solving, rather than an individual organization’s problem.

Addressing turnover: Some organizations tend to have high turnover and/or movement of staff within the organization. High turnover rates were reported most commonly with CPS and with LE patrol officers. When coordination between MDT organizations was predicated on relationships between individuals in an organization, turnover in those positions could disrupt agency coordination. Thus, it is important for MDTs to avoid relationships between organizations being overly dependent on relationships between single individuals within those organizations. As one respondent put it:

“You gotta find, as they say, the pillars that are gonna be there. If you keep assigning new people all the time, you need to find at least two stable from each agency that are going to be there long-term, and they’ve shown the interest.”

Training needs. MDT members frequently discussed three main themes related to training: needs for topical training, need for cross-training, and challenges in obtaining training.

More training. Overall, MDT members wanted more training on a variety of topics. Participants from nearly all MDT groups, including some medical professionals without specialized training in child abuse, thought more training would be helpful. Requested topics included:
- Child abuse investigation.
- The medical evaluation process.
- Working with victims and their families.
- Crime Victims Compensation (CVC) processes and requirements.
- Cultural competence

Not only did participants identify a desire for advanced training, but they also often mentioned the need for ongoing basic training to address staff turnover and provide “refreshers” to existing team members.

A significant number of LE officers were not conversant with current standards for medical evaluations in sexual abuse cases. This was most apparent with the Texas statute “96-hour rule,” which states that if a victim presents to the hospital within 96 hours of the alleged incident, hospitals are required to provide an evaluation. Since many law enforcement entities use this statute to guide decision-making about whether to request an evaluation, it is important that they know the correct timeframe. Many officers thought the timeframe was shorter: 72, 48, or even 24 hours. Additionally, many officers thought an outcry of penetration was required for an evaluation.

**Cross-training.** Many study participants identified a need for MDT members to understand MDT organizations other than their own. This was seen as critical to effective collaboration across agencies. Specific topics mentioned as important included:

- Each organization’s mission, requirements, timeframes, limitations
- What a typical day looks like for an MDT member from that organization.
- Who to call and under which circumstances.

Participants discussed different models for such cross-training. Although comprehensive trainings might provide a more complete picture, such intensive training requires more funding and greater time commitments. Therefore, many participants saw this approach to cross-training to be less feasible than other approaches. Two other cross-training models seemed to work in several communities. The first of these was including short trainings as a portion of the regular MDT case review meetings in which each MDT organization presented something about their specialty or about what other organizations need to know to understand their work context. The second effective model was “ride-alongs” where individuals from one agency would follow an MDT member from another agency as that member went about their workday.

**Training challenges.** Although additional training was seen as very important, participants noted several challenges in implementing trainings. Larger trainings can be very hard to schedule given the multiple schedules that need to be coordinated. Further, it can be difficult to free up personnel from small departments or organizations to attend these trainings. For example, several participants referenced the CACTX yearly conference and many stated that they had not
ever been able to attend due to either scheduling difficulties or the need to provide coverage in their organization. Participants also frequently mentioned ongoing struggles in obtaining resources to pay for trainers, travel, etc.
SURVEY FINDINGS

In addition to the findings from the focus groups, responses from the online survey yielded valuable information about medical evaluations for child abuse victims. A total of 319 professionals from 47 MDTS completed the survey.

SURVEY PARTICIPANTS

Before discussing content related to medical evaluations, a description of survey participants is presented.

Professional background. As part of the survey, participants were asked to select their primary profession. At least one participant from each of the professions participating in MDTs was represented in the findings. Most of the participants (32%) were CAC staff. An additional 24% of participants were law enforcement professionals. The remaining groups of professionals had lower rates of participation: 16% were CPS workers, 10% were medical professionals, 6% were prosecutors and 3% were mental health professionals not on the CAC staff. An additional 9% of professionals identified as “other” and primarily noted that they were victims’ advocates or mental health professionals employed with a CAC. Figure 4 below categorizes the professions of participants.
Community type and profession. Participants identified their MDT, which was cross-referenced with a list provided by CACTX (see Appendix B) to classify their community type as small/rural, mid-size or large/urban. A fairly equal number of participants were from large/urban (42%) and mid-size (41%) areas. Only 17% of participants were from small/rural areas. The largest percentage of participants (16%) was CAC workers from large/urban areas. The second largest percentage of participants (12.5%) was law enforcement professionals from mid-size areas. Groups with some of the smallest percentages of participants include medical professionals from small/rural areas (1.3%) and mental health professionals from both small/rural and mid-size areas (0.6%). Figure 5 below shows the community types where participant’s MDTs are located.
**Length of time in profession.** Figure 6 below details the amount of time members of the MDT had been in their current position. In general, participants reported having multiple years of experience in their current position. Only 16.4% of participants reported having less than one year of experience and 28.8% of participants had one to three years of experience in their current positions. The majority of participants (54.8%) had four or more years of experience in their current positions. Based on Figure X below, medical providers had the most years of experience in their current positions as 69.7% of medical providers had eight or more years of experience. Mental health professionals not employed by the CAC also indicated substantial experience as 50% had eight or more years of experience. The remaining professionals had relatively similar distributions in terms of years of experience.
**Law enforcement characteristics.** If a participant indicated they were a law enforcement professional, they were asked additional questions specifically related to their position and agency. Of the 75 law enforcement professionals, 14.7% were from small/rural areas, 53.3% were from mid-sized communities and 32.0% were from large/urban areas. Figure 7 below details the various positions/titles of law enforcement professionals. Figure 8 on the following page details the types of law enforcement agencies of participants. The majority (65%) of law enforcement professionals were detectives. In terms of type of law enforcement agency, the majority (58.7%) were from city police departments while 36.0% were from Sheriff’s Departments. Only 1.3% of participants identified as being from constable’s offices and 4.0% identified as being from “other” agencies. Those from other agencies primarily noted they were from juvenile probation agencies. Of those responding, only 8% worked in agencies with a sexual assault unit and 13.3% had a specialized child abuse unit.
Fig. 8 // Type of law enforcement agency by community type

- **RURAL**
  - City Police Department: 63.6%
  - County Sheriff’s Department: 27.3%
  - County Constable Precinct: 9.1%
  - Other: 0%

- **MID SIZE**
  - City Police Department: 52.5%
  - County Sheriff’s Department: 40%
  - County Constable Precinct: 2.5%
  - Other: 5%

- **URBAN**
  - City Police Department: 66.7%
  - County Sheriff’s Department: 33.3%
  - County Constable Precinct: 0%
  - Other: 0%

- **TOTAL**
  - City Police Department: 58.7%
  - County Sheriff’s Department: 36%
  - County Constable Precinct: 4%
  - Other: 1.3%
Child welfare worker characteristics. The 51 professionals who indicated they were child welfare workers were asked additional questions regarding their positions within their agency. Of those, 47.1% were caseworkers, 29.4% were supervisors and 5.9% were program directors. One regional director also completed the survey. Of these professionals, 15.7% indicated they had “other” positions noting that they were investigators or program administrators. Child welfare workers were also asked if they worked within a specialized sexual abuse unit. Only 18.4% of workers were part of a specialized sexual abuse unit and according to Figure 9 below, most of these workers were in large/urban areas and none were in rural areas.

Fig. 9// CPS specialized sexual abuse unit by community type

- YES: 18%
- NO: 82%
Medical providers. Thirty-two medical professionals completed the survey. The majority of participants were nurses (56%) or doctors (25%). The remaining 19% indicated that they were nurse practitioners. Of the doctors, only 12.5% had a child abuse specialization. Figure 10 below indicates the primary practice setting by community type. The largest number of medical professionals (56.2%) was from large/urban areas. Most of the professionals indicated that their practice setting was “other,” which included a CAC or clinic based setting (21.9% in both mid-sized and large/urban areas). In terms of affiliation with a local hospital, 65.6% of medical professionals indicated they were affiliated with a hospital.
Medical professionals were also asked about MEDCARES. Approximately 31% indicated they were MEDCARES providers. Only 3.1% of medical providers said they consult with a MEDCARES provider while 65.7% said they do not consult with a MEDCARES provider. As seen in Figure 11 below, most of the MEDCARES providers worked in large/urban areas while only one MEDCARES provider indicated they worked in a rural area.

Fig. 11// Medical Professionals: Consultation with MEDCARES medical provider

RURAL (N=4)

MID-SIZE (N=10)

URBAN (N=18)

TOTAL (N=32)

- I am a MEDCARES provider.
- I consult with a MEDCARES provider.
- I do not consult with a MEDCARES provider.
Prosecutors. Prosecutors were the least represented group among survey participants. Of the 20 prosecutors who completed the survey, 50% were Assistant District Attorneys and 25% were Assistant County Attorneys. Figure 12 below indicates the breakdown of prosecutor positions. Half of the prosecutors were from mid-sized areas while 25% were from small/rural and large/urban areas. Only 20% of the prosecutors were part of a specialized child abuse unit.
**Child Advocacy Center staff.** Staff from CACs were the most represented group of participants. A total of 102 staff completed the survey. Half of the staff was from large/urban areas, 32.3% were from mid-sized areas, and 17.7% were in small/rural areas. Of the participating CAC staff, 27% were forensic interviewers and 20% were executive directors. Figure 13 below provides a detailed breakdown of CAC staff by agency position.
**MEDICAL EVALUATIONS: WHO CONDUCTS AND WHERE?**

The online survey was designed to gather information about how medical evaluations are being conducted across the state. Based on the qualitative data collected, there appeared to be varying procedures and protocols for evaluations. Survey findings confirmed some variation in how evaluations are conducted.

**Acute sexual abuse evaluations.** Figure 14 below details who conducts medical evaluations in different community types, while Figure 15 illustrates where evaluations occur. According to participants, regardless of community type, SANEs conduct most medical evaluations for child abuse victims whose abuse occurred within the previous 96 hours. Eighty-six percent of participants reported that SANE nurses perform these evaluations in their communities. Only a small percentage (6%) of acute evaluations are conducted by forensic nurse examiners (the more general title for nurses doing forensic work, who may or may not have SANE training), emergency room doctors (8%) or private doctors (4%). Doctors with a child abuse specialization conduct 10% of evaluations, but nearly all of these were in large/urban areas.
In large/urban areas, the majority of acute sexual abuse evaluations are conducted at local hospital while in small/rural areas, the majority these evaluations are conducted at hospitals in another community. In terms of evaluations conducted at CACs, large/urban areas appear to have the most capacity for conducting medical evaluations at their CACs.

**Non-acute sexual abuse evaluations.** In addition to acute sexual abuse evaluations, participants were asked questions regarding non-acute evaluations for sexual abuse victims. Figure 16 on the following page details who conducts medical evaluations in different community types while Figure 17 illustrates where exams occur. As with acute evaluations, medical evaluations for child abuse victims whose abuse occurred after 96 hours are primarily conducted by SANE nurses regardless of the community type; 69% of participants reported that SANE nurses perform non-acute evaluations in their communities. Unlike with acute evaluations, fewer non-acute evaluations in large/urban areas are conducted by SANES (54%) because doctors with child abuse specialization conduct 29% of these evaluations.
In urban areas, non-acute evaluations appear to primarily occur at CACs. Evaluations in suburban areas occur at local hospitals and evaluations in rural areas occur at hospitals in other communities.
Fig. 17 // Where are medical evaluations conducted after the 96-hour timeframe?
Physical abuse evaluations. Despite the fact that focus group participants discussed evaluations for physical abuse victims much less frequently, the online survey asked participants where physical abuse victims received evaluations. There was some variation among participants regarding who conducts evaluations, but the variation does not appear to differ greatly by community type. For instance, 49% of physical abuse evaluations are conducted by emergency room doctors. In small/rural areas, 63% of these evaluations are conducted by emergency room doctors while 41% are conducted by private doctors. Perhaps the most surprising finding was that 17% of respondents did not know who conducted physical abuse evaluations in their areas.

In terms of where these evaluations are conducted, the majority are conducted at local hospitals regardless of community type. Similar to the findings discussed above for sexual abuse evaluations, large/urban areas appear to have the most capacity to conduct evaluations at their CACs.
Fig. 19// Where are medical evaluations conducted for reported physical abuse?

- At our local hospital
- At a hospital in another community
- At our CAC
- At a private medical office
- Other
- Don’t know

RURAL
MID-SIZE
URBAN
MEDICAL EVALUATIONS & THE MDT

Additional questions were asked of participants to understand how their MDTs make decisions and process case information related to medical evaluations.

Medical evaluation protocols. Figure 20 below illustrates participant responses to questions related to medical evaluations. Participants were asked to read statements and rate their level of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree. For the purposes of presenting these findings, responses were collapsed into three categories: disagree, neutral and agree. Most participants responded that they agreed that their MDT has a written protocol for medical evaluations (71.7%) and that they understand the purpose of evaluations for physical abuse victims (75.3%) and sexual abuse victims (77.7%). However, just over half of the participants agreed that their MDT has a protocol that is followed by all members (54.9%).

Importance of medical evaluations. Figures 21 and 22 illustrate participant responses to questions about the importance of medical evaluations. Because focus group participants tended to discuss the importance of medical evaluations differently based on their professional background, several survey questions addressed the reasons MDT members think evaluations are important. Figure 21 below presents the top response categories by community type. This Figure shows that while small/rural and mid-sized areas frequently cited additional outcries as an important reason for medical evaluations, this was not so in large/urban areas.
Fig. 21// Medical Evaluations: Importance by community type

| RURAL | • Additional outcries or disclosures may be made by a child during the evaluation. (98.1%) |
|       | • Children get tested for sexually transmitted diseases. (94.2%) |
|       | • Children are reassured that their bodies are okay. (92.2%) |

| MID-SIZE | • Additional outcries or disclosures may be made by a child during the evaluation. (96.4%) |
|          | • Children get tested for sexually transmitted diseases. (94.6%) |
|          | • Evaluations assist with forensic evidence gathering. (96.4%) |
|          | • Information obtained during the evaluation is not considered hearsay in criminal proceedings. (94.6%) |

| URBAN   | • Evaluations assist with forensic evidence gathering. (97.2%) |
|         | • Children get tested for sexually transmitted diseases. (93.6%) |
|         | • Children are reassured that their bodies are okay. (97.2%) |
Fig. 22 // Medical evaluations: Importance

- Forensic evidence for case prosecution.
- Children get tested for sexually transmitted diseases.
- Female children get tested for pregnancy.
- Information obtained during the evaluation is not considered hearsay in criminal proceedings.
- Juries expect that there would be an evaluation done.
- Children are reassured that their bodies are okay.
- Additional outcry or disclosures may be made by a child during evaluation.
- Evaluations may improve children's mental health.
- Evaluations may reassure parents that their child is okay physically.
- Evaluations assist with forensic evidence gathering.
Collaboration regarding medical evaluations. Figure 23 below illustrates participant responses to questions related to how their MDT works together to obtain medical evaluations and make use of the data gathered. Most participants responded that medical evaluations make their jobs easier (81.8%) and that the information from medical evaluations is shared with the MDT members (86.0%). While most participants said they agreed with their team members about when an evaluation was necessary (77.6%), only 48.3% said that the MDT decides together who should get a medical evaluation.

Training regarding medical evaluations. Figure 24 on the following page illustrates participant responses to questions related to training and education regarding medical evaluations. Interestingly, most participants said they understood the purpose of a medical evaluation (87%); however, only 58.2% believed they could describe what happens during an evaluation. Furthermore, most participants (81.7%) felt their MDT would benefit from additional training and only 35.8% agreed that training on medical evaluations was available to all MDT members.
Barriers to Medical Evaluations

Because the primary purpose of this study is to understand factors contributing to the low rates of evaluations in the state, information from focus groups was used to develop questions to obtain information about barriers to medical evaluations. Participants were asked to read statements and rate their levels of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree.

Access to Medical Evaluations. Figure 25 below illustrates participant responses to questions related to medical evaluations and issues of access. Less than half of participants (47.2%) agreed that their community had a local hospital that provides infrastructure support for medical evaluations. Most participants agreed that transportation (66.2%) and appropriate medical equipment (68%) was available in their area. In general, 66.7% of participants agreed that children who needed medical evaluations were receiving them.
**Medical evaluation barriers.** Figures 26 and 27 illustrate participant responses to additional questions related to barriers to medical evaluations. Unlike results discussed above, these questions were negatively phrased as a reliability check on the positively-phrased questions. Figure 26 below summarizes the barriers highlighted by participants in differing community types. In all areas, lack of hospital support was one of the top three barriers as was law enforcement not authorizing medical evaluations. In small/rural areas, specifically, lack of qualified medical professionals was often noted as a barrier.
Fig. 26// Medical evaluation barriers: Top responses by community type

<table>
<thead>
<tr>
<th>Community Type</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>RURAL</td>
<td>The local hospital is not supportive of a SANE program (34.0%).</td>
</tr>
<tr>
<td></td>
<td>Qualified medical professionals are not available to provide evaluations (21.6%).</td>
</tr>
<tr>
<td></td>
<td>Law enforcement does not want to authorize an evaluation (20.0%).</td>
</tr>
<tr>
<td>MID-SIZE</td>
<td>The local hospital is not supportive of a SANE program (22.1%).</td>
</tr>
<tr>
<td></td>
<td>The local hospital is not supportive of child abuse programs (15.8%).</td>
</tr>
<tr>
<td></td>
<td>Law enforcement does not want to authorize an evaluation (14.2%).</td>
</tr>
<tr>
<td>URBAN</td>
<td>Law enforcement does not want to authorize an evaluation (15.2%).</td>
</tr>
<tr>
<td></td>
<td>The local hospital is not supportive of a SANE program (14.8%).</td>
</tr>
<tr>
<td></td>
<td>There are not funds to pay for evaluations (13.9%).</td>
</tr>
</tbody>
</table>
Fig. 27// Barriers to getting medical evaluations

- We do not have access to a confidential and appropriate location to conduct medical evaluations.
- The local hospital is not supportive of child abuse programs.
- The local hospital is not supportive of a SANE program.
- The prosecutor in this area does not support obtaining medical evaluations.
- Law enforcement does not want to authorize an evaluation.
- Families do not want evaluations.
- Victims do not want evaluations.
- There are not funds to pay for evaluations.
- Law enforcement cannot transport victims to evaluations.
- Qualified medical professionals are not available to provide evaluations.
**Improvements to medical evaluations.** Figure 28 summarizes participant responses to questions about ways to increase rates of medical evaluations. The most common responses appear to be related to payment structure and the top recommendation is that hospitals should not charge more than the reimbursement rate for evaluations. Additional recommendations are that hospitals should offer more support to SANE programs and communities should have more qualified providers to conduct evaluations. Finally, training is needed regarding medical evaluations.
**MDT COMPOSITION**

Survey participants were asked information about their MDT and their participation in the MDT. Of those participants who responded, the majority had been participating in their MDT for one or more years. Figure 29 below shows the amount of time survey participants had been participating in their MDT.

*Fig. 29// Length of time participating in the MDT by community type*

**Child abuse training.** Survey participants were also asked if they had received any training or education regarding child abuse issues prior to participating in their MDT. Overall, most participants indicated they had training and/or education in child abuse issues. However, only 60% of prosecutors indicated they had prior training on child abuse issues.
MDT Case Review Facilitation. Survey participants were asked who facilitated their MDT case reviews. The majority of participants (84.5%) responded that their CAC staff facilitated their case reviews. Some participants indicated that their MDT was facilitated by prosecutors (13.4%), law enforcement (5.2%), medical providers (1.0%) or CPS workers (3.3%). Participants could choose more than one option as a response to this question. Thus, percentages do not add up to 100% and suggest that MDTs may be co-facilitated by different professionals.

Law enforcement participation. All survey participants were asked to identify who participated in their MDT case review meetings. Table 2 below indicates law enforcement positions represented on the MDT by community type. In terms of law enforcement, detectives from either police or sheriff’s departments were the most represented professionals. Small/rural areas were more likely to have professionals in upper management positions participate in MDTs as indicated by higher participation by police chiefs, police chief deputies and Sheriffs in these areas. Representation from constable’s offices was rare across all community types. Some participants indicated other law enforcement agencies participated in their MDTs, such as school district police, district attorney investigators, juvenile probation officers, Texas Rangers, and Department of Public Safety officers.
**Participation by medical professionals.** Figure 30 below shows the percentage of respondents who noted that specific medical professionals participate in their MDTs. Across community types, SANEs were the group with the highest reported rates of participation on MDTs. A higher percentage of pediatricians participated in large/urban MDTs compared to mid-sized and small/rural areas. Participants who indicated that “other” medical professionals participated on their MDT noted that these professionals were pediatric nurse practitioners, hospital representatives and medical social workers.

![Medical professional MDT participation by community type](image)

**Child Protective Services participation.** Figure 31 on the following page shows the percentage of respondents who noted that specific CPS workers participate in their MDTs. CPS caseworkers participated in MDTs in all community types. As areas increased in population, they had higher percentages of upper level administrators participating in MDTs. For instance, 4.7% of participants from large/urban areas indicated that a regional director participated on their MDT and 35.4% indicated that a program director participated in their MDT. These rates of supervisory participation were lower for mid-sized and small/rural areas where caseworkers might be more accessible to the MDT. Other CPS staff who participate in MDTs included investigators, conservatorship workers and/or family-based services workers.
Fig. 31 // CPS MDT participation by community type

- CPS CASEWORKER I: 29.4%
- CPS CASEWORKER II: 23.5%
- CPS CASEWORKER III: 15.7%
- SUPERVISOR: 5.9%
- PROGRAM DIRECTOR: 2%
- REGIONAL DIRECTOR: 2%
- OTHER: 2%

Bar chart showing participation by role and community type:
- Rural
- Mid-size
- Urban
Prosecutor participation. Figure 32 below shows the percentage of respondents who noted that specific prosecutors participate in their MDTs. Across community types, participants identified high percentages of District Attorneys and Assistant District attorneys who participated in their MDTs. County Attorneys and Assistant County Attorneys were more likely to participate in rural areas. In the “other” category, participants noted that CPS prosecutors, victim’s assistance coordinators and other agency representatives participated in their MDTs.
**CAC staff participation.** Table 33 below shows the percentage of respondents who noted specific CAC staff participate in their MDT. Participants reported high percentages of forensic interviewers who participate in their MDTs. Program directors were also frequently reported as MDT participants. Participants who listed “other” staff indicated that CAC interns and coordinators also participated in their MDT. In addition to CAC mental health professionals, 20% of participants indicated that mental health professionals not employed by the CAC participate in the MDT.
**MDT TEAM FUNCTIONING**

Survey participants were asked a series of questions about their MDT’s functioning. The primary purpose of these questions was to understand how the functioning of the MDT may impact the completion of medical evaluations. Participants were asked to read statements and rate their level of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree. For the purposes of presenting these findings, responses were collapsed into three categories: disagree, neutral, and agree.

**MDT Purposes and Procedures.** Figure 34 below shows the percentage of responses related to MDT purposes and procedures. In general, participants agreed with statements suggesting that their MDTs have clear purposes and procedures. A large percentage of participants (90.6%) agreed that their MDT had clear confidentiality agreements while 87% agreed that written interagency agreements were in place. However, only 64.5% of participants agreed that the MDT regularly reviewed its processes and procedures.

![Fig. 34// MDT purpose and procedures](image)

**MDT leadership and participation.** Figure 35 on the following page shows the percentage of responses related to MDT leadership and participation. In general, participants agreed with statements suggesting that MDTs have clear leadership and strong participation. Participants agreed that the MDT facilitator promoted collaboration (87.2%) and that the MDT meetings were run effectively (86.5%). However, only 70.6% of participants indicated that members attended MDT meetings regularly.
**MDT communication.** Figure 36 on the following page shows the percentage of responses related to MDT communication. As with the prior sections, participants generally agreed that their MDT had effective communication. Participants agreed that they work with other team members regularly (81.6%) and that team members are accessible outside of case reviews (81.7%). Participants also tended to agree that members could accept feedback (71.8%), listen to each other (83.9%) and participate in decision-making (79.2%).
MDT support, trust and commitment. Figure 37 shows the percentage of responses related to MDT support, trust and commitment. The vast majority of participants reported that the work of the team is valuable (90.6%) and they understood the roles of the MDT team members (91.8%). Participants also agreed that the work of the MDT was a priority for them (84.7%) and that they trust other team members (88.0%).

MDT education and training. Figure 38 on the next page shows the percentage of responses related to MDT education and training. While the aspects of MDT functioning discussed above suggest strong agreement about MDT functioning, there was less agreement about education and training. The majority of respondents were either neutral or disagreed that training was important to their MDT. As a result, 70.9% felt that more training was needed to improve their MDT effectiveness and 75.5% responded that more training would be helpful. Participants’ responses also indicate that MDTs vary in their use of training opportunities. More than half of MDTs do not use the suggested 15-minute monthly trainings at their case review meetings. These trainings, which are recommended by CACTX, provide an opportunity for brief cross-training and networking at meetings. However, 54% of participants said that their MDTs provide opportunities for other types of cross-training regularly and 66.4% said their MDTs provided regular educational opportunities.
Fig. 38 // MDT education and training

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our MDT facilitator provides educational opportunities regularly.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>Our MDT facilitator provides cross training opportunities regularly.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>Team members take advantage of educational opportunities.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>Team members take advantage of cross training when offered.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>MDT training and education is provided to new team members.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>More education and training would be helpful to this MDT.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>We use brief 15 minute trainings once a month at our MDT case review meetings.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>Additional cross training and education would make this MDT more effective.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
<tr>
<td>Cross training and education are priorities in this MDT.</td>
<td><img src="image" alt="Percentage Distribution" /></td>
</tr>
</tbody>
</table>
RECOMMENDATIONS

Based on the findings from focus groups and the online survey, it is recommended that CACTX and CACs work to improve the rates of medical evaluations for child abuse victims in Texas by taking the actions described below.

OPEN THE BILLING BLACK BOX

Billing for medical evaluations is a convoluted process that few members of MDTs appear to understand, yet the process greatly influences the rates of medical evaluations in their areas. The status quo procedures are that acute and non-acute sexual abuse evaluations may be compensated by the Attorney General’s Office through the Crime Victim’s Compensation Fund. For forensic purposes, law enforcement agencies are charged with initially paying for the evaluations and are therefore the agencies that authorize them. Law enforcement agencies then receive reimbursement for the evaluation from the Attorney General’s Office. While a seemingly logical process, there are many unintended consequences to these procedures. First, law enforcement agencies must have a system in place to cover the cost of medical evaluations until they receive reimbursement. For smaller agencies, covering the cost of medical evaluations puts an undue burden on their agency, particularly if the full amount of an evaluation is not reimbursed. In fact, there is no standard rate for medical evaluations. The Attorney General’s Office reimburses for evaluations at a standard rate, but hospitals and SANEs may charge more than the reimbursable rate. Thus, law enforcement agencies may not receive full reimbursement for their expenses. Some participants noted that the reimbursement rate for evaluations had not changed since 1999 and that costs for evaluations are not on par with the reimbursed rate. Even when reimbursement occurs, it may not actually reach the law enforcement agency’s budget because reimbursement is made to the local government and may not be passed through to the law enforcement agency.

To open this “black box of billing,” actions should be taken to streamline the reimbursement process. Options should be explored to pay hospitals and medical providers directly for evaluations so that complicated issues with law enforcement reimbursement are avoided all together.

INCREASE HOSPITAL SUPPORT THROUGH POSITIVE REINFORCEMENT

Hospitals providing medical evaluations for child abuse cases usually have to make significant investments in the program and often accrue significant costs. Costs and dedicated staff time make it difficult to get hospitals to support SANE or related programs. Many MDTs mentioned that since additional funds are not usually available, they found it important to supply other, non-fiduciary benefits to the hospitals. One CAC actively worked to get items into the local paper about how the hospital helped abused kids. Study participants suggested that it was critical that both CACTX and local CACs explore strategies to increase hospital motivation to invest in child abuse services.
Rather than passively relying on support from local hospitals, CACTX should develop a “CACTX report card” of hospitals who are strongly supportive of child abuse services. Such report cards are common among advocacy groups as they are a way to honor and reinforce positive relationships. CACTX should explore options of having the OAG publicly recognize hospitals active in child abuse services and develop strategies for local CACs to help get a supportive hospital “good press.” A rating system would offer local CACs a starting point for discussing relationship and infrastructure building with their local hospitals.

**DEVELOP STATEWIDE GUIDELINES FOR WHEN A MEDICAL EVALUATION IS REQUIRED**

In nearly every community, MDT members stated that all child victims received a medical evaluation “if the facts of the case warrant one.” However, the criteria used to decide whether an evaluation was warranted varied significantly across communities and across professions. CACTX should develop protocol recommendations for when medical evaluations are required and explore options for codifying recommendations so that MDTs are required to follow protocols.

**INCLUDE PHYSICAL ABUSE AND NEGLECT**

Protocols for obtaining medical evaluations in cases of physical abuse and neglect were inconsistent and often non-existent. The lack of consistency exists for two reasons. First, the Attorney General’s Office does not reimburse law enforcement for evaluations for child physical abuse and neglect victims in the same way it reimburses for sexual abuse. In these non-sexual abuse cases, health insurance or crime victim’s compensation as the payer of last resort is used to reimburse for medical costs. Thus, the financial burden lies with families. Second, many communities lack access to a forensic medical examiner for physical abuse and neglect cases. Even though a community may have access to a SANE, many SANEs believe that in-depth assessment of many types of physical abuse and neglect is outside of their scope of practice. CACTX should develop a workgroup to examine this issue in greater detail and develop a plan for how to include physical abuse and neglect medical evaluations within CAC protocols.

**EXPAND ACCESS TO MEDCARES**

Having ready access to a MEDCARES site and the professional services and consultation these sites provide was strongly predictive of medical evaluation rates. Many MDT members noted that “if Dr. X says to do it, then we do it.” Clearly, the opinions of physicians are highly valued and their recommendations are carried out. However, many small/rural communities lacked access to physicians with child abuse specializations. CACTX should support efforts to expand MEDCARES so that both small/rural and mid-sized communities have easy access to MEDCARES providers that enables them to have regularly scheduled consultations and to develop working relationships.
**CHANGE THE CONVERSATION**

There is general confusion about medical evaluations for sexual abuse victims. Many non-medical professionals discussed medical evaluations as being similar to well-woman evaluations. Thus, there is a pervasive belief that medical evaluations violate and traumatize children. Given that MDT members are highly motivated to protect children, the inclination is to avoid evaluations if there is no obvious forensic purpose. CACTX should create a campaign to change this conversation to focus less on the forensic aspect of evaluations and more on the medical need for evaluations. As was suggested by one CAC director, medical evaluations should be called “well-child evaluations.” Because well-child checks are a standard part of pediatric medical care, both families and professionals are familiar with the concept of regular exams for their children.

**ENGAGE IN DISCUSSION ABOUT FORENSIC MEDICAL SERVICE DELIVERY.**

Many Texas communities lack ready access to medical professionals with specialized training in child abuse assessment and treatment, which can create significant barriers to obtaining medical evaluations. There are at least two possible models to address this barrier:

1. Recruit and train more medical professionals in smaller communities to conduct medical evaluations of child abuse; or
2. Provide support services so that smaller communities can more readily access the services available in urban centers.

There seems to be some controversy about which approach to take in Texas. The benefit of the first approach is that it lessens wait times for victims and reduces many burdens on MDT members, such as providing transportation and the time it requires. However, as discussed above, it can be difficult to maintain a cadre of trained medical professionals in smaller communities due to increased demands on their time and increased difficulty meeting the requirements to maintain certifications. Thus, some medical professionals argue that forensic medical services are specialized services that are rightly centralized in urban centers. Resolution of this issue is beyond the scope of this study, but does pose an interesting question for those attempting to gain better access to medical evaluations. This conversation is on-going within the sexual assault community. CACTX should take an active role in this discussion to ensure that the needs of child victims are met.

**ENCOURAGE MEDICAL PROFESSIONALS’ REGULAR PARTICIPATION IN THE MDT.**

Regular contact with a medical professional trained in child abuse assessment and treatment was one of the largest predictors of medical evaluation rates. In order to encourage the participation of medical professionals in MDTs, CACTX should assist and train CACs to make use of services such as Skype to have medical professionals attend MDT meetings when travel distances are prohibitive. CACs and CACTX should continue to invite medical professionals to participate in
trainings, regional meetings, or other forums where they can interact with other MDT members. CACTX and CACs should support more consistent use of the FACN by CPS workers.

**IMPROVE USE OF MEDICAL EVALUATIONS IN CRIMINAL AND CIVIL PROCEEDINGS**

When medical evaluations were perceived as helpful to criminal proceedings, law enforcement and prosecutors were usually more motivated to play an active role in encouraging, requiring or requesting medical evaluations. Prosecutors noted the presence of the “CSI effect” where juries expect that cases brought to trial will have some sort of positive physical findings. Because positive physical findings are rare in medical evaluations of child abuse, it is important that MDT members, particularly prosecutors and medical providers, be well-versed in explaining a lack of physical findings. CACTX should assist CACs in developing specialized training for its MDT members and other professionals on testifying and explaining to juries the issues with physical findings. Such training is particularly important for medical professionals who may be new to court proceedings.

**DEVELOP AND SUPPORT ADDITIONAL EDUCATION AND TRAINING.**

This study highlighted a number of training needs for professionals in the MDT. Figure 39 on the following page highlights some of the more prominent training needs that were identified. In general, very basic information is needed to help professions understand medical evaluations and their importance. However, specific trainings were identified for various professions.
While training and education are clearly needed, there are barriers to obtaining it. Law enforcement and CPS cited turnover issues as a factor in their lack of knowledge about medical evaluations. Lack of funds, staff and time were also cited as barriers. In order to address these barriers, CACTX should identify creative training solutions. For instance, online trainings could be an effective use of limited training resources and may be useful in reaching MDT members. Further, online courses with attached professional continuing education credits would likely result in greater participation than those without such credits.
Additionally, cross-training should be used if at all possible. To foster collaboration across agencies, many study participants identified a need for MDT members to understand MDT organizations other than their own. Many CACs arranged smaller, more informal cross-trainings and these were often highly effective. Cross-training was also useful in addressing some knowledge gaps that created barriers to medical evaluations and use of the results of evaluations. For example, in communities where medical professionals taught other MDT members about what evaluations do – and do not – consist of, law enforcement and CPS workers seemed more inclined to refer children for evaluations. Also, in communities where prosecutors provided training to medical professionals about testifying, there seemed to be more effective use of the medical evaluation results.

CACTX should also encourage discipline-specific mentoring. Some MDT members may be able to accept training from a member of their own profession more readily than they might accept training from someone from a different profession. Such discipline-specific mentoring can also be an effective strategy to prevent burnout and help in learning how to manage a number of discipline-specific challenges. Although some mechanisms for profession-specific mentoring exist in CAC protocols, both CACTX and local CACs should explore how they could work with other professions to expand mentoring.

**Provide safe space for all MDT members**

While it was not a focus of this study, information about MDT functioning yielded interesting findings related to differing strategies for self-care among MDT members. Those members who lacked specialized child abuse training included law enforcement officers, prosecutors and some medical professionals. They disclosed that working with child abuse victims was overwhelming and that being on the “front line” was incredibly difficult. Because there was little space within their professional discipline or workplaces to process the emotional strain of their work, CACs should strive to encourage open dialogue that allows these professionals to process and disclose personal stress related to their work.

**Continue research**

While this study provided insight into rates of medical evaluations, there are still unanswered questions that CACTX and/or its national affiliate should continue to explore. Primarily, it is not known whether all children who need medical evaluations are receiving them. A significant challenge to assessing the appropriateness of current protocols is that there are no common criteria stating which victims need a medical evaluation. Without such criteria, it is impossible to assess the match between which children need an evaluation and which get them. To truly understand the current status of child abuse medical evaluations in Texas, each of these issues would require future research. Additionally, there is little information available to compare Texas protocols for medical evaluation to those in other states. It would be useful to compare Texas protocols to those of other states with higher rates of medical evaluations as this might help highlight potential best practices that could be adopted here.


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Focus Group Guide

Introduction

Script: You are being asked to participate in a research study examining procedures and barriers around obtaining medical examinations for child abuse victims. The research has several goals, including:

- to understand existing procedures for obtaining medical examinations for child abuse victims,
- to understand differences between community types in both procedures and barriers,
- to identify possible barriers to obtaining evaluations,
- and finally, to identify best practices for obtaining medical evaluations.

Participation in this study will consist of attending a focus group and providing input to the research team about the above issues. The research team will keep all input confidential. Specifically, information provided to the research team will be presented only in aggregate form and no input will be linked to any specific participant. Focus groups will last approximately one hour and will be recorded for analysis purposes. Participation in this study is entirely voluntary.

- Review consent form
- Get permission to audiotape
- Answer any questions about the study

Questions

1. Could you describe the MDT in this community?
   Possible questions to help explore this topic:
   a. Who is on the MDT?
   b. What is your role on this MDT?
   c. Who leads / organizes the MDT?

2. Could you talk generally about the role of child medical evaluations in alleged abuse cases?
   Possible questions to help explore this topic:
   a. Do you think it is important to do medical evaluations? Why or why not?
   b. Are there conditions that would make you more or less inclined to want a medical evaluation done?
c. Do you feel like you have to justify this component of child abuse investigation / care?

d. (If they discuss resistance to medical evaluations in the MDT): In your experience, what is the resistance to obtaining child medical evaluations?

e. What concerns do you have about medical evaluations in your community?

f. (If they educate about medical evaluations) When it comes to medical evaluations, on what topics do you spend the most time providing education? To whom do you provide education / re-education?

g. What is the impact of medical evaluations on case prosecution? (including on juries).

3. How do child abuse victims receive medical evaluations in your community?

   Possible questions to help explore this topic:

   a. What are the procedures for medical exam referrals? (Who takes lead, transports, who conducts, etc.)

   b. In general, how is it decided which cases are referred for evaluations?

   c. Could you talk about if procedures differ by abuse types and if so, in what ways?

   d. What are the guidelines for referrals for medical evaluations?

      i. If there are guidelines, who set(s) them?

      ii. If there aren’t guidelines, reasons for this? Pros/cons to this?

4. What are the barriers in your community to child abuse victims receiving medical evaluations?

   Possible questions to help explore this topic:

   a. How does the makeup of your MDT impact getting medical evaluations completed?

   b. What barriers do you think exist to getting evaluations completed?

      ▪ What barriers are there specifically in your discipline (CAC, LE, CPS, Med, Pros)?

      ▪ What barriers are there generally?

   c. Do these barriers vary by type of abuse or other case characteristics (victim age or gender, relationship to the perpetrator, acute/chronic case, etc.)?

   d. Do you think these barriers might differ by community characteristics (population size, state region, dominant culture of the area, etc.)?

   e. What factors might make the barriers worse?

   f. What factors might help overcome the barriers?
g. How have you seen MDTs successfully address such barriers? Or, how might you imagine MDTs could address such barriers?

h. Please describe your idea of the very best practices possible regarding medical evaluations for communities such as yours.

5. Compared to other localities, how well do you think your MDT is doing regarding getting children medical evaluations?

   Possible questions to help explore this topic:
   a. Is there anything particular about this community that impacts rates of medical evaluations?
   b. Is there anything particular about this community that impacts MDT composition?
   c. How do you think the issues of this study might be impacted by community type/size – large urban, mid-sized, rural?

6. Could you talk about your MDT’s functioning, effectiveness, and needs?

   Possible questions to help explore this topic:
   a. Are there other professionals you think it would be useful for the MDT to collaborate with? If so, who?
   b. Are there training requirements for MDT members? If so, what are those?
   c. What supports does your organization need from the MDT that it is not currently getting?
   d. Do you think the collaboration positively impacts conviction rates in your community?
   e. What are common barriers to strong MDT functioning? (Either here or in other localities)
   f. How effective do you think this MDT is?
   g. What makes this MDT effective?
   h. What could be done to improve this MDT?

7. What question or questions should we have asked, but didn’t, about the issue of medical evaluations for child abuse cases?

   Possible questions to help explore this topic:
   a. Are there any other important issues we should know about?
   b. If you were making recommendations to increase the rates of medical evaluations, what would you suggest?
c. Are there any educational standards you think should be mandated for MDT member continuing education?
### List of Children’s Advocacy Centers in Texas

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WHAT IS A CHILD ABUSE PEDIATRICIAN?
What is a Child Abuse Pediatrician?

**WHO:** Child Abuse Pediatricians are doctors with special training, experience, and skills in evaluating children who may be victims of some type of abuse or neglect.

The special training includes:

- Graduation from college and medical school
- Three or four years of residency training in the medical care of children
- Additional training and experience in Child Abuse Pediatrics.
- Certification by the American Board of Pediatrics and may have additional certification in the subspecialty of Child Abuse Pediatrics

Other kinds of health providers, such as Family Medicine or Emergency Physicians and nurse practitioners, may also have expertise in Child Abuse Pediatrics.

**WHAT:** Child Abuse Pediatricians gather history from parents and families, talk to children, examine children, review blood tests, x-rays, and other tests, and may order and review additional tests. Child Abuse Pediatricians often work within a Multidisciplinary Team of other physicians, hospital staff, child protective service agency workers, and law enforcement to gather information and make sure that all agencies involved understand the medical concerns about your child.

**WHEN:** Child Abuse Pediatricians are contacted by medical staff or investigative agencies when a child is a suspected victim of abuse. Child Abuse Pediatricians may also be asked for help by parents or your child’s primary care doctor. Not all hospitals and communities have a Child Abuse Pediatrician locally. In certain cases, a Child Abuse Pediatrician may evaluate your child’s records to provide an expert opinion if asked by a court, police, child protective services, or lawyers. These requests may occur well after your child’s injury.

**WHERE:** You and your child may meet a Child Abuse Pediatrician in the hospital or in a child advocacy center (a community agency designed to evaluate child victims of sexual abuse, physical abuse, neglect, or other violence).

**WHY:** Because of their special training and skills, Child Abuse Pediatricians are the doctors most able to help determine if and how your child was injured. When appropriate, Child Abuse Pediatricians actively search for medical problems or other explanations for your child’s symptoms.

**HOW:** Child Abuse Pediatricians carefully review all of the details about your child and why the concern for abuse exists. The evaluation includes speaking to many professionals involved in the care and protection of your child, such as your child’s primary care doctor, therapist, child protective service worker, and police officer. Child Abuse Pediatricians evaluate many cases each year, and often, the diagnosis is not abuse. Child Abuse Pediatricians often testify in court to help a judge and jury understand your child’s medical concerns and injuries and what they mean.

**IMPORTANT POINTS:**

- Child Abuse Pediatricians do **not** decide who has custody of a child or which home the child lives in.
- Child Abuse Pediatricians do **not** arrest people or determine who is “guilty.”
- Child Abuse Pediatricians do **not** decide who is a good or better parent.

*Child Abuse Pediatricians are your partners in making sure your child is safe and healthy.*

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NATIONAL CHILDREN’S ALLIANCE
ACCREDITATION STANDARDS
Standards for Accredited Members
Revised
Effective – 2017

Updated 8/20/2015
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MULTIDISCIPLINARY TEAM (MDT)

STANDARD: A MULTIDISCIPLINARY TEAM FOR RESPONSE TO CHILD ABUSE ALLEGATIONS INCLUDES REPRESENTATION FROM THE FOLLOWING:

- LAW ENFORCEMENT
- CHILD PROTECTIVE SERVICES
- PROSECUTION
- MEDICAL
- MENTAL HEALTH
- VICTIM ADVOCACY
- CHILDREN’S ADVOCACY CENTER

Rationale
A functioning and effective multidisciplinary team approach (MDT) is the foundation of a CAC. An MDT is a group of professionals of specific, distinct disciplines that collaborates from the point of report and throughout the child and family’s involvement with the CAC. The primary goal of the MDT is to assure the most effective coordinated response possible for every child and family. The purpose of interagency collaboration is to coordinate intervention so as to reduce potential trauma to children and families and improve services overall, while preserving and respecting the rights, mandates and obligations of each agency. A CAC is an interagency system response and not just a facility. All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate professional response. Quality assurance and a review of the effectiveness of the collaborative efforts are also critical to the MDT response.
Representatives of law enforcement, child protective services, prosecution, medical, mental health, and victim advocacy, together with CAC staff, comprise the core MDT. Some CACs, including those in small, rural communities, may employ one person to fill multiple roles. For example, the CAC Director may also serve as the Victim Advocate or a CPS worker may function as a forensic interviewer and a caseworker. What is important is that each of the above-mentioned functions is performed by a member of the MDT while maintaining clear boundaries between each function. MDTs may also be expanded to include other professionals such as guardians ad litem, adult and juvenile probation, dependency (civil) attorneys, out-of-home care licensing personnel, federal investigators, school personnel, domestic violence providers and others, as needed and appropriate for an individual child and family and the community the CAC serves.

Generally, a coordinated, MDT approach facilitates efficient gathering and sharing of information, broadens the knowledge base with which decisions are made and improves communication among agencies. From each agency’s perspective, there are also benefits to working on an MDT. More thorough and shared information, improved and timely evidence gathering, and the involvement of the prosecutor from the beginning stages of the case may contribute to a more successful criminal justice outcome. An MDT response also fosters needed education, support and treatment for children and families that may enhance their willingness to participate in the criminal justice system and as effective witnesses. MDT interventions in a neutral, child-focused CAC setting are associated with less anxiety, fewer interviews, increased support, and more appropriate and timely referrals for needed services. In addition, parents and other caregivers are empowered to protect and support their children throughout the investigation and prosecution and beyond.

Law enforcement personnel find that a suspect may be more likely to cooperate when confronted with the strength of the evidence generated by a coordinated MDT approach. Law enforcement personnel also appreciate that support and advocacy functions are attended to, leaving them more time to focus on other aspects of the investigation. They work more effectively with CPS on child protection issues and benefit from other MDT members’ training and expertise in communicating with children and understanding family dynamics. As a result of effective information sharing, CPS workers are often in a better position to make recommendations regarding placement and visitation, the monitoring of the child’s safety and parental support, and can provide assistance to non-offending parents. Medical providers benefit from the history obtained during the coordinated interview and, in turn, are available to consult about the advisability of a specialized medical evaluation and the interpretation of medical findings and reports. Mental health providers may provide the MDT with valuable information regarding the child’s emotional state and treatment needs and ability to participate in the criminal justice process. A mental health professional on the MDT helps ensure that assessment, treatment, and related services are more
routinely offered and made available to children and families. **Victim advocates** are available to provide needed crisis intervention, safety planning, referrals for additional services, ongoing support, information and case updates, and court advocacy in a timely fashion. This helps the MDT anticipate and respond to the specific needs of children and their families more effectively, lessens the stress of the court process, and increases access to resources needed by the child and family, including access to victims of crime funding. And, of course, **Prosecutors**, have a critically important role in holding offenders accountable and ensuring community safety.

**CRITERIA**

**Essential Components**

A. The CAC/MDT has a written interagency agreement signed by authorized representatives of all MDT components that clearly commits the signed parties to the CAC model for its multidisciplinary child abuse intervention response. The interagency agreements include:

a. Law Enforcement
b. Child Protective Services
c. Prosecution
d. Mental Health
e. Medical
f. Victim Advocacy
g. Child Advocacy Center

**STATEMENT OF INTENT:** Written agreements formalize interagency cooperation and commitment to MDT/CAC policy and practice ensuring continuity of practice. Written agreements may be in different forms such as memoranda of understanding (MOUs), and/or interagency agreements (I/As), and are signed by the leadership of participating agencies (e.g. police chiefs, prosecuting attorney, agency department heads, supervisors, etc.) or their designees. These documents should be developed with input from the MDT, reviewed annually and must be re-executed upon change in practice, policy or current agency leadership.

B. Written protocols and/or guidelines that address the functioning of the MDT, the roles and responsibilities of each discipline, and their interaction in the CAC are developed with input from the MDT, reviewed minimally every 3 years, and updated as needed to reflect current practice.
STATEMENT OF INTENT: The involvement of the agency leaders and MDT members is critical to ensuring that the policies and procedures by which investigations are conducted and services provided are consistently followed.

C. All members of the MDT including appropriate CAC staff, as defined by the needs of the case are routinely involved in investigations and/or MDT interventions.

STATEMENT OF INTENT: The purpose of multidisciplinary involvement for all interventions is to assure that the unique needs of children are recognized and met. This means that informed decision-making occurs at all stages of the case so that children and families benefit optimally from a coordinated response. Multidisciplinary intervention begins at initial outcry or report and includes, but is not limited to, first response, pre- and post- interview debriefings, forensic interviews, consultations, advocacy, evaluation, treatment, case reviews, and prosecution.

D. The CAC/MDT’s members participate in effective information sharing that ensures the timely exchange of case information within the MDT, including CAC personnel and is consistent with legal, ethical and professional standards of practice.

STATEMENT OF INTENT: Effective communication and information sharing happen at many points in a case. Both are key dynamics for MDTs in order to minimize duplicative efforts, enhance decision-making, and maximize the opportunity for children and caretakers to receive the services they need.

E. The CAC has written documentation describing how information sharing is communicated among MDT members and how confidential information is protected.

STATEMENT OF INTENT: The CAC/MDT’s written documents must delineate how pertinent information is communicated and how confidential information is protected. Most professions represented on the MDT have legal, ethical and professional standards of practice with regard to confidentiality, but they may differ across disciplines. States may have laws such as the Health Information Portability and Accountability Act (HIPAA) that govern this practice. The CAC/MDT must create written confidentiality and information sharing policies that specifically apply to the MDT, staff and volunteers.

F. The CAC provides routine opportunities for MDT members to provide feedback and suggestions regarding procedures/operations of the CAC/MDT. The CAC has a formal process for reviewing and assessing the information provided.
STATEMENT OF INTENT: CACs should have both formal and informal mechanisms allowing MDT members to regularly provide feedback regarding the operations of the CAC, addressing operational/administrative matters (e.g., transportation for clients, use of the facility, equipment upgrades) and multidisciplinary team issues (e.g., communication, case decision making, documentation and record keeping, conflict resolution, etc.).

CACs should strive to create an atmosphere of trust and respect that fosters opportunities for open communication and enables MDT members to share ideas and raise concerns.

Feedback and/or suggestions from MDT members might also be provided utilizing the Outcome Measurement Survey tool (OMS), team satisfaction surveys, suggestion boxes, MDT meetings specifically scheduled for this purpose, among others.

G. The CAC/MDT annually provides or facilitates, and demonstrates MDT member participation in, relevant training or other educational opportunity focused on issues relevant to investigation, prosecution, and service provision for children and their non-offending caregivers.

STATEMENT OF INTENT: Ongoing learning is critical to the successful operation of CACs/MDTs. The CAC identifies and/or provides relevant educational opportunities for MDT members. These should include topics that are cross-discipline in nature, are MDT-focused, and enhance the skills of the MDT members.
CULTURAL COMPETENCY AND DIVERSITY

STANDARD: THE CHILDREN’S ADVOCACY CENTER PROVIDES CULTURALLY COMPETENT SERVICES FOR ALL CAC CLIENTS THROUGHOUT THE LIFE OF CASE

Rationale
Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community. Cultural competency is as basic to the CAC philosophy as developmentally appropriate, child-friendly practice. Like developmental considerations, diversity issues influence nearly every aspect of work with children and families, such as welcoming a child and family to the center, employing effective forensic interviewing techniques, assessing the likelihood of abuse, selecting appropriate mental health providers and securing services for a child and family that is both relevant and accessible. To effectively meet clients’ needs, the CAC and MDT must be willing and able to understand the clients' worldview, adapt practices as needed, and offer assistance in a manner in which it can be utilized. Striving towards cultural competence is an important and ongoing endeavor and an integral part of every facet of a CAC’s operations and service delivery.

Proactive planning and outreach should focus on culture and degree of acculturation, ethnicity, religion, socioeconomic status, disability, gender, gender identity and expression, and sexual orientation. These factors contribute to a client’s worldview, unique perceptions and experiences throughout the investigation, intervention, and case management process. Addressing these factors in a culturally sensitive environment helps children and families of all backgrounds feel welcomed, valued, and respected by staff, MDT members and volunteers.

CRITERIA

Essential Components

A. The CAC conducts a community assessment at a minimum of every 3 years, which includes:

   a. Community demographics,
   b. CAC client demographics,
c. Analysis of disparities between these populations,
d. Methods the CAC utilizes to identify and address gaps in services,
e. Strategies for outreach to un- or underserved communities,
f. A method to monitor the effectiveness of outreach and intervention strategies.

STATEMENT OF INTENT: In order to serve a community in a culturally competent manner, a CAC must have a comprehensive assessment of their entire community/jurisdiction that focuses on a range of issues including, but not limited to: race, ethnicity, gender, gender identity and expression, sexual orientation, disabilities, income, geography, religion and culture. The assessment should inform the development of goals and strategies that ensure that the CAC delivers high quality, relevant and accessible services to all children and families in need.

B. The CAC must ensure that provisions are made for non-English speaking and deaf or hard of hearing children and their family members throughout the investigation, intervention, and case management process.

STATEMENT OF INTENT: The ability to effectively communicate is critical in creating an environment in which children and families feel comfortable, safe, and are respected and supported. Language barriers can significantly impact the ability to obtain accurate information from the child and family, and hamper the ability for children and families to understand their roles, expectations, concerns and decisions regarding the investigation and intervention services. Language barriers may compound children and families’ feelings of fear, anxiety, and confusion. The CAC must explore a variety of resources or solutions to ensure adequate provisions are made to overcome language/communication barriers. In order to protect the integrity of the investigation and services, care should be taken to ensure that appropriate translators are utilized. CACs should not utilize children or client family members to translate for MDT members.

C. CAC services are accessible and tailored to meet the individualized and unique needs of children and families regarding culture, development and special needs throughout the investigation, intervention, and case management process.

STATEMENT OF INTENT: It is the responsibility of the CAC and MDT members to ascertain the diverse backgrounds and unique needs of the children and families being served. From the moment of first contact with the child and family, the MDT should identify any issues that may affect service delivery. Understanding the child and family’s background will help to understand their perceptions of the abuse and attributions of responsibility; understand the
family’s degree of acculturation and comprehension of laws; address any religious or cultural beliefs which may affect disclosure and follow-up with services, and recognize the impact of prior experience with police and government authorities both in this country and in their countries of origin.

Further, the CAC must be accessible to children with physical disabilities. Investigation and case management services must be responsive to children with cognitive delays and medical and mental health disorders.

With knowledge, preparation, and necessary skills, the MDT can obtain as complete and accurate information as possible and more effectively interpret and respond to the child and family’s needs.

D. The CAC demonstrates ongoing efforts to recruit, hire, and retain staff, volunteers, and board members that reflect the demographics of the community.

STATEMENT OF INTENT: Actively seeking to recruit, hire and retain staff, volunteers and board members that reflect the demographics of the community and the clientele served is critical to achieving an overall response to children and families that is inclusive, relevant and effective.
STANDARD: FORENSIC INTERVIEWS ARE CONDUCTED IN A MANNER THAT IS LEGALLY SOUND, OF A NEUTRAL, FACT FINDING NATURE, AND ARE COORDINATED TO AVOID DUPLICATIVE INTERVIEWING.

Rationale
The purpose of a forensic interview in a CAC is to obtain information from a child about the abuse allegations in a developmentally and culturally sensitive, unbiased, legally and fact-finding manner that will support accurate and fair decision-making by the MDT within the criminal justice, child protection, and service delivery systems. Forensic interviews shall be child-centered and coordinated to avoid duplication. When a child is unable or unwilling to provide information regarding any concern about abuse, other interventions to assess the child’s experience and safety are required.

The MDT/CAC must adhere to research-based forensic interview guidelines that create an interview environment that enhances free recall, minimizes interviewer influence and gathers information needed by all the MDT members involved to avoid duplication of the interview process. CAC/MDT protocols and practice need to be congruent. The CAC/MDT must monitor these guidelines over time to ensure that they reflect current practice.

Forensic interviews are the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution, are a gateway to services for the child and family, and may be the beginning of the road toward healing for many children and families. The manner in which a child is treated during the initial forensic interview may significantly impact the child’s understanding of, and ability to respond to the intervention process and/or criminal justice system. Forensic interviews must be conducted by an appropriately trained professional. Quality interviewing involves an appropriate, neutral setting, effective communication among MDT members, employment of legally sound interviewing techniques, and the selection, training and supervision of interviewers.

CACs vary with regard to who conducts the forensic interview. This role shall be filled by a CAC employed forensic interviewer, law enforcement officers, CPS workers, federal law enforcement officers or other MDT members according to the resources available in the community. At a minimum, any professional in the role of a forensic interviewer must have initial and on-going formal forensic interviewer training that is approved by NCA for purposes of accreditation. State laws may dictate which professionals can or should conduct forensic interviews.
The CAC/MDT’s written documents must include the general interview protocol, selection of an appropriately trained interviewer, sharing of information among MDT members, and a mechanism for collaborative case planning. Additionally, for CACs that conduct *Extended Forensic Evaluations*, a separate, well-defined protocol must be also be articulated.

**CRITERIA**

**Essential Components**

_A. Forensic interviews are provided by MDT/CAC staff that has specialized training in conducting forensic interviews._

CAC must demonstrate that all forensic interviewer(s) have successfully completed training that includes a minimum of 32 hours instruction and practice, and at a minimum includes the following elements:

a. _Evidence supported interview protocol_,

b. _Pre- and post- testing reflecting understanding of the principles of legally sound interviewing_,

c. _Content includes at a minimum: Child development, question design, implementation of the protocol, dynamics of abuse, disclosure process, cultural competency, suggestibility_,

d. _Practice component with a standardized review process_,

e. _Required reading of current articles specific to the practice of forensic interviewing._

*This curriculum must be included on NCA’s approved list of nationally or state recognized forensic interview trainings or submitted with the accreditation application.*

**STATEMENT OF INTENT:** A system must be in place to provide initial training on forensic interviewing for anyone conducting a forensic interview at the CAC. Many CACs use a combination of MDT members and CAC staff to conduct forensic interviews. While many of the members of the MDT may have received general interview training, forensic interviewing of alleged victims of child abuse, and in the context of an MDT response, is considered specialized and thus requires additional specialized training prior to conducting forensic interviews.

_B. Individuals with forensic interviewing responsibilities must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 8 contact hours every 2 years._
STATEMENT OF INTENT: The CAC and/or MDT must provide initial and ongoing opportunities for professionals who conduct forensic interviews to receive specialized training.

C. The CAC/MDT’s protocols reflect the following items:
   a. Case acceptance criteria
   b. Criteria for choosing an appropriately trained interviewer (for a specific case),
   c. Personnel expected to attend/observe the interview,
   d. Preparation/information sharing & communication between the MDT and the forensic interviewer,
   e. Use of interview aids,
   f. Use of interpreters,
   g. Recording and/or documentation of the interview,
   h. Interview methodology (i.e., state or nationally recognized forensic interview training model(s)),
   i. Introduction of evidence in the forensic interviewing process,
   j. Sharing of information among MDT members,
   k. A mechanism for collaborative case coordination,
   l. The determining criteria and process by which a child has a multi-session or subsequent interview.

STATEMENT OF INTENT: The general forensic interview process must be described in the agency’s written guidelines or agreements. These guidelines help to ensure consistency and quality of interviews and subsequent MDT discussions and decision-making.

D. MDT members with investigative responsibilities on a case observe the forensic interview(s) to ensure necessary preparation/information sharing with the forensic interviewer and MDT and interviewer coordination throughout the interview and post interview process.

STATEMENT OF INTENT: MDT members, as defined by the needs of the case, are present for the forensic interview. This practice provides each MDT member access to the information necessary to fulfill their respective professional roles. MDT members present include local, state, federal or tribal child protective services, law enforcement and prosecution; others may vary based on case assignments and the unique needs of the case.

E. For cases meeting the CAC case acceptance criteria as outlined in the MDT protocol, forensic interviews are conducted at the CAC, at a minimum of 75% of the time.
STATEMENT OF INTENT: Forensic interviews of children, as defined in the CAC/MDT’s written protocols, will be conducted at the CAC rather than at other settings. The CAC is the setting where the MDT is best equipped to meet the child’s needs during the interview.

On rare occasions as determined and approved by the MDT, when interviews take place outside the CAC, the agreed-upon forensic interview guidelines must be utilized. Some CACs have established interview rooms outside of the primary CAC such as at a satellite office. In an alternate setting, MDT members must assure the child’s comfort, privacy, and protection from alleged offenders or others who may unduly influence the child.

CACs are encouraged to develop policies that will provide the most comprehensive services and benefit to all children in their communities. Case acceptance criteria may include the various types of abuse which children are victims of and/or witness, other forms of violence/trauma, jurisdictional issues, or the ages of children.

F. **Individuals who conduct forensic interviews at the CAC must participate in a structured peer review process for forensic interviewers a minimum of 2 times per year, as a matter of quality assurance.** Peer review includes participants and facilitators who are trained to conduct child forensic interviews and serves to reinforce the methodology(ies) utilized and provide support and problem-solving regarding shared challenges. Structured peer review includes:

a. **Ongoing opportunities to network with, and share learning and challenges with peers,**
b. **Review and performance feedback of actual interviews in a professional and confidential setting,**
c. **Discussion of current relevant research articles and materials,**
d. **Training opportunities specific to forensic interviewing of children and the CAC-specific methodologies.**

STATEMENT OF INTENT: Participation in peer review is vitally important to assure that forensic interviewers remain current and further develop and strengthen their skills based on new research and developments in the field that impact the quality of their interviews. Peer review is a complement, not a substitute, for supervision, case review and case planning.

G. **The CAC/MDT coordinates information gathering including history taking, assessments and forensic interview(s) to avoid duplication.**

STATEMENT OF INTENT: All members of the MDT need information to complete their respective assessments and evaluations. Whether it is the initial information gathered prior to the forensic interview, the history taken by the
medical provider prior to the medical evaluation, or the intake by the mental
health or victim services provider, every effort should be made to avoid
duplication of information gathering from the child and family members and
ensure information sharing among MDT members.
VICTIM SUPPORT AND ADVOCACY

STANDARD: VICTIM SUPPORT AND ADVOCACY SERVICES ARE PROVIDED TO ALL CAC CLIENTS AND THEIR CAREGIVERS AS PART OF THE MULTIDISCIPLINARY TEAM RESPONSE.

Rationale
The focus of victim support and advocacy is to help reduce trauma for the child and family members and to improve outcomes. In fact, research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members. Coordinated victim advocacy services encourage access to, and participation in, investigation, prosecution, treatment and support services and, thus, are a core component of the MDT’s response. Up-to-date information and ongoing support and access to comprehensive services are critical to a child and family’s comfort and ability to participate in an ongoing investigation, possible prosecution, intervention and treatment.

The victim support and advocacy responsibilities are implemented consistent with victims’ rights legislation in the CAC’s state and the complement of services in the CAC’s coverage area. Many members of the MDT may serve as an advocate for a child within their discipline system or agency. However, victim-centered advocacy is a discipline unto itself with a distinct role on the MDT that coordinates and provides services to ensure a consistent and comprehensive network of support for the child and family.

Children and families in crisis need assistance in navigating the multiple systems involved in the CAC response. More than one victim advocate may perform these functions at different points in time, requiring seamless coordination that ensures continuity and consistency in service delivery. This is the responsibility of the CAC and must be defined in the CAC/MDT’s written documents. Some CACs may employ staff that performs advocacy functions (e.g., family advocates, care coordinators, victim advocates, and child life specialists). Some CACs may link with local community-based advocates (e.g., domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates), and/or system-based advocates (e.g., law enforcement victim advocates, prosecutor-based victim witness coordinators). And some CACs do both by employing and linking with such advocates. All advocates providing services to CAC clients must meet the prescribed training and supervision requirements.
CRITERIA

Essential Components

A. Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training in Victim Advocacy. The CAC must demonstrate that all Victim Advocates providing services to CAC clients have successfully completed training that includes a minimum of 24 hours instruction including, but not limited to:

   a. Dynamics of abuse,
   b. Trauma-informed services,
   c. Crisis assessment and intervention,
   d. Risk assessment and safety planning,
   e. Professional ethics and boundaries,
   f. Understanding the coordinated multidisciplinary response,
   g. Assistance in accessing/obtaining victims’ rights as outlined by law,
   h. Court education, support and accompaniment.
   i. Assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, interpreters, among others as determined for individual clients.

STATEMENT OF INTENT: Victim support and advocacy is integral and fundamental to the MDT response. The support/advocacy responsibilities may be filled by a designated victim advocate and/or by another member of the MDT with appropriate experience and training and that does not conflict with the other role they have on the MDT.

If multiple advocacy agencies share the delivery of services, the CAC is responsible for establishing protocols and linkage agreements agreed upon by the MDT that clearly define the victim advocacy roles and ensure seamless coordination of victim advocacy services.

B. Individuals who provide victim advocacy services for children and families at the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of 8 contact hours every 2 years.

STATEMENT OF INTENT: The CAC and/or MDT must provide initial and ongoing opportunities for professionals who provide advocacy services to receive specialized training and peer support. It is vitally important that victim
advocates remain current on developments in the fields relevant to their delivery of services to children and families and to continue to develop their expertise.

C. Victim Advocates serving CAC clients must provide the following constellation of services:

a. Crisis assessment and intervention, risk assessment and safety planning and support for children and family members at all stages of involvement with CAC,

b. Assessment of individual needs, cultural considerations for child/family and ensure those needs are addressed,

c. Presence at CAC during the forensic interview in order to participate in information sharing, inform and support family about the coordinated, multidisciplinary response, and assess needs of child and non-offending caregiver,

d. Provision of education and access to victim’s rights and crime victim’s compensation,

e. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance etc.),

f. Provision of referrals for trauma focused, evidence-supported mental health and specialized medical treatment, if not provided at the CAC.

g. Access to transportation to interviews, court, treatment and other case-related meetings,

h. Engagement in the child’s/family’s response regarding participation in the investigation/prosecution,

i. Participation in case review to: communicate and discuss the unique needs of the child and family and associated support services planning; ensure the seamless coordination of services; and, ensure the child and family’s concerns are heard and addressed,

j. Provision of updates to the family on case status, continuances, dispositions, sentencing, inmate status notification (including offender release from custody),

k. Provision of court education & courthouse/courtroom tours, support, and court accompaniment.

l. Coordinated case management meetings with any and all individuals providing victim advocacy services.

STATEMENT OF INTENT: While the particular constellation of services required by children and families will vary based upon their unique needs and the legal requirements of any civil and/or criminal cases, all children and families need support in navigating the various systems they encounter which are often unfamiliar to them. Crisis assessment and intervention, advocacy and support services help to identify the child and family’s unique needs, reduce fear and anxiety, and expedite access to appropriate services. Families can be assisted
through the various phases of crisis management with problem solving, access to critical treatment and other services, and ongoing education, information and support. Crises may recur with various precipitating or triggering events such as financial hardships, child placement, arrest, change/delay in court proceedings, preparation for court testimony, etc. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including child abuse, are informed regarding their rights as crime victims, including information about, and eligibility for, crime victim compensation. Caregivers who are affected by the crime may also be entitled to services. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained as necessary and made available to all children and their caregivers.

Victim support and advocacy is integral and fundamental to the MDT response. The support/advocacy function may be filled by a paid CAC staff person or a trained MDT member serving in that designated role. Regardless of the CAC’s model, appropriately trained individual(s) must be identified to fulfill these responsibilities. If more than one victim advocate is providing services to the same family, case management meetings that provide opportunities for discussion of individual and shared case responsibilities, needed services, follow-up, and ongoing assessment and intervention are required.

Often families have never been involved in this multi-system response, which can prove intimidating and confusing. Active outreach requires follow-up with families beyond initial assessment and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case.

In the aftermath of victimization, the child and family typically feels a significant loss of control. Education provides information that is empowering. Education must be ongoing and even repetitive as needed because families may be unable to process so much information at one time, particularly in the midst of a crisis, and their needs change over time. The family may be dealing with immediate safety issues, and may be coping with the emotional impact of the initial report and ensuing process. They may need a variety of concrete medical, mental health, and social services. As the case dynamics change, and as the case proceeds through the various systems, the needs of the child and family must continue to be assessed so that additional relevant information, support and services can be offered.

D. **Active outreach and follow-up support services for caregivers are consistently available.**
STATEMENT OF INTENT
Often families have never been involved in this multi-system response, which can prove intimidating and confusing. Active outreach requires follow-up with families beyond initial assessment and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case.

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E. The CAC/MDT’s written protocols/guidelines include availability of victim support and advocacy services for all CAC clients throughout the life of the case and participation of victim advocate(s) in MDT case review.

STATEMENT OF INTENT: Because victim support/advocacy is a central function of the CAC response, the availability and provision of ongoing victim support and advocacy by designated, trained individuals must be included in the CAC/MDT’s written documents. The manner in which services, both within and outside the CAC, are coordinated must be clearly defined, including the role of the victim advocate during the interview process, follow-up, and case review.
MEDICAL EVALUATION

**STANDARD:** SPECIALIZED MEDICAL EVALUATION AND TREATMENT SERVICES ARE AVAILABLE TO ALL CAC CLIENTS AND COORDINATED AS PART OF THE MULTIDISCIPLINARY TEAM RESPONSE.

**Rationale**
All children who are suspected victims of child sexual abuse are entitled to be offered a medical evaluation by a provider with specialized training. The collection and documentation of possible forensically significant findings are vital. However, decisions regarding the referral of children for medical examinations should NOT be limited to those in which forensically significant information is anticipated. Medical evaluations should be prioritized as emergent, urgent and non-urgent based on specific screening criteria developed by specially trained and skilled medical providers or by local multidisciplinary teams that include qualified medical representation. Some children also benefit from follow-up examinations to re-assess findings and conduct further testing.
A medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate and complete history is essential in making medical diagnoses and determining appropriate treatment of child abuse. Recognizing that there are several acceptable models that can be used to obtain a history of the abuse allegations and that forensic interview techniques are specialized skills that require training, information gathering must be coordinated with the MDT to avoid duplication. Because children have previous understanding of, and familiarity with, the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators. In fact, some children are able to describe residual physical symptoms to medical providers even when no injury is seen. If the in-depth forensic interview is being obtained by a non-medical member of the MDT, further medical history will still likely be needed from the caregiver and/or child to complete the medical evaluation (See Med-Appendix 1 for an example of Components of Medical History for Child Sexual Abuse Evaluation).

A. Medical evaluations are conducted by health care providers with specific training in child sexual abuse that meets one of the following training standards.

Training and Eligibility Standards for a Medical Provider:

Physicians, advance practice nurses, physician assistants and sexual assault nurse examiners (SANE’s) without advance practice training may all engage in medical evaluation of child abuse as a medical provider. Due to differences in foundational training in pediatric assessment by provider type (see Med-Appendix 2), the following Training Standards must be met by the medical provider of a CAC (regardless of whether the exams are occurring on or off-site):

The CAC must demonstrate that its medical provider meets at least ONE of the following Training Standards:

- Child Abuse Pediatrics Sub-board eligibility or certification
- Physicians without board certification or board eligibility in the field of Child Abuse Pediatrics, Advanced Practice Nurses, and Physician Assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse (see Appendix 2).
- SANE’s without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency based clinical preceptorship. This means a preceptorship with an experienced provider in a clinical setting where the SANE can demonstrate competency in performing exams. (see Med-Appendix 2 or IAFN guidelines).
Regardless of provider type, all providers should be licensed to practice (and be in current good standing) by their corresponding state board of practice regulation. Nurses must practice within the scope of their applicable state Nurse Practice Acts. A medical director (physician or advanced practice nurse) is needed for non-advanced practice nurses to assist with the development of practice protocols and treatment needs of the patient including referrals for other medical or mental health issues that are discovered during the evaluation. The medical director may or may not also meet qualifications as an “advanced medical consultant” who can perform review of examination findings. (“Advanced medical consultant” defined below in the Continuous Quality Improvement section). If the medical director does not also serve as a medical provider for the CAC, this person should, at a minimum, be familiar with the essential components of the medical standard and the mission of the CAC.

Some CACs have access to qualified medical providers as full or part-time staff while others provide this service through affiliation and linkage agreements with local providers or other regional facilities. Whether the exams occur on-site or off-site via a linkage agreement, the medical provider must meet the eligibility standard for training (above) and Continuous Quality Improvement.

**Continuous Quality Improvement for the medical component of the CAC:**

The medical provider must be familiar and keep up-to-date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect, American Professional Society on the Abuse of Children, and the Centers for Disease Control and Prevention.

Accuracy in interpretation of examination findings is vitally important to the MDT. The medical provider must participate and provide documentation of such participation in the following Continuous Quality Improvement activities in order stay current in the field of child sexual abuse. Continuous Quality Improvement includes continuing education and expert review of positive findings with an “advanced medical consultant.”

**B. Medical professionals providing services to CAC Clients must demonstrate continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 years.**

( Teaching in the area of child abuse that is approved to provide CEU or CME activity also qualifies for ongoing education credit.)
C. Medical professionals providing services to CAC clients must demonstrate, at a minimum, that 50% of all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone expert review by an “advanced medical consultant”.

**STATEMENT OF INTENT:** While it is recommended that ALL examinations with findings that the medical provider deems are abnormal or “diagnostic” of trauma from sexual abuse be submitted for expert review, the medical provider must be able to provide documentation of participation in expert review with an “advanced medical consultant” on at least 50% of abnormal exams for the purpose of CAC case tracking information that could be requested for review in the accreditation process.

The following providers qualify as an “advanced medical consultant” that could offer expert review of examination findings:

*Child Abuse Pediatrician (preferred)  
  Review with a Child Abuse Pediatrician could occur via direct linkage agreement with a specific provider or through *MyCaseReview* sponsored by the Midwest Regional CAC, or other identified State-based medical expert review systems that has access to an “advanced medical consultant.”

*Physician or Advanced Practice Nurse with the following qualifications:  
  1. Has met the minimum training standards outlined for a CAC medical provider (outlined above).  
  2. Has performed at least 100 child sexual abuse examinations.  
  3. Current in CQI requirements (continuing education and participation in expert peer review on their own cases).

The CAC and medical provider must work collaboratively to establish a method to track de-identified case information as part of the CQI process (see Med Appendix 3).

**D. Specialized medical evaluations for the child client are available on-site or through written linkage agreements with other appropriate agencies or providers.**

**STATEMENT OF INTENT:** Specialized medical evaluations can be provided in a number of ways. Some CACs have a qualified medical provider who comes to the center on a scheduled basis, while in other communities the child is referred to a medical clinic or health care agency for this service. CACs need not be the provider of primary care but they must have protocols in place outlining the linkages to a facility with a qualified medical provider and other needed healthcare services.
E. Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.

STATEMENT OF INTENT: In many communities, the cost of the medical evaluation is covered by public funds. In other settings, limited public funding requires that individuals who can pay or are insured cover the cost of their own exam, or apply for reimbursement through Victim Compensation. In either scenario, ability to pay should never be a factor in determining who is offered a medical evaluation.

F. The CAC/MDT’s written protocols/guidelines include access to appropriate medical evaluation and treatment for all CAC clients.

STATEMENT OF INTENT: Because medical evaluations are a critical component of the CAC’s multidisciplinary response, the CAC’s written protocols must detail how its clients access these services. Many CACs provide services to victims of physical abuse and neglect in addition to sexual abuse. All CACs must have written protocols and agreements outlining how medical evaluations for all types of abuse and neglect would occur. CACs that provide medical evaluations for sexual abuse, but not specifically for physical abuse or neglect, need written procedures for how a medical evaluation will be obtained when there are allegations of physical abuse or neglect. These procedures should include how to obtain treatment for injuries and the management of emergency or life-threatening conditions that may become evident during a sexual assault exam.

G. The CAC/MDT’s written protocols/guidelines include the circumstances under which a medical evaluation for child sexual abuse is recommended.

STATEMENT OF INTENT: The purpose of a medical evaluation in suspected child abuse extends far beyond providing an evidentiary examination for the purpose of the investigation. The primary goals of the medical evaluation are to:

- Help ensure the health, safety, and well-being of the child
- Evaluate, document, diagnose, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family
- Refer for therapy to address the trauma related to the abuse/assault, if not provided by another member of the MDT/CAC.
CACs differ in their practices of how the medical evaluation is made available. The MDT’s written protocol or agreement must include qualified medical input to define the referral process and how, when, and where the exam is made available. Examinations can be differentiated between those needed **emergently** (without delay), **urgently** (scheduled as soon as possible with qualified provider), **non-urgently** (scheduled at convenience of family and provider but ideally within 1-2 weeks), and some patients will benefit from a **follow-up** examination. (see Med Appendix 4)

CACs are responsible for ensuring that qualified examiners at the appropriate location and time evaluate children, minimizing unnecessary medical evaluations. This often requires initial conversations with emergency departments and primary care providers to develop a process for referral to the specialized medical provider as defined by the needs of the child. In addition, exams should be performed by experienced examiners and photo-documented to minimize repeat examinations.

**H. Documentation of medical findings by written record and photo-documentation.**

**STATEMENT OF INTENT:** The medical history and physical examination findings must be carefully, thoroughly and legibly documented in the medical record. The medical record should also include a statement as to the significance of the findings and treatment plan. Medical records should be maintained in compliance with federal rules governing protection of patient privacy. Medical records can be made available to other medical providers for the purpose of other needed treatment of the patient and to those agencies mandated to respond to a report of suspected child abuse. Even in situations where the medical record can legally be provided without separate written consent or court order, a log of disclosures should be maintained with the medical record in accordance with federal privacy rules. (see med appendix 5)

Diagnostic-quality photographic documentation of the ano-genital exam findings should be obtained in all cases of suspected sexual abuse using still and/or video documentation. This is particularly important if the examination findings are thought to be abnormal. Photographic documentation allows for review for CQI, for obtaining consultation or second opinion, and may also obviate the need for a repeat examination of the child. CACs should have policies for storage and release of examination images that protect the sensitive nature of the material. In the uncommon exception where photo-documentation is not possible due to the child’s discomfort with the equipment or equipment malfunction, diagram drawings with detailed written description of findings should occur.

Detailing procedures for the documentation and preservation of evidence (labeling, processing and storing) in written protocols and agreements can help
to assure the quality and consistency of medical evaluations. Such protocols can also serve as a checklist and training document for new examiners. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

I. **MDT members and CAC staff are trained regarding the purpose and nature of the medical evaluation for suspected sexual abuse.** Designated MDT members and/or CAC staff educate clients and/or caregivers regarding the medical evaluation.

**STATEMENT OF INTENT:** The medical evaluation for suspected sexual abuse often raises significant anxiety for children and their families, usually due to misconceptions about how the exam is conducted and what findings, or lack of findings, mean. When an appropriately trained provider performs the examination, it is usually well tolerated. In many CAC settings, the client is introduced to the exam by non-medical personnel. Therefore, it is essential for MDT members and CAC staff to be trained about the nature and purpose of a medical evaluation so that they can competently respond to common questions, concerns and misconceptions.

J. **Findings of the medical evaluation are shared with the MDT in a routine, timely and meaningful manner.**

**STATEMENT OF INTENT:** Because the medical evaluation is an important part of the response to suspected child abuse and neglect, findings of the medical evaluation should be shared with, and explained to, the MDT in a routine and timely manner so that concerns can be discussed and case decisions can be made effectively. The duty to report findings of suspected child abuse to the mandated agencies is an exception to HIPAA privacy requirements, which also allows for ongoing communication.
MENTAL HEALTH

STANDARD: EVIDENCE BASED TRAUMA-FOCUSED MENTAL HEALTH SERVICES, DESIGNED TO MEET THE UNIQUE NEEDS OF THE CHILDREN AND CAREGIVERS, ARE CONSISTENTLY AVAILABLE AS PART OF THE MULTIDISCIPLINARY TEAM RESPONSE.

Rationale
A CAC has as its mission: protection of the child, justice and healing. Healing may begin with the first contact with the MDT, whose common focus is on minimizing potential trauma to children. Without effective therapeutic intervention, many traumatized children will suffer ongoing or long-term adverse social, emotional, developmental and health outcomes that may impact them throughout their lifetimes. Evidenced-based treatments and other practices with strong empirical support reduce the impact of trauma and the risk of future abuse. For these reasons, an MDT response must include a trauma history, screening/assessment of trauma and abuse-related symptoms, and evidence based trauma-focused mental health services for child victims and caregivers.

Evidence also shows the importance of collaboration of community professionals to improve outcomes for children and families. The CAC case review process provides a vehicle for these collaborative discussions.

Family members are often the key to the child’s recovery and ongoing protection. Their mental health is often an important factor in their capacity to support the child. Therefore, family members may benefit from counseling and support to address the emotional impact of the abuse allegations, reduce or eliminate the risk of future abuse, and address issues which the allegation may trigger. Mental health treatment for caregivers, many of whom have victimization histories themselves, are current victims of intimate partner violence, may focus on support and coping strategies for themselves and their child, information about sexual abuse, dealing with issues of self-blame and grief, family dynamics, parenting education and the impact of abuse and trauma histories. Siblings and other children may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic relationship.

CRITERIA

Essential Components
A. Mental health services are provided by professionals with training in, and who deliver, trauma-focused, evidence-supported, mental health treatment. All mental health providers for CAC clients, whether providing services on-site or by referral and linkage agreement with outside individuals and agencies, must meet the following training requirements:

1. The CAC must demonstrate that its mental health provider(s) has completed 40 contact hour CEUs in accordance with the provider’s mental health related license requirements, CEUs from specific evidence-based treatment for trauma training, and clinical supervision hours by a licensed clinical supervisor.

2. In addition, the CAC must further demonstrate that its mental health provider(s) meets at least ONE of the following academic training standards:
   a. Master’s Degree/Licensed/certified or supervised by a licensed mental health professional.
   b. Master’s degree/license-eligible in a related mental health field.
   c. Student intern in an accredited mental health related graduate program, when supervised by a licensed/certified mental health professional. (Both the student intern and supervising licensed mental health professional must meet the previously indicated 40 hour training requirements.)

B. Clinicians providing mental health treatments to CAC clients must demonstrate completion of continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 years.

STATEMENT OF INTENT: Because new research constantly emerges regarding the efficacy of mental health treatment modalities, it is vitally important for clinicians to remain updated about new research, evidence-supported treatment methods, and developments in the field that would impact their delivery of services to clients.

C. Evidence-supported trauma-focused mental health services for the child client are consistently available and include:

   a. Trauma-specific assessment including traumatic events and abuse-related trauma symptoms,
   b. Use of standardized assessment measures initially to inform treatment, and periodically to assess progress and outcome,
   c. Individualized treatment plan based on assessments that are periodically re-assessed,
   d. Individualized evidence supported treatment appropriate for the child clients and other family members,
e. Child and caregiver engagement in treatment,
f. Referral to other community services as needed.

STATEMENT OF INTENT: The above description of services should guide discussions with all professionals who may provide mental health services, whether onsite or by referral and linkage agreement. This will ensure that appropriate services are available for child clients and that the services are outlined in linkage agreements.

D. Mental health services are available and accessible to all CAC child clients regardless of ability to pay.

STATEMENT OF INTENT: CACs have a responsibility to identify and secure alternative funding sources to ensure that all children have access to appropriate, specialized mental health services regardless of ability to pay.

E. The CAC/MDT’s Interagency Agreement/MOU or written protocols/guidelines include access to appropriate trauma-informed mental health assessment and treatment for all CAC clients.

STATEMENT OF INTENT: Because mental health is a core component of a CAC’s multidisciplinary team response, the CAC/MDT’s Interagency Agreement/MOU or written protocols must detail how such care may be accessed by its clients.

F. The CAC/MDT’s written protocols/guidelines define the role and responsibility of the mental health professional on the MDT, to include:
   a. Attendance and participation in MDT case review,
   b. Sharing relevant information with the MDT while protecting the clients’ right to confidentiality,
   c. Serving as a clinical consultant to the MDT on issues relevant to child trauma and evidence based treatment,
   d. Supporting the MDT in the monitoring of treatment progress and outcomes.

STATEMENT OF INTENT: Evidence shows the importance of collaboration of community professionals to improve outcomes for children and families. A trained mental health professional participating in the MDT case review process assures that the children’s treatment needs are being assessed and their mental health can be monitored and taken into account as the MDT makes case decisions. In some CACs this may be the child’s treatment provider; in others it may be a mental health consultant.

G. The CAC/MDT’s written protocols/guidelines include provisions about
the sharing of mental health information and how client confidentiality and mental health records are protected in accordance with state and federal laws.

STATEMENT OF INTENT The forensic process of gathering evidentiary information and determining what the child may have experienced is separate from mental health treatment. Mental health treatment is a clinical process designed to assess and mitigate the long-term adverse impacts of trauma or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Each CAC should be aware that medical and mental health treatment records containing identifiable “protected health information” (or PHI) are protected by HIPAA. Records pertaining directly to an investigation of child abuse can be exempt from HIPAA and not require caregiver consent for release, but the CAC should maintain a log of disclosures of medical and mental health treatment information per HIPAA regulations.

MDT protocol must include specific guidelines for the MDT and mental health providers regarding what and how information can be shared with the MDT during case review in accordance with local laws and professional practice standards.

H. The CAC must provide supportive services for caregivers to address:
   a. The safety of the child,
   b. The emotional impact of abuse allegations,
   c. Reduce or eliminate the risk of future abuse,
   d. Address issues or distress which the allegations may trigger.

Services are made available on-site or through linkage agreements with other appropriate agencies or providers.

STATEMENT OF INTENT Evidence clearly demonstrates that caregiver support is essential to the recovery of child victims, sibling support, and overall family functioning and well-being. CACs have long provided such supportive services through caregiver support groups, mental health services for caregivers and siblings either on-site or by linkage agreement, including ongoing follow-up.

It is important to consider the range of mental health issues that could impact the child’s recovery or safety with particular attention to the caregiver’s mental health, substance abuse, domestic violence, and other trauma history. Family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues which the allegations may trigger. Siblings and other children may also benefit from opportunities to discuss their own reactions.
and experiences and to address family issues within a confidential therapeutic relationship.

**I. Clinicians providing mental health treatments to CAC clients must participate in ongoing clinical supervision/consultation.**

**STATEMENT OF INTENT:** Clinical supervision/consultation for mental health clinicians provides ongoing support and training necessary to ensure appropriate and quality services to the clients they serve. Moreover, this clinical supervision is required for licensure in many states and may include individual and/or group supervision. Options for meeting this standard include:

a. Supervision by a senior clinician on-staff at the CAC; or
b. When a CAC does not have more than one clinician, negotiating with a senior clinician in the community who serves children and families and accepts referrals from the CAC; or
c. Participating in a supervision call with mental health providers from other CACs within the state, either individually or as a group; or
d. A state chapter or one or more CAC contracts with a senior clinician to provide supervision and consultation calls.

Most clinical professions (i.e., clinical social workers, licensed professional counselors, marriage and family therapists, etc.) have a structure for clinicians to become clinical supervisors. CACs may wish to investigate this option in their state. CACs can also negotiate with those who are TFCBT master trainers for on-going clinical consultation. While there are many options for implementing appropriate clinical supervision/consultation, it is important to remember that having supervision on one evidence-based treatment does not necessarily include all the clinical interventions needed within a CAC. Therefore, comprehensive interventions will need to be addressed in ongoing clinical supervision.
CASE REVIEW

STANDARD: A FORMAL PROCESS IN WHICH MULTIDISCIPLINARY DISCUSSION AND INFORMATION SHARING REGARDING THE INVESTIGATION, CASE STATUS AND SERVICES NEEDED BY THE CHILD AND FAMILY IS TO OCCUR ON A ROUTINE BASIS.

Rationale
Case review is the formal process that enables the MDT to monitor and assess its effectiveness - independently and collectively - ensuring the safety and well-being of children and families. It is intended to monitor current cases, not as a retrospective case study. CACs must create an environment and a forum where complex issues can be raised and discussed. Case review is a formal process by which knowledge, experience and expertise of MDT members is shared and discussed, and informed decisions made, where collaborative efforts are fostered, formal and informal communications are promoted, mutual support is provided, and protocols/procedures are reviewed. The process encourages mutual accountability and helps to assure that children’s needs are met sensitively, effectively and in a timely manner. Case review should occur at least once a month. It is not meant to pre-empt ongoing discussions, and ongoing discussions are not meant to take the place of formal case review.

Every CAC must have a process and set the criteria for reviewing cases. Depending on the size of the CAC’s jurisdiction or caseload, the method and timing of case review may vary to fit the unique needs of a CAC community. Some CACs review every case, while other programs review only complex or problematic cases or cases involved in prosecution. Representatives from each core discipline must attend and/or provide input at case review. Confidentiality should be addressed in the written protocol or guidelines. State and/or federal law may govern information sharing among MDT members, including during case review.

CRITERIA

Essential Component

A. *The CAC/MDT’s written protocols/guidelines include criteria for case review and case review procedures.*

The CAC/MDT’s written documents must include:
  a. frequency of meetings;
  b. designated attendees;
  c. case selection criteria;
d. process for adding cases to the agenda;

e. designated facilitator and/or coordinator;

f. mechanism for distribution of agenda and/or notification of cases to be discussed;

g. procedures for follow-up recommendations to be addressed;

h. location of the meeting.

STATEMENT OF INTENT: To maximize efficiency and to enhance the quality of case review, the CAC’s written documents clearly define the process.

B. A forum for the purpose of reviewing cases is conducted at least once a month.

STATEMENT OF INTENT: Case review affords the MDT the opportunity to review active cases, provide updated case information, address obstacles to effective investigations and service delivery, and coordinate interventions. It is a planned meeting of all MDT partners and occurs at least once a month for cases coming from the CAC’s primary service area. Case review is in addition to informal discussions and pre- and post-interview debriefings.

C. MDT partner agency representatives actively participating in case review must include, at a minimum:

a. law enforcement
b. child protective services
c. prosecution
d. medical
e. mental health
f. victim advocacy, and
g. Children’s Advocacy Center

STATEMENT OF INTENT: Full MDT representation at case review promotes an informed process through the contributions of diverse professional perspectives and expertise. Case review must be attended by the identified agency representatives capable of making, informing and/or advocating for decisions and providing the team with knowledge and expertise of their specific profession. All those participating should be familiar with the CAC/MDT process and the purpose and expectations of case review. The forensic interviewer, irrespective of which agency employs him/her, should be present at case review. Moreover, it is strongly encouraged for case review participants to be those who are actively working on the cases under review rather than their supervisors, in order to ensure direct communication between all parties. In those rare circumstances in which a discipline cannot be present in person, alternative means (including conference call or video conferencing) should be used to ensure the participation of all required disciplines.
D. Case review is an informed decision-making process with input from all MDT partner agency representatives.

STATEMENT OF INTENT: In order to make informed case decisions and improve client outcomes, essential information and professional expertise are required from all disciplines. This means that decisions are made with as much information as available, interventions receive the input, discussion, and support of all involved professionals, efforts are coordinated and non-duplicative, and all aspects of the case are covered. The process should ensure that no one discipline dominates the discussion, but rather all team members have a chance to adequately address their specific goals, mandates, case interventions, questions, concerns and outcomes.

Generally, the case review process should:

a. review interview outcomes;
b. discuss, plan and monitor the progress of the investigation;
c. review medical evaluations;
d. discuss child protection and other safety issues;
e. provide input for prosecution and sentencing decisions;
f. discuss emotional support and treatment needs of the child and family members and strategies for meeting those needs;
g. assess the family’s reactions and response to the child’s disclosure and involvement in the criminal justice/child protection systems;
h. review criminal and civil (dependency) case updates, ongoing involvement of the child and family, and disposition;
i. make provisions for court education and court support;
j. discuss ongoing cultural and special needs issues relevant to the case;
k. ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

E. A designated individual coordinates and facilitates case review and communicates the recommendations for follow-up.

STATEMENT OF INTENT: The person designated to lead and facilitate the meetings should have training and/or experience in facilitation. Proper planning and preparation for case review includes setting the agenda, notification of all case review participants, ensuring that all relevant information is shared and discussed and that the child and family’s input is considered. A comprehensive review of cases in a well-facilitated manner helps ensure mutual accountability and quality assurance. A process for communicating recommendations and decisions from case review to the appropriate individuals for implementation must be outlined as well.
CASE TRACKING

STANDARD: CHILDREN’S ADVOCACY CENTERS MUST DEVELOP AND IMPLEMENT A SYSTEM FOR MONITORING CASE PROGRESS AND TRACKING CASE OUTCOMES FOR ALL MDT COMPONENTS.

Rationale
Case tracking systems provide essential demographic information, case information and investigation/intervention outcomes. It can be used for program evaluation (i.e., identifying areas for continuous quality improvement, ongoing case progress and outcomes) and generating statistical reports. Effective case tracking systems can also enable MDT members to accurately inform children and families about the current status and disposition of their cases.

There are additional reasons for establishing a case tracking system. One is the usefulness and ease of access to data that is frequently requested for grants and other reporting purposes. The usefulness and ease of access to data, collected across programs, can be assembled locally, regionally, statewide and nationally for advocacy, research and legislative purposes in the field of child maltreatment. This data also may be required for federal funding reporting requirements. Each CAC needs to determine the type of case tracking system that will suit its needs and be supported by its available resources. Case tracking should be compliant with all applicable privacy and confidentiality requirements.

CRITERIA

Essential Components

A. The CAC/MDT’s written protocol/guidelines include tracking case information until final disposition.

STATEMENT OF INTENT: Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response. Often MDT members will have a system to collect their own agency data; however, the MDT response requires the sharing of this information to better inform decision-making. The CAC/MDT’s written documents must detail a process for case tracking.

B. The CAC tracks and minimally is able to retrieve NCA Statistical Information.
NCA statistical information minimally includes the following data:

a. demographic information about the child and family;
b. demographic information about the alleged offender;
c. type(s) of abuse;
d. relationship of alleged offender to child;
e. MDT involvement and outcomes;
f. charges filed and case disposition in criminal court;
g. child protection outcomes; and
h. status/follow-through of medical and mental health referrals.

STATEMENT OF INTENT: CACs are required to collect and demonstrate the ability to retrieve case specific information for all CAC clients. This includes basic demographic information, services provided and outcome information from MDT partner agencies. An, accurate, comprehensive case tracking system is only possible when all MDT members support the need to submit data in a thorough and timely fashion. Codifying case tracking procedures in CAC/MDT’s written documents underscores its importance and helps to assure accountability in this area.

C. An individual is identified to implement the case tracking process.

STATEMENT OF INTENT: Case tracking is an important function of the CAC and can be a time-consuming task depending on case volume. Accuracy is critical and, for this reason, an individual must be identified to implement and/or oversee the case tracking process. Some CACs define case tracking as part of the MDT coordinator’s or case manager’s role. Some dedicate a position, part- or full-time, for data collection and database maintenance or assign the responsibility to an administrative assistant. Other programs utilize trained volunteers (who have signed confidentiality agreements) to input data.

D. CAC/MDT’s written protocols/guidelines must outline how MDT partner agencies access case specific information and/or aggregate data for program evaluation and research purposes.

STATEMENT OF INTENT: Because case data may be useful to MDT members for a variety of purposes, it is important that they have access to aggregate and/or specific case information. Centers should also develop policies regarding how this data may be released to participating agencies or parties other than the MDT that adheres to confidentiality requirements.

E. CAC has a mechanism for collecting client feedback to inform client service delivery.
STATEMENT OF INTENT: Continuous quality assurance is the hallmark of a well-functioning CAC. This requires seeking feedback directly from caregivers regarding the services they received so that improvements may be made in service delivery on an ongoing basis. Client feedback may include client satisfaction surveys and/or outcome data. Care should be taken that survey instruments are valid and reliable. CACs may use a variety of valid instruments and assessment tools to meet this requirement. However, those Children’s Advocacy Centers who actively participate in NCA’s OMS (Outcome Measurement System) may be assured that they meet and exceed this requirement.
ORGANIZATIONAL CAPACITY

STANDARD: A DESIGNATED LEGAL ENTITY RESPONSIBLE FOR PROGRAM AND FISCAL OPERATIONS HAS BEEN ESTABLISHED AND IMPLEMENTS BASIC SOUND ADMINISTRATIVE POLICIES AND PROCEDURES.

Rationale
Every CAC must have a designated legal entity responsible for the governance of its operations. The role of this entity is to oversee ongoing business practices of the CAC, including setting and implementing administrative policies, hiring and managing personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.

There are many options for CAC organizational structure depending upon the unique needs of its community. CACs may be an independent non-profit agency, affiliated with an umbrella organization such as a hospital or other non-profit human service or victim service agency, or part of a governmental entity, such as prosecution, social services, law enforcement. Each of these options has its strengths and limitations, and implications for collaboration, planning, governance, community partnerships and resource development. Ultimate success requires that, regardless of where the program is housed or under what legal auspices, all agencies in this collaborative effort feel equal investment in, and ownership of, the program.

CRITERIA

Essential Components

A. The CAC is an incorporated, private non-profit organization or government-based agency or a component of such an organization or agency.

STATEMENT OF INTENT: The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This can be an independent not-for-profit, a component of such an entity, or a government-based entity.

B. The CAC maintains, at a minimum, current general commercial liability, professional liability, and Directors and Officers liability as appropriate for its organization.
STATEMENT OF INTENT: Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Nonprofit CACs, including those that are a component of an umbrella nonprofit or nonprofit hospital, must carry, at a minimum, general commercial liability, professional liability, and Directors and Officers liability insurance. Government-based CACs must carry, at a minimum, general commercial liability and professional liability insurance or provide documentation of comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed such as renters, property owners, and automobile insurance.

C. The CAC has written administrative policies and procedures that apply to staff, board members, volunteers and clients.

Every CAC must have written policies and procedures that govern its administrative operations. Administrative policies and procedures include, at a minimum:

a. job descriptions,
b. personnel policies,
c. financial management policies,
d. document retention and destruction policies,
e. safety and security policies.

D. The CAC has an annual independent financial review (Budget is equal to or less than $200,000) or financial audit (Budget exceeds $200,000).

STATEMENT OF INTENT: Confidence in the integrity of the fiscal operations of the CAC is critical to the long-term sustainability of the organization. An annual independent audit is one tool to assess for fiscal soundness and internal controls for financial management. A financial review is sufficient for those CACs with annual actual expenses equal to or less than $200,000.

Reporting Requirements for Audited Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) in excess of $200,000 are required to have an audit of their financial statements. If a management letter is prepared by the independent accountant (CPA), it should be included with the audit report.

Reporting Requirements for Reviewed Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) equal to or less than $200,000 are required to have a review of their financial statements. The review must be in compliance with SSARS 19. If a management letter is prepared by the independent accountant (CPA), it should be included with the review report.
E. The CAC has, and demonstrates compliance with, written screening policies for staff and volunteers that include criminal background, sex offender registration, and child abuse registry checks and provides training and supervision to staff and volunteers.

STATEMENT OF INTENT: Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts a formal screening process for staff. This process should be documented in a written policy. Staff must receive initial and ongoing training and supervision relevant to their role.

Volunteers perform a wide variety of functions within CACs. Sometimes, CACs can attract people who may not be emotionally prepared for the activities of the CAC and/or may attract potential or actual offenders. Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts a formal screening process for onsite volunteers as well. Volunteers must receive training and supervision relevant to their role.

F. The CAC has a written Succession Plan to insure the orderly transition and continuance of operation of the CAC.

STATEMENT OF INTENT: A succession plan will assist in safeguarding the CAC against unplanned or unexpected change. This kind of risk management is equally helpful in facilitating a smooth leadership transition when it is predictable and planned. A succession plan outlines a leadership development and emergency succession plan for the CAC, and reflects its commitment to sustaining a healthy functioning organization. The plan should be developed specific to the uniqueness of the CAC, and include at a minimum;
   a. Temporary staffing strategies,
   b. Long-term and/or permanent leadership replacement procedures,
   c. Cross-training plan,
   d. Financial considerations,
   e. Communication plan

G. The CAC has addressed its sustainability through the implementation of a current strategic plan approved by the governing entity of the CAC.

STATEMENT OF INTENT: In order to assure long-term viability of the organization, the CAC should have a plan that addresses programmatic and operational needs. The governing entity could be an oversight committee or a board of directors, as appropriate for the CACs organizational structure.

H. The CAC promotes employee well-being by: providing training and information regarding the effects of vicarious trauma; providing techniques for building resiliency to its employees; and maintaining organizational and supervisory strategies to address vicarious trauma and its impact upon staff.
STATEMENT OF INTENT: To reduce employee burnout and improve employee retention the CAC should develop practices that identify and mitigate against those factors impacting staff well-being, quality of services, and staff turnover. This includes not only identifying the risk of vicarious trauma for front-line staff but also techniques for building resiliency in workers. Furthermore, the CAC must develop and maintain organizational and supervisory strategies to address vicarious trauma when it arises in staff.

I. The CAC promotes MDT well-being by providing access to training and information on vicarious trauma and building resiliency to MDT members.

STATEMENT OF INTENT: CACs have an important role in strengthening the functioning of the MDT. A highly functioning multidisciplinary team is one in which vicarious trauma can be acknowledged and addressed. While MDT partner agencies have primary responsibility for the health of their workers, the CAC is responsible for providing access to training and information regarding vicarious trauma and resiliency to team members. Moreover, the health of the MDT directly impacts service delivery to children and families. Therefore, attention given to this issue can improve outcomes for abused children and their caregivers.
CHILD-FOCUSED SETTING

STANDARD: THE CHILD-FOCUSED SETTING IS COMFORTABLE, PRIVATE, AND BOTH PHYSICALLY AND PSYCHOLOGICALLY SAFE FOR DIVERSE POPULATIONS OF CHILDREN AND THEIR FAMILY MEMBERS.

Rationale
A CAC requires a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be appropriately conducted and other CAC services can be provided for children and families. While every center may look different, the criteria below help to define some specific ways that the environment can help children and families feel physically and psychologically safe and comfortable. These include attending to the physical setting and assuring it meets basic child safety standards, ensuring that alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating an environment that reflects the diversity of clients served.

There is no one “right” way to build, design or decorate a CAC. The CAC should have adequate square footage and conform to generally accepted safety and accessibility guidelines, fire codes, etc. Consideration should be given to future growth and the need for additional space as caseloads increase and additional program components are needed. Care should be taken to ensure that MDT members have access to work space and equipment onsite to carry out the necessary functions associated with their role on the MDT including, but not limited to, meeting with families and appropriate sharing of necessary information.

Special attention should be given to designing and decorating the client service areas. The appearance of the CAC can help facilitate the participation of children and families in the process, largely by helping to alleviate anxiety and instill confidence and comfort in the intervention system. It should communicate, through its design, decor and materials, that the CAC is a welcoming and child-oriented place for all children and their non-offending family members.

CRITERIA

Essential Components

A. The CAC is a designated, task-appropriate facility or space which includes the following:
a. The CAC is maintained in a manner that is physically and psychologically safe for children and families,
b. The CAC provides observation or supervision of clients within sight or hearing distance by CAC staff, MDT members or volunteers at all times,
c. The CAC is convenient and accessible to clients and MDT members,
d. Any areas where children may be present, and toys and other resources are “childproofed” and cleaned and sanitized to be as safe as possible.

STATEMENT OF INTENT: The CAC has an identified location that is a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other services can be provided for children and families. CACs range from small, refurbished houses, to a renovated wing of a county office building or community hospital, to newly built facilities.

A center that is physically safe for children is central to the creation of a child-focused setting. This can be a challenge as centers are host to children of a variety of ages and developmental stages. Materials and center furnishings should be selected with this in mind.

To assure a physically and psychologically safe environment, children and families must be observed or supervised by CAC staff, or MDT members, or volunteers ensuring that they are within sight or hearing distance at all times. Some CACs are built so that the waiting room can be seen from the receptionist’s desk. Other CACs have volunteers scheduled to supervise play in the waiting room whenever the center is open for clients.

When planning the location of a center, it is important to evaluate the site’s accessibility for clients and MDT partner agencies. Considerations should include transportation assistance, travel distances, availability of parking, public transportation, and how welcoming a particular neighborhood is for clients of diverse cultural and socioeconomic backgrounds. Additionally, planning should include consideration for clients who will return to the center for ongoing services such as follow-up meetings, medical appointments, or therapy services.

B. The CAC has written policies and procedures that ensure separation of victims and alleged offenders.

STATEMENT OF INTENT: The CAC has a setting that is physically and psychologically safe for child clients and separation for children and alleged offenders is ensured. During the investigative process, logic dictates that children will not feel free to disclose abuse if an alleged offender accompanies them to the interview and sits just down the hall in the waiting room. This
separation of children from alleged offenders should also extend to children and perpetrators in unrelated cases. If a CAC shares space with an existing agency that provides services to offenders, facility features and scheduling must assure separation between children and family members and alleged offenders.

The CAC has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and as appropriate throughout delivery of the full array of CAC services.

Many CAC’s serve a vital role in their community by providing services to children with problematic sexual behaviors. CAC’s offering services to this population should have policies and procedures in place to maintain physical and psychological safety for child victims and their families. This includes protected service times when child victims would not be at the center, separate entrances and waiting areas or providing services through linkage agreements at off-site locations.

C. The CAC makes reasonable accommodations to make the facility physically accessible.

STATEMENT OF INTENT: Recognizing that not all centers are located in custom-designed or new buildings, CACs should make reasonable accommodations to make the facility physically accessible. If the CAC cannot be structurally modified, arrangements for equivalent services are made at alternate locations. The Americans with Disabilities Act (ADA) and/or state legislation provides guidelines on accessibility and CACs must be compliant with those guidelines.

D. The facility allows for live observation of interviews by MDT members.

STATEMENT OF INTENT: Understanding that multiple interviews and/or multiple interviewers is often stressful for children, interviews should be observed by MDT members in a space other than the interview room to reduce or eliminate a need for duplicative interviews, whether or not interviews are recorded. The MDT should also be able to communicate with the interviewer in some manner to provide input and feedback during the live interview with the child.

E. Separate and private area(s) are available for those awaiting services, for case consultation and discussion, and for meetings or interviews.

STATEMENT OF INTENT: To assure a physically and psychologically safe environment for children and families, confidentiality and respect for client privacy is of paramount concern in a CAC. It is not acceptable for team members or
CAC staff to discuss cases with children or families where visitors or others not
directly involved with the case may overhear them. Separate areas should also
be made available for private family member interviews and so that individual
family members may privately discuss aspects of their case. Care should be
taken to assure that segregated meeting areas are not only physically separate,
but also soundproofed so that conversations cannot be overheard. Some
centers have placed soundproofing materials in walls when building or
refurbishing their centers. Others have placed stereos or “white noise” machines
in rooms to block sound.
**The sample resources in the appendix are intended for resource and example only and are not intended to “prescribe” how an individual CAC would address specific issues in the medical standard**

**Appendix 1:**

**Medical History for Child Sexual Abuse**

**Common Components of Medical History for Possible Sexual Abuse**

(Needed to guide testing, treatment and make diagnosis)

Sources: Child, Parent/caregiver, Investigator/FI, social work/advocate, medical records. Coordination and collaboration should occur to avoid duplication in the child being asked to recount details of the abuse event.

**History of Present Illness (HxPI):**

- History of the event:
  - What happened, when, where, who was involved
- History of the contact:
  - Body sites involved, actions involved, associated symptoms
- What has happened since the event?
  - Physical/emotional symptoms/behavioral response
  - Safety threats, bullying, school performance
  - Family relationships
- What response has already occurred?
  - Prior medical exam and treatment
  - Interview by investigators or CAC staff
  - Counseling/mental health screening

**Past Medical History (PMHx):**

- Significant Illnesses/Surgeries/Hospitalizations
- Development (including sexual development and menstrual history in girls)
- Behavioral, educational or mental health issues
- Prior abuse and sexual history (current and past legal-aged, consensual partners)
- Medications, allergies and vaccination history (esp. HPV and Hep B)

**Family History (FamHx):**

- Significant health problems in parents, siblings and close relatives.
Social History (SocHx):

- Home composition, violence in the home, substance abuse by patient or those in the home.
- Does the patient feel safe and supported by current caretakers?
- Prior child welfare involvement in the family.

Review of Body Systems (ROS): Ongoing or current problems/concerns (usually 10 systems)

- Head, Eyes, Ears, Nose, Throat = HEENT
- Respiratory (breathing)
- Cardiac (heart)
- Hematology (bruising or bleeding)
- Endocrine = glands (weight gain/loss)
- Neurology = brain (headaches, seizures, balance)
- Gastrointestinal = GI (nausea, vomiting, constipation, diarrhea, rectal pain/bleeding/DC)
- Genitourinary = GU (discharge, burning, dysuria, bleeding, pain, lesions)
- Skeletal (bones and joints)
- Skin (rashes, lesions, tattoos, bruises)
IMPORTANT DEFINITIONS

**Didactic Training:** Didactic training for CAC medical providers should cover examination positions (supine, lateral, knee chest, etc), examination techniques (gathering of forensic evidence, samples for STI testing, labial traction, use of cotton swab with pubertal females to demonstrate edges of hymen, foley catheter, etc), and the review of multiple examples of:

- a) anatomical variants
- b) acquired or developmental conditions that mimic abuse
- c) accidental trauma and sexual abuse trauma
- d) STIs, including information on each STI and on forensic evidence

**Competency Based Clinical Preceptorship:** A clinical training component that provides observation and training with an experienced examiner. Length of the preceptorship is determined by the time it takes the trainee to demonstrate competency in obtaining needed medical history, using appropriate exam techniques, obtaining diagnostic quality photo-documentation, and applying strategies for testing for STI's/pregnancy and appropriate prophylactic regimens.

**TABLE 1: Medical Disciplines, NCA Training Requirements and Credentialing Entity**

<table>
<thead>
<tr>
<th>Role</th>
<th>Foundational Training Requirements</th>
<th>NCA Training Requirements</th>
<th>Licensing Entity</th>
</tr>
</thead>
</table>
| Physician (MD or DO)          | Undergraduate Degree  
4 years of Medical School  
3-5 years of Residency  
1-3 years of Fellowship (optional) | ✓ 16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse      | State Medical Board            |
| Pediatrician (MD or DO)       | Undergraduate Degree  
4 years of Medical School  
3 years of Residency  
1-3 years of Fellowship (optional) |                                                                                           | American Board of Pediatrics (ABP)         |
| Child Abuse Pediatrician      | Undergraduate Degree  
4 years of Medical School  
Peds or Med PedsResidency  
Child Abuse Fellowship  
Board examination in Child Abuse Pediatrics | No additional training requirements                                                        | American Board of Pediatrics (ABP)         |
| Advance Practice Nurse (APRN) | Undergraduate Degree  
2 years of Graduate School | ✓ 16 hours of formal didactic                                                            | State Nursing Board           |
<table>
<thead>
<tr>
<th>Profession</th>
<th>Education Level</th>
<th>Certification Training</th>
<th>State Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner (NP)</td>
<td>Undergraduate</td>
<td>Clinical Certification Exam</td>
<td>State Nursing Board</td>
</tr>
<tr>
<td></td>
<td>Degree</td>
<td>2 years of Graduate School Clinical Certification Exam</td>
<td></td>
</tr>
<tr>
<td>Pediatric Nurse Practitioner (PNP)</td>
<td>Undergraduate</td>
<td>Clinical Certification Exam</td>
<td>State Nursing Board</td>
</tr>
<tr>
<td></td>
<td>Degree</td>
<td>2 years of Graduate School Clinical Certification Exam</td>
<td></td>
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<tr>
<td>Physician’s Assistant (PA)</td>
<td>Undergraduate</td>
<td>Certification Exam</td>
<td>State Licensing Board</td>
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<tr>
<td></td>
<td>Degree</td>
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<tr>
<td>Nurse (RN)</td>
<td>Nursing Degree</td>
<td>Certification Exam</td>
<td>State Nursing Board</td>
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<tr>
<td>Adolescent/Adult Sexual Assault Nurse Examiner (SANE-A)</td>
<td>Nursing Degree (RN or BSN) 40 hour SANE-A training</td>
<td>Competency Based Clinical Preceptorship</td>
<td>State Nursing Board</td>
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</tr>
<tr>
<td>Pediatric Sexual Assault Nurse Examiner (SANE-P)</td>
<td>Nursing Degree (RN or BSN) 40 hour SANE-P training</td>
<td>Competency Based Clinical Preceptorship</td>
<td>Some states have state-specific forensic nursing requirements. Providers who have completed SANE training and preceptorship may choose to apply for certification by IAFN.</td>
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Appendix 3:

Continuous Quality Improvement

<table>
<thead>
<tr>
<th>IMPORTANT DEFINITIONS</th>
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<tr>
<td><strong>Continuous Quality Improvement:</strong> is the process-based, data-driven approach to improving the quality of a product or service. It operates under the belief that there is always room for improving operations, processes, and activities to increase quality.</td>
</tr>
<tr>
<td><strong>Advanced Medical Consultant:</strong> A Child Abuse Pediatrician, Physician or Advanced Practice Nurse who:</td>
</tr>
<tr>
<td>1. Has met the minimum training outlined for a CAC provider (see above)</td>
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<tr>
<td>2. Has performed at least 100 child sexual abuse examinations</td>
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<tr>
<td>3. Current in CQI requirements (continuing education and participation in expert review on their own cases)</td>
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<tr>
<td><strong>Expert Review:</strong> Expert review of examination findings is a de-identified continuous quality improvement (CQI) activity and is NOT a consultation/second opinion.</td>
</tr>
<tr>
<td>1. The CAC should have included in their policies and procedures how the continuous quality improvement activity of expert review is documented.</td>
</tr>
<tr>
<td>2. The CAC should track if an exam is felt to be abnormal either through a patient log kept in a secured location or through the MDT case review process. The number of abnormal exams and percent of exams reviewed by an expert provider should be available if requested for site review purposes/practice audits.</td>
</tr>
<tr>
<td>3. The medical provider or organization who provides the expert review should maintain a de-identified log noting how many times they have provided examination review for a specific provider. Notation of whether consensus was reached is also recommended.</td>
</tr>
<tr>
<td>4. A MOU between the CAC/medical provider and the person serving as the expert reviewer outlining the roles and responsibilities should be considered to delineate roles and expectations.</td>
</tr>
</tbody>
</table>

**Expert Review**

NCA Medical Standard for Accreditation states that “all medical professionals providing services to CAC clients must demonstrate, at a minimum, that 50% of all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone expert review by an advanced medical consultant”.

- a. Advanced Medical Consultants as defined above should also have abnormal exams reviewed by another expert.
- b. An “abnormal” exam is one that has acute or healed physical findings in the ano-genital area indicating that abuse/assault has occurred. Laboratory testing for STI’s or pregnancy and DNA evidence collection are NOT included in the definition of an abnormal exam.
Sample Expert Review Log

Below is a sample table that can be created in an Excel document or preferred database to track the review of abnormal exams by an advanced medical consultant. It is recommended that every CAC Medical provider keep such a log on file for review by NCA Site Reviewers.

<table>
<thead>
<tr>
<th>Date</th>
<th>Site/examiner</th>
<th>Pre/post puberty</th>
<th>Examiner findings/concerns</th>
<th>Reviewer findings</th>
</tr>
</thead>
<tbody>
<tr>
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Sample Language for Memorandum of Understanding with Advanced Medical Consultant

MOU for Expert Review of Examinations with Abnormal Findings

It is understood that the examination review services represent a continuous quality improvement (CQI) activity and are not intended to serve as medical consultation or provision of direct patient care so results of CQI activity should not be documented in the patient’s medical record. It is the responsibility of the medical provider of the CAC to document the findings of the examination in the patient’s medical record, establish referral protocols with the CAC’s medical director, communicate the findings with the appropriate MDT members and be available for case review and court testimony if needed. This MOU for examination review services does not act as or substitute for the role of the local medical director of the CAC.

A process for tracking information from the examination review process is needed for both CQI as well as for application for accreditation/re-accreditation with the National Children’s Alliance.

The CAC and/or the medical provider will maintain a de-identified log of the number of cases in which the medical examination was deemed to represent an “abnormal” examination. An “abnormal” exam is defined as an exam in which acute or healed physical injuries to the anal or genital areas of the patient which would be used to indicate that physical injury from sexual abuse had occurred are identified. Abnormal laboratory tests (sexually transmitted infections and pregnancy) and results of biologic evidence collections are not included in the definition of “abnormal” exams for the purpose of this examination review activity.

The medical provider of the CAC will maintain a log documenting the number of cases with abnormal findings submitted for expert review. Patient information on the log will either be de-identified or maintained in a secure, locked location to protect sensitive health information.

The medical provider serving as the expert reviewer will maintain a de-identified log listing the date, examiner and whether the reviewer agreed with the examiner’s conclusion of abnormal findings on the examination.

Logs should be maintained for a minimum of 5-years to coincide with the cycle for re-accreditation.

CAC Director  
CAC Medical Provider  
Expert Reviewer
### Appendix 4:

**Examination Referral and Timing**

<table>
<thead>
<tr>
<th>Indications for emergency evaluation</th>
<th>Timing of Exam</th>
<th>Medical Indications</th>
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</table>
|                                     | Exam scheduled without delay | • Medical, psychological or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking  
• Alleged assault that may have occurred within the previous 72 hours (or other state-mandated time interval) necessitating collection of trace evidence for later forensic analysis  
• Need for emergency contraception  
• Need for post-exposure prophylaxis (PEP) for STIs including Human Immunodeficiency Virus (HIV) |

| Indications for urgent evaluation | Exam scheduled as soon as possible with qualified provider | • Suspected or reported sexual contact occurring within the previous 2 weeks, without emergency medical, psychological or safety needs identified |

| Indications for non-urgent evaluation | Exam scheduled at convenience of family and provider but ideally within 1-2 weeks | • Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by MDT, or family concern for sexual abuse, but contact occurred more than 2 weeks prior without emergency medical, psychological or safety needs identified |

| Indications for follow-up evaluation | As determined by qualified provider | • Findings on the initial examination are unclear or questionable necessitating reevaluation  
• Further testing for STIs not identified or treated during the initial examination  
• Documentation of healing/resolution of acute findings  
• Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations |

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The 5 P’s
Other indications for medical evaluation even if outside of the DNA collection window

1. Pain/bleeding with/after contact
2. Potential for STI’s due to nature of contact
   a. Many STI’s do not cause symptoms
3. Perpetrator exposed
   a. Sibling/household contacts of the alleged offender
4. Pornography (child) use by caregiver/household contact
5. Patient/parent concern
   a. Patients often have distorted thoughts of body due to perpetrator manipulation
   b. Initial partial disclosures are common

Appendix 5:

Disclosure Log for Protected Health Information (PHI)

Maintain in patient’s chart

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of PHI disclosed</th>
<th>Entity receiving PHI</th>
<th>Purpose of Disclosure (Investigation, billing, continuity of care…)</th>
<th>Person making disclosure</th>
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Annotated Bibliography of the Empirical and Scholarly Literature Supporting the Ten Standards for Accreditation by the National Children’s Alliance

Commissioned by National Children’s Alliance®

This project was supported by Grant No. 2010-CI-FX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice
Introduction

First Edition
In 2010, the National Children’s Alliance engaged the National Children’s Advocacy Center (NCAC) to help explicate the foundations for the standards devised for accreditation of children’s advocacy centers throughout the United States. The goal was to identify and explicate the existing research, scholarship, empirical data, formal theory, management practice, complementary professional standards, or other evidence that provides foundation for each of the standards.

Two important criteria guided the formulation of the NCAC’s project plan:

1. All potentially relevant literature would be consulted in the search for research, theory, synthetic writings, scholarly discourse, and management practices pertinent to the standards, and
2. Only the best and/or most relevant publications would be selected to document the evidence for each standard.

Faculty, researchers and knowledgeable practitioners were engaged to recommend seminal publications and to review candidate publications for quality. The group of reviewers included Lisa Jones, PhD, Harold Johnson, PhD, Linda Cordisco Steele, MEd, LPC, Betsy Goulet, MA, Karen Farst, MD, MPH, Charles Wilson, MSSW, Dan Powers, ACSW, LCSW, Julie Pape Blabolil, MA, RN, CNP, Chris Newlin, MS, LPC, and Andra Chamberlin, MA.

The compilation of 87 articles was prepared by NCAC Research Librarians, David N. King, MLS, PhD, Cindy Markushevski, MA, MLIS and Muriel K. Wells MA, MLIS.

Second Edition
In 2013, the National Children’s Alliance engaged the NCAC to identify and explicate additional research, 2010-2013, providing foundation for the standards for accreditation. Articles were reviewed by Chris Newlin, MS, LPC and Linda Cordisco Steele, MEd, LPC. The compilation of 49 additional publications was prepared by NCAC Research Librarian, Muriel K. Wells, MA, MLIS.
The authors of this project wish to thank the following expert evaluators for their guidance in selection and evaluation of the literature.

MULTIDISCIPLINARY TEAM

Lisa M. Jones, PhD, is a Research Assistant Professor of Psychology at the Crimes against Children Research Center at the University of New Hampshire. She has over ten years of experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Dr. Jones has authored or co-authored several influential papers on national trends in sexual victimization of children and youth. She helped to direct a five-year, quasi-experimental Multi-site CAC Evaluation Project, funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent Internet safety prevention programs.

CULTURAL COMPETENCY

Harold Johnson, PhD, is a Professor of Special Education at Michigan State University (MSU). Prior to his arrival at MSU, he was a professor at Kent State University (1980-2006), a public school administrator (1975-1977) and a teacher of students who were deaf/hard of hearing (1971-1975). His research has focused upon the use of web-based technologies and resources to reduce isolation, facilitate collaboration, recognize excellence and enhance teaching/learning within K-20 deaf education. Currently, his research focuses on the incidence, recognition, impact and prevention of child abuse and neglect as experienced by children with disabilities.

FORENSIC INTERVIEWS

Linda Cordisco Steele, MEd, LPC, is the Curriculum Chair and Senior Trainer for the National Children’s Advocacy Center’s Child Forensic Interviewing Programs. In addition, Linda currently conducts forensic interviews at CACs in Kentucky and Alabama. Linda has previously served as Clinical Director and as a forensic interviewer for three Children’s Advocacy Centers: the Prescott House CAC in Birmingham, Alabama; the National Children’s Advocacy Center in Huntsville, Alabama; and The Safehouse in Albuquerque, New Mexico. While in Albuquerque, Linda served as the Project Director of the Mobile Interviewing Project, which serves the Navajo Nation and Zuni Pueblo, and is a program of All Faiths Receiving Home in Albuquerque. She has also served as Clinical Director, Director of Victim Services, and Acting Executive Director of the Crisis Center of Jefferson County in Alabama. Linda has twenty years of experience in therapy and advocacy work with victims and extensive training experience regionally and nationally. Linda earned her Masters in Education from the University of Pittsburgh and is a Licensed Professional Counselor.

VICTIM SUPPORT/ADVOCACY

National Children’s Advocacy Center
Bibliography of the Empirical and Scholarly Literature Supporting the Ten Standards for NCA Accreditation : Second Edition
August 2013
Betsy Goulet, MA, is a national consultant/trainer as well as a state contractor for the Illinois State’s Attorneys Appellate Prosecutor’s Office where she coordinates statewide trainings and manages grants. Her successful grant writing has resulted in nearly 2 million dollars in funding for a variety of state and nonprofit agencies. Since 1986, Ms. Goulet has been working in the field of child sexual abuse, beginning with her first position as the victim advocate at a rape crisis center. Ms. Goulet was the founding director of the Sangamon County Child Advocacy Center from 1989-1995 and organized the Illinois Chapter of Children’s Advocacy Centers, serving as that organization’s first president. From 1995 until June of 2002 she was the Children’s Policy Advisor to the Illinois Attorney General. In that role she drafted several pieces of legislation, including amendments to the Children’s Advocacy Center Act and the creation of the Sex Offender Management Board. From 2002 – to 2007 Ms. Goulet was a Membership Consultant for the National Children’s Alliance in Washington, D.C., conducting national accreditation site reviews and providing training for multidisciplinary team members and children’s advocacy center staff. Ms. Goulet trains nationally on victim advocacy. She teaches as an adjunct faculty member at the University of Illinois, Springfield in the Public Administration graduate programs, and also at Athens State (Alabama) University’s Child Advocate Studies Program (CAST). In her second year as a doctoral student in the Public Administration program at UIS she is currently researching the impact of evidence-based practices in children’s advocacy centers on public policy decisions.

MEDICAL EVALUATION

Karen Farst, MD, MPH, received her undergraduate and medical school education at Texas Tech University followed by residency training in Internal Medicine and Pediatrics at the University of Arkansas for Medical Sciences (UAMS) and Masters of Public Health at the Faye Boozman College of Public Health in Little Rock, AR. While in practice in Arkansas following residency, she volunteered on the medical staff at the Benton County Children’s Advocacy Center which eventually led to pursuit of fellowship training in Child Abuse Pediatrics at Cincinnati Children’s Hospital. She has been on staff with the Department of Pediatrics of UAMS since 2004, working with the Team for Children at Risk in the field of Child Abuse Pediatrics as well as General Pediatrics in the Emergency Department at Arkansas Children’s Hospital. She provides lectures on child abuse topics to the medical students, residents and fellows at UAMS as well as to child welfare, law enforcement and other related child abuse agency staff statewide. She has been invited to lecture nationally by the American Academy of Pediatrics, National Children’s Alliance, and Regional Children’s Advocacy Centers’ Medical Training Academy. Dr. Farst also provides medical peer review to examiners at children’s advocacy centers in Arkansas, and publishes clinically based guidelines/articles in the field of Child Abuse Pediatrics.

MENTAL HEALTH

Charles Wilson, MSSW, directs the California Evidence-Based Clearinghouse for Child Welfare. He is the Executive Director of the Chadwick Center for Children and Families and the National Children’s Advocacy Center.
Sam and Rose Stein Endowed Chair in Child Protection at Children's Hospital-San Diego, where he oversees a large multi-service child and family maltreatment organization providing prevention, intervention, medical assessment, and trauma treatment services; along with professional education and research. Mr. Wilson serves as the director of the Safe Kids California Project, funded by the US/HHS Children's Bureau. He co-chairs the Child Welfare Committee of the SAMHSA-funded National Child Traumatic Stress Network and serves on the Board of the California Chapter of the National Children's Alliance. He is project director for the Chadwick Trauma-Informed Systems Project which is exploring strategies for improving child welfare response to highly traumatized children. Formerly the Executive Director of the National Children's Advocacy Center in Huntsville, Alabama, Mr. Wilson has served in a variety of roles in public child protection, from a front line worker in Florida and Tennessee in the 1970s, to the State Child Welfare Director in Tennessee (1982-1995). He is past President of the American Professional Society on Abuse of Children and past Vice President of the National Association of Public Child Welfare Administrators and a former ex-officio member of the National Children's Alliance Board of Directors. Mr. Wilson is a frequent speaker at national and international conferences and seminars and the author or co-author of numerous publications, articles, book chapters on team investigation of child abuse, forensic interviewing, evidence-based practices, and trauma-informed child welfare. He is the co-author of the book *Team Investigation of Child Sexual Abuse: The Uneasy Alliance.*

**CASE REVIEW**

**Dan Powers, ACSW, LCSW,** currently serves as Clinical Director for Collin County Children's Advocacy Center; a child friendly facility in Plano, Texas, housing 120 professionals dealing with victims of child abuse and family violence. He supervises a staff of 16 therapists and clinical interns providing no cost services to victims of abuse and family violence as well as their non-offending family members. As Clinical Director he is responsible for clinical operations and program development as well as directing the Advocacy Center’s clinical internship and training program. Dan has over 16 years of experience working within the field of child maltreatment and family violence. He specializes in program development and the treatment of traumatized children, adolescents and their families. In addition, he provides expert court testimony and consultation related to child maltreatment and family violence. Dan has presented workshops on a state and national level in the area of child abuse and family violence. Topics have included dynamics of child sexual abuse, ethics of child abuse reporting, adolescent sex offenders, non-offending parents, child, adolescent and family therapy, as well as the effective use of and ethical issues related to multi-disciplinary teams.

**CASE TRACKING**

**Julie Pape Blabolil, MA, RN, CNP,** is a consultant for the Homeland & Civilian Solutions Business Unit of Science Applications International Corporation. She is also a Pediatric Nurse Practitioner at the Children’s Hospital of Minnesota. Previously she was Programs Director of the National Children’s Alliance.
ORGANIZATIONAL CAPACITY

Chris Newlin, MS, LPC, is the Executive Director of the National Children’s Advocacy Center (NCAC), where he is responsible for providing leadership and management of the NCAC, as well as participating in national and international training and leadership activities regarding the protection of children. The NCAC was the first Child Advocacy Center in the United States, and continues to provide both prevention and intervention services for child abuse in Huntsville/Madison County, Alabama, and also houses the NCAC National Training Center, the Southern Regional CAC, and the Child Abuse Library Online (CALiO™). In these capacities, Chris overssees a staff of 48 professionals and a yearly budget of 5 million dollars. He has worked in both urban and rural Children’s Advocacy Centers; and currently serves on the National Children’s Alliance/Regional Children’s Advocacy Center Management Team, National Children’s Alliance Board of Directors, and Alabama Network of Children’s Advocacy Centers Board of Directors; and is a member of the International Society for the Prevention of Child Abuse and the Association for the Treatment of Sexual Abusers. Chris graduated from Hendrix College, the University of Central Arkansas, and the Harvard Business School Executive Education Program.

CHILD-FOCUSED SETTING

Andra Chamberlin, MA, is a trainer for the National Children’s Advocacy Center and has over 22 years of experience in the child abuse field, conducting over 1,000 recorded forensic interviews of children. She was also part of the community organization that established the Children’s Advocacy Center in Midland, Texas, and served as the Program Director/Lead Forensic Interviewer for 14 years. Andra has ten years of experience in developing, teaching, evaluating, and improving forensic interview trainings provided by the CAC Texas to child abuse professionals tasked with conducting interviews of children. In addition, she has presented at local, regional, state, and national child abuse conferences. Andra earned both a Masters in Applied Research Psychology and a Bachelor of Arts in Sociology from the University of Texas of the Permian Basin.
Bibliography of the Empirical and Scholarly Literature Supporting the Ten Standards for NCA Accreditation

Second Edition

Chris Newlin
Linda Cordisco Steele
Muriel K. Wells
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Multidisciplinary Team


Aaron Miller, MD, MPA, is Director of the Lincoln Child Advocacy Center, Lincoln Medical and Mental Health Center, Bronx, New York, and Assistant Professor of Clinical Pediatrics, Weill Cornell Medical College. Dr. Miller founded the Partnership to Protect Children, which brought a multi-disciplinary team approach to fight child abuse in Malawi. He is a member of the Ray E. Helfer Society. David Rubin, MD, MSCE, is senior co-director of PolicyLab: Center to Bridge Research, Practice, and Policy and Director of Research and Policy for Safe Place: The Center for Child Protection & Health at The Children’s Hospital of Philadelphia, and an Associate Professor at the University of Pennsylvania School of Medicine. Dr. Rubin also serves as a Senior Fellow with the Leonard Davis Institute of Health Economics at the Wharton School. Dr. Rubin has focused his academic pursuits on health policy and practice for vulnerable populations. He has spoken before the U. S. House of Representatives as a representative of the American Academy of Pediatrics’ Task Force on Foster Care. He is a member of the Ray E. Helfer Society.

The purpose of this study was to describe trends in felony child sexual abuse prosecutions across two adjoining districts in New York City from 1992-2002. One of the districts experienced a significant increase in Children’s Advocacy Center (CAC) participation in child sexual abuse cases compared to a neighboring district whose use of CAC’s did not change substantially. The authors’ hypothesis was that the growth in the use of CAC’s in one district compared to the other would correlate with a relative increase in the prosecutions of child sexual abuse.

Felony prosecutions of child sexual abuse (CSA) doubled in the district where the use of CAC’s nearly tripled, while little increase (25%) in felony prosecutions of CSA was found in a neighboring district, where the use of CAC’s remained fairly constant over time. However, the percentage of prosecutions ending in conviction did not change appreciably between the districts over time.

The methodology was thoroughly described, along with a brief overview of the prosecutorial pathway for child sexual abuse cases. Tables are provided which illustrate the demographics of children in Child Protective Services (CPS) investigations in the two districts in 2002, incident rates of CSA cases substantiated by CPS, incident rates of felony prosecutions by the district attorney’s office, incident rate ratios of felony prosecutions by year, and felony conviction rates over time.
The authors offered a cautionary note concerning the interpretation of the data they report and other limitations, including the fact that District One included data for victims 14-17, District Two did not. Their discussion of the results also referred to previous articles in the literature which have found CAC’s to have had a positive influence in evaluating and coordinating child sexual abuse cases. They issued a call for further research to delineate how CAC’s impact the likelihood of prosecution of child sexual abuse.


Rosalyn M. Bertram, Ph.D. is associate professor at the University of Missouri-Kansas City School of Social Work. She has published several articles about the theory base for model fidelity in the wraparound approach to collaborative, ecological, strengths-based family centered team efforts, and is an advisor in the National Wraparound Initiative. Her current research examines theory-based multi-systemic team development at administrative and supervisory levels in Kansas City's response to reports of child sexual abuse. Dr. Bertram teaches advanced level courses about families, communities, child welfare, and evidence-based practice.

Administrators from police, child protective services, forensic and medical evaluators, prosecutors, family court and treatment providers in Kansas City, Missouri clarified the roles of multi-system response to child sexual abuse by applying a theory-based model for team development. This exploratory study examined the efficacy of the model for resolving inter-agency conflict and may contribute to constructing logic models in multi-system collaboration. The author was engaged by a Child Protection Center governance group as a consultant to assist with resolving issues within a multidisciplinary team (MDT) involving damaged trust, reductions in state funding, staff turnover and lags in multi-system communication and response. The author proposed a Systemic Team Development (STD) model to resolve the problems occurring within the MDT. Theory based constructs of team composition and structure were evaluated through semi-structured interviews of team members and observation of team processes. Interviews revealed diverse and conflicting views about individuals and agencies. Team meetings involved identifying a commonly defined structure of goals and rules and establishment of a basis for engagement in assessment and planning. The STD model required team members to pause and agree upon a summation of assessment before creating plans of action. This examination resulted in the conclusion that the group lacked clarity of the different levels of activities contributing to contributed to confusion on roles and responsibilities. Further meetings were held to clarify and refine these issues. The status agreement was used with the stated goals to develop a plan of action. The author concluded that despite changes in participants who had earlier hindered
collaboration, and despite differences of perspectives, the administrators agreed upon specific timelines and actions each agency should accomplish so that information and services were more timely and more integrated. A collaborative structure including a co-authored a manual for this best practice protocol, training of staff, and agreement to share a database to evaluate agencies' abilities to accomplish protocol timelines and activities was developed. Researcher bias was not detected within the report, however it must be considered when reviewing these results.


Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology at the Crimes Against Children Research Center at the University of New Hampshire (CRCC). Tonya Lippert, PhD, MSSW, is on the faculty at Portland State University and is with CARES NW in Portland, Oregon. Theodore P. Cross, PhD, was the director of the Multi-Site Evaluation of Children’s Advocacy Centers at the CRCC. He is now a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. Danielle Maurice is a doctoral student at Brandeis University. Karen Davison, LMSW, is with the School of Social Work at the University of Denver.

This study examined the length of time between key events, including total case processing, of child sexual abuse cases. The authors completed a thorough review of the literature including a review of (Smith & Elstein, 1993) in which a national survey of prosecutors on their experience prosecuting child sexual abuse cases. Sixty-nine percent of prosecutors believed that child sexual abuse cases took more time from filing to disposition than did assault rape cases. The review also found that most studies show that it takes about one year from filing to disposition for child sexual abuse cases. This study examined the length of time between three phases of prosecution: (1) charging decision, (2) case resolution process, and (3) total case processing time. These values were compared across three sites, one with a Children’s Advocacy Center (CAC), and two comparison communities without CACs. Data were collected between December 2001 and December 2003 from case files. The cases were followed until June 2005 to obtain criminal justice outcomes; 44% had a guilty plea, 30% were pending after 2 years, and 26% went to trial. Most cases took between 31 and 60 days to reach indictment. Cases which were seen at the CAC had a significantly quicker charging decision time than those at either of the two comparison sites. CAC cases had a quicker preliminary processing time than the two comparison communities. The authors suggested that this may possibly indicate greater involvement of prosecutors initially during the process.
Limitations to this study were given, including the fact that the three comparison communities were all from within the same county, perhaps limiting the generalizability of the findings and second, a number of important variables were not included in the study which could help to shed light on the variations in case resolution time. From the data collected the authors made three suggestions. First, CACs could potentially identify effective case flow management; second, they suggest that more research is needed to examine variables which might influence case resolution time; and third, more research is needed on how case resolution time affects children.


Paula M. Wolfteich, PhD, is an Assistant Professor of Clinical Psychology at Florida Institute of Technology, and Director of their Family Learning Program, a state-funded program that serves sexually abused children and their families. Brittany Loggins, MS, is a Counselor in Winder, Georgia. This article was written while they were both at the Department of Psychology and Counseling at Valdosta State University.

This study compared outcomes from 184 child abuse and neglect cases which were served through three different modes of Child Protection Services (CPS) including a Children’s Advocacy Center (CAC). Outcomes studied were efficiency, substantiation, arrest and prosecution, and revictimization. The methodology was explained textually and with a table illustrating the demographics of the three different groups. Outcomes were also illustrated in tabular form. CACs showed increased substantiation and a shorter investigative period than traditional CPS. Discussion and limitations of the study were thorough, and the authors concluded that the main advantage of CACs is their multidisciplinary nature.


Steve M. Powell is the Chief Executive Officer, President and founder of Healthcare Team Training (HTT). Powell has been involved in human factors education and teamwork training in the US Navy, commercial airline industry, and the healthcare industry for over 25 years. His most recent experience includes patient safety and patient-centered care training, curriculum development, root cause analysis, research, and team-based simulation. He earned a Masters in Human Factors from Embry-Riddle Aeronautical University and is a graduate of the Naval
Postgraduate safety school and earned his undergraduate degree in Mathematics from the University of North Carolina at Chapel Hill. He serves as a Board member for the North Carolina Center for Hospital Quality and Patient Safety. Susan M. Hohenhaus earned her Doctorate in Law and Policy at Northeastern University, Boston, Massachusetts. She holds a master’s degree in Social Policy and Health Care Policy and a Bachelor of Science degree in Community Health and Human Services from Empire State College, and an associate’s degree in nursing from Regents College of the University of the State of New York. With more than 30 years’ experience as an emergency nurse, Hohenhaus is executive director for the Emergency Nurses Association and was previously the director of ENA’s Institute for Quality Safety and Injury Prevention, and president of Hohenhaus and Associates, a health care consulting company.

This article describes the methods included in crew resource management that foster an environment of mutual respect among professionals working together from disciplines. The focus is upon using methods from the aviation industry to improve communication and reduce error within the healthcare industry. The authors suggest that these methods can be used within multidisciplinary teams. The program, crew resource management (CRM), recommends that hierarchy should be flattened so that all members of the team are empowered to speak up about any concerns. Three components of CRM are reviewed. The first component is briefings. Briefings review tasks of each team member and provide opportunity to discuss contingency plans. In a study of medical teams using briefings, it was found that nurse staffing turnover rates were reduced by 50% compared to teams seldom using briefings. The second component is the use of checklists and best practices. Due to the number of interruptions in the medical environment, the use of a checklist and following best practices provides for strengthened acceptance of responsibility. The third component of CRM is communication that fosters an environment of mutual respect. Use of this approach has been shown to provide a “psychological safety” among team members which promotes the voicing of concerns. The authors suggest that by following CRM procedures of standardized procedures and checklists as well as implementation of teamwork training to foster mutual respect, multidisciplinary teams can reduce error and serve clients more effectively. It should be noted that the authors are paid consultants to healthcare teams.


Daniel W. Smith, PhD, is the Director of Training at the Medical University of South Carolina’s National Crime Victims Research & Treatment Center. Tricia H. Witte, PhD, is an Assistant
Professor of Psychology at Birmingham Southern College in Birmingham, Alabama. Adrienne E. Fricker-Elhai, PhD, is a clinical psychologist specializing in child and adolescent psychology in Sioux Falls, South Dakota.

This study compared CAC-based procedures and outcomes to those in Child Protective Service (CPS) investigations not based in CAC’s during a four month period in one mid-south rural county. The CAC’s showed increases of involvement of local law enforcement in investigation, medical examinations, substantiation, referral for prosecution and conviction rates, and mental health referrals, when compared to non-CAC based CPS. Limitations of the study were discussed and suggestions for future research were made.


Each of the four authors was affiliated with the Crimes against Children Research Center (CCRC) at the University of New Hampshire when this article was published. Lisa M. Jones, PhD, is a Research Assistant Professor of Psychology and has over 10 years of experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Dr. Jones has authored or co-authored several influential papers on national trends in sexual victimization of children and youth. She helped to direct a five-year, quasi-experimental Multi-Site CAC Evaluation Project, funded by OJJDP. Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent Internet safety prevention programs. Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology; Monique Simone, MSW, is Research Associate; and Theodore P. Cross, PhD, was the Director of the Multi-Site Evaluation of Children’s Advocacy Centers at the CCRC. He is now a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign.

The authors reviewed the research relevant to seven practices considered by many to be among the most progressive approaches to criminal child abuse investigations. This article was intended for professionals involved in child abuse investigations. Following a brief introduction, the authors provided an overview of the research to date conducted in each of the seven areas considered to be best practices for criminal child abuse investigations: (1) multidisciplinary team investigations, (2) trained child forensic interviewers, (3) videotaped interviews, (4) specialized forensic medical examiners, (5) victim advocacy programs, (6) improved access to mental health treatment for victims, and (7) Children’s Advocacy Centers. Research supporting competing views is discussed as well as areas of research which are lacking. The article was completed with a list of implications for practice, policy, and research and an extensive bibliography.

The authors of this article are both affiliated with the Hunter College School of Social Work at the City University of New York. Marina Lalayants is a Doctoral Candidate and Adjunct Lecturer and Irwin Epstein, PhD, is Professor of Applied Social Work.

The article began with the premise that although multidisciplinary teams (MDT) are used with increasing regularity, the field had not acquired adequate information about their structural variations, implementation processes, or effectiveness. The audience for this article was those involved with investigation of child abuse cases. The authors examined teams’ possible weaknesses and discuss implications for future evaluation. This article critically reviewed the MDT research literature and summarizes the evidence concerning MDT benefits. The literature review sections cover Team Practice in Child Protection, Definitions of MDTs, Team Models and Compositions, and MDT Effectiveness. The extensive review of the research literature drew the following conclusions: agencies reviewed more suspected cases, missed fewer cases, resolved more cases successfully and they reduced fragmentation and duplication. Synthesis of the research also revealed that team members reported the MDT approach helped bring a more positive view of working conditions, decreased stress, and improved client relations while providing moral support and confidence. Clients found services more accessible and less fragmented. The literature also revealed several areas in which problems can occur. What may seem dysfunctional by one team member may be viewed as an objective by another. Among the most common barriers to team effectiveness were: (1) defining shared goals and objectives, (2) conflicting theories and ideologies about child abuse and neglect, (3) lack of consensus, (4) turf disputes, (5) agency territorialism, (6) power struggles, (7) confusion about leadership roles and the ownership of the case, and feelings of excessive case scrutiny, and (8) that interdisciplinary decision making is more time consuming than traditional approaches. Although this review of the research on MDT effectiveness was the most extensive to date, the authors suggest that areas needing further attention are: (1) more consistent operational definitions of short- and long term MDT outcomes, (2) more descriptive quantitative studies of variations in MDT designs and structures, and (3) more qualitative studies of MDT collaborative processes.


Each of the authors of this article was affiliated with Temple University when it was written. Bernie Sue Newman, PhD, is Chair of the Social Work Department and an Associate Professor; Paul Dannenfelser, MSSW, is a Field Education Specialist, and Derek Pendleton, BS, was an
The authors surveyed 290 CPS and LE investigators who use a CAC in their investigations of criminal cases of child abuse to determine the reasons chosen for using a CAC. Included is historical information about the development of CACs, followed by an explanation of the research design. The study describes the five major reasons front-line LE and CPS investigators use CACs when investigating cases of child abuse: (1) child-friendly environment; (2) referrals, support, assistance with counseling, medical exam; (3) expertise of interviewers at the CAC; (4) formal protocol when a sexual abuse case is investigated; and (5) access to video and audio equipment and two-way mirror. Included in the article is a list and discussion of ways the participants considered CACs could be more helpful including more staff availability, more and larger facilities, and better communication and collaboration.


Kathleen Coulborn Faller, Ph.D., A.C.S.W., D.C.S.W., is Marion Elizabeth Blue Professor of Children and Families in the School of Social Work at the University of Michigan. She is also Director of the Family Assessment Clinic, a program at the University of Michigan School of Social Work that involves collaboration with the Law School and the Medical School. She is Principal Investigator on Training Program on Recruitment and Retention of Child Welfare Workers and Principal Investigator of the University of Michigan site of National Child Welfare Workforce Institute. She is a well-known author of numerous books and articles in the literature on child maltreatment, including *Interviewing Children about Sexual Abuse: Controversies and Best Practice* (2007). She has conducted over 300 juried conference presentations at state, national, and international conferences and over 250 workshops addressing controversies of interviewing children about sexual abuse, the co-morbidity of child maltreatment and parental substance abuse, domestic violence, and cultural competence in child welfare. James Henry, PhD, MSW, joined the faculty of Western Michigan University in 1997 after 17 years in Child Protective Services. He is a Professor of Social Work and Program Director for Western Michigan University’s Children’s Trauma and Assessment Clinic. Last year Dr. Henry was the recipient of a continuing award of $300,723 from the U.S. Department of Health and Human Services to be used to reform child welfare service delivery in the state of Michigan.

Criminal case files resulting from use of a community collaboration protocol for case management of child sexual abuse were outlines and examined. This target audience for this article was communities and professionals involved in the investigation and prosecution of child sexual abuse cases. The authors approached the study from the standpoint of the belief that successful community collaboration can be achieved. A brief review of the literature was followed by a description of the components of the community case management plan. Data
were abstracted from 323 criminal records files for sex crimes against children, the total number of closed cases from 1988 to 1998. Twelve variables were examined to define the effectiveness of the community’s plan for case management of sexual abuse: (1) protective services and law enforcement involvement, (2) videotaping of child interviews, (3) medical exams, (4) child disclosure of abuse, (5) child and family response to the abuse, (6) child placement, (7) suspect confessions, (8) suspect polygraph findings, (9) suspect pleas to sex offenses, (10) trials, (11) child testimony, and (12) sentences received by offenders. Results and implication for policy are discussed. The study found an offender confession rate of 64% and 69% of referred cases were charged. The charging rate of cases in this study also compares favorably to the charging rate reported in Cross and colleagues’ research (Cross, Whitcomb, & De Vos, 1994; Cross, De Vos, & Whitcomb, 1995), who studied criminal prosecution in four jurisdictions, and to that found by MacMurray (1988, 1989), who examined case outcomes for 87 Massachusetts cases. In both studies a little more than half of cases were charged.


Donald C. Bross, JD, PhD, is a noted author and advocate for abused children and is affiliated with the Kempe Children’s Center, Department of Pediatrics, University of Colorado School of Medicine. C. Henry Kempe was one of the first to introduce the team approach to the diagnosis and treatment of abused children in 1958. Jon Korfmacher, PhD, is an expert in the field of early childhood intervention programs.

This article described the role of outside multidisciplinary forensic teams consultations based on the perception of agencies who pay for their services. The concept of outside multidisciplinary teams is scarce in the literature and this article describes the history and types of services of this consulting forensic team in their approach to complex criminal and civil abuse cases. The methodology and results of the State and Regional Team (START) review are provided, as well as the discussion of the limitations of the survey. One third of the cases studied would not have proceeded to an appropriate criminal or civil resolution without the consultation of the START team. Still in existence today, this multidisciplinary team allows expertise to be utilized in rural geographical areas such as Colorado, Alaska, Wyoming and Idaho.

Jerome R. Kolbo, PhD, is a professor of Social Work and Associate Dean, College of Health and Human Sciences, at the University of Southern Mississippi. Edith Strong, MA, MSW, is an Adjunct Instructor of Sociology at Seton Hill University. This article was authored while both were affiliated with the West Virginia University School of Social Work.

A national survey was conducted to examine the trends in multidisciplinary system design and to measure the potential benefit of multidisciplinary teams from the perspective of the respondents, state-level Child Protective Services staff. Trends and patterns supported by the data, specifically configuration, legislation and protocol, functions, composition and representation are summarized. No two states present the same approach with their MDT’s. Challenges were addressed and recommendations for future research were explained.


Patricia Tjaden, PhD, a recognized expert on violence against women and director of the Tjaden Research Corporation, and Jen Anhalt, a researcher at the Center for Policy Research, designed this study to provide empirical data on the types of collaborative investigative strategies being implemented by law enforcement and child protective services (CPS).

The study examined the impact of these strategies on case processing and case outcomes, as well as the administrative and institutional barriers that may impede collaborative investigations. Also examined were the experiences of families and practitioners with the joint investigative process. Child Protective Services records across five study sites for 1,829 cases were reviewed. Each case was tracked to its police department to determine what if any action was taken by the police to investigate the report. Then cases were tracked into the respective criminal courts to determine what if any criminal actions were taken. Major findings were categorized by prevalence of joint investigations, characteristics of cases with joint investigations, impact on case processing and outcomes, practitioner experiences, and obstacles to implementing joint investigations. Among the findings was a positive and significant relationship between the degree of cooperation existing between police and CPS and the frequency with which joint investigations are conducted. Another finding was that the manner in which joint investigations were operationalized affected the frequency in which they were conducted. Findings of positive outcomes in each area prompted the authors to recommend joint investigations for all jurisdictions.

Paula Kienberger Jaudes, MD, has been a leading advocate for children for almost three decades. In 1993 she became the first physician in the United States to be named medical director of a state child welfare agency, the Illinois Department of Children and Family Services. She is President and CEO of La Rabida Children's Hospital and Professor of Pediatrics at the University of Chicago.

This article described the Victim Sensitive Interviewing Program (VSIP) developed in 1986 at the La Rabida Children’s Hospital and Research Center in Chicago. Sexual abuse evaluations for the time period two years before the VSIP was developed were compared with VSIP evaluations for two years after it was developed. There were significant decreases in the number of interviews and number of interviewers. Significant increases were found in identification of perpetrator, charges being pressed after identification of the perpetrator and indication of cases of sexual abuse by the state child welfare agency.
Cultural Competency and Diversity


Nancy Smith, MS, is director of the Vera Center on Victimization and Safety. Smith trains on issues of domestic violence and sexual violence, collaboration, needs assessment, strategic planning, and capacity building. Sandra Harrell, MS, is Project Director of the Accessing Safety Initiative at the Center on Victimization and Safety.

This paper reports a summary of the findings emerging from a project to learn more about the factors that contribute to sexual abuse of children with disabilities. The main problem addressed was the fact that children with disabilities are three times more likely than other children to be victims of sexual abuse, yet despite these numbers, abuse of children with disabilities has not attracted the attention of policymakers, practitioners, advocates, or community members. A second issue of focus was the fact that these children are also less likely to receive victim services and supports. The study was conducted by review of the literature, interviews with key stakeholders, and a national roundtable with participants from a wide variety of backgrounds who were brought together to discuss the issues related to victims of sexual abuse with disabilities, including an understanding of the factors that contribute to the high rates of abuse, the unique dynamics of these cases, the preventive and intervention responses, and to identify critical gaps in current efforts. This paper reports an overview of research on incidence and prevalence, the dynamics of the abuse, and the recommendations that the panel compiled. Several points were derived from the literature supporting the fact that children with disabilities are at a significantly higher risk for abuse than children without disabilities. Gaps in understanding of these issues brought up questions such as: What are the national prevalence rate and the institutional setting rate for abuse? Do the rates vary by disability type and degree? Who were the offenders and what percentage of incidents are reported? The interviews with stakeholders provided significant information including the understanding that discrimination against children with disabilities remains persistent. This discrimination has caused responses and supports for children to be structured their dependency resulting in a culture of compliance. It was further found that children with disabilities are systematically denied basic information about sexual health and relationships. The research and the stakeholders point to the fact that children with disabilities have a greater dependence on others and therefore, perpetrators are often connected to the children through their disability. Another finding was the great lack of primary prevention efforts specifically geared toward preventing abuse of children with disabilities. The final finding was the fact that public awareness about sexual abuse of children with disabilities is lacking on every level. Several recommendations were developed including the development of a national strategy to among other things: engage key stakeholders, increase public awareness, increase research and
funding, advance public policy and legislation, target prevention efforts, and build advocacy, service, and criminal justice responses.


Alan J. Dettlaff, associate professor, University of Illinois at Chicago earned an MSW and PhD at the University of Texas at Arlington. Dr. Dettlaff's research interests focus on improving outcomes for children of color in the child welfare system through the elimination of racial disparities. Dr. Dettlaff is actively involved in research addressing the overrepresentation of African American children in the child welfare system and identifying and understanding the unique needs of immigrant Latino children who come to the attention of this system. His current research includes examination of the factors that contribute to disparate outcomes for African American in the child welfare system and examination of the current state of policy and practice with immigrant children and families. Ilze Earner, associate professor in the Hunter College School of Social Work, City University of New York earned an MSW from California State University and PhD from Columbia. In 1999, she founded the Immigrants and Child Welfare Project providing consulting, technical assistance and training on issues related to foreign-born populations and child welfare. Dr. Earner has published extensively on topics related to program and curriculum development about refugees, immigrants and human trafficking.

This study analyzed characteristics, risk factors, and incidence of maltreatment among children of immigrants and compared those factors to children in U.S.-born families. Data was taken from the National Survey of Child and Adolescent Well-Being (NSCAW), consisting of 5,501 randomly selected children, their caregivers, and child welfare caseworkers. Prevalence rates and statistical tests were weighted to provide estimates for the national population of children who were subjects of reports to CPS agencies. Just over two thirds of child with foreign-born parents and subjects of CPS reports were Hispanic, while about 15% were non-Hispanic White, followed by 10% non-Hispanic Black and over 7% non-Hispanic Asian. Data analysis showed that children of immigrants were more than twice as likely to be subjects of CPS reports of alleged sexual abuse than children of U.S.-born parents and more than three times as likely to be subjects of reports of alleged emotional abuse. However, children of U.S.-born parents were nearly ten times more likely to be subject of reports of neglect. No significant difference in maltreatment substantiation rates were found between the two groups. Risk factors for abuse were identified for purposes of analysis. Risk factors such as alcohol abuse and drug abuse were found to be three times more prevalent in the homes with U.S.-born parents than in the homes with immigrant parents. The U.S.-born parents were also significantly more likely to have intellectual or cognitive impairment. The researchers identify some implications of the findings:
1) Immigrant families may have strengths that can be used to facilitate positive outcomes such as they reasons for migrating including the desire for better lives for their children and the presence of extended family for support; 2) Many problems affecting immigrant families originate outside the family in places such as public schools and within social and economic structures, in many cases causing disadvantages with regard to accessing services; and 3) Child welfare agencies need to address emotional abuse through prevention efforts and information provision. The study was limited by the inability to identify differences among immigrant families with relation to immigrant status. A second limitation was the reliability and validity of caseworker reports of parent and family risk factors. The researchers suggest that future studies should address these issues by collecting data on these measures.


Catherine Lawrence is Assistant Professor in the School of Social Welfare at SUNY-Albany. Her research examines social welfare policy in the United States, with a focus on families, poverty, child welfare and the distribution of social goods. Previously, she was a graduate Research Associate at the Nelson A. Rockefeller Institute of Government, SUNY, where she published work on state policy implementation. Monna Zuckerman is Lecturer in the School of Sociology, Anthropology and Social Work at Skidmore College. Brenda D. Smith is Associate Professor at the University of Alabama, School of Social Work with research and expertise in child welfare services and policy and frontline practice in human service organizations. Junqing Liu is Research Assistant Professor at the University of Maryland, School of Social Work. Liu’s area of research and expertise is in child welfare issues.

This research provides review of the literature supporting the need for cultural competence. Second, it reports the results of a program to increase participant knowledge of cultural competence. Also reported are measures of participant attitudes toward need for cultural competence as well as level of application to practice. Problems evidenced in the literature and included for this research are: 1) Over-representation or disproportionality of minority children in child welfare services, and 2) The majority of child welfare professionals have earned professional degrees that did not include cultural competence training. Due to this lack of professional training in cultural competence, the authors describe and report the results of a training program designed to increase knowledge of several areas related to cultural competence and then integrating the concepts into practice. The Bennett (1993) model incorporating six levels of cultural competence was used in this training. The training included a substantial amount of information related to Native American families and the Indian Child Welfare Act.
Participants reported having very little or no previous training in the ICWA, while those who reported some previous training also reported little understanding of its implications for their practice. Of the 162 professionals who completed the two-day training, 151 or 93% completed a follow-up survey. Twenty-five percent of those who completed surveys were chosen to participate in interviews. The survey showed a significant increase in knowledge across all topics. There was a significant increase in knowledge related to the ICWA. Findings further indicated that participant attitudes reflected a willingness to seek information and to incorporate new knowledge into practice. Results further indicated that training in cultural competence can influence professionals’ perceptions of their frontline practice. The authors suggested that further study into the effects of cultural competency training upon frontline decision making should be undertaken. There were no apparent researcher biases related to this study.


Dolores Bigfoot is Assistant Professor of Research, Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center. Bigfoot is Director of the Native American Division, providing oversight and administration for all programs that have Native American emphasis. She also provides consultation and training to tribes, organizations, and state and federal personnel in cross-cultural issues and issues of diversity, also on cultural traditions and parenting practices. Beverly Funderburk is Associate Professor or Research in the Department of Pediatrics, Section of Developmental and Behavioral Pediatrics in the University of Oklahoma Health Sciences Center. She conducts treatment and training in Parent-Child Interaction Therapy. Dr. Funderburk's research interests include issues of training and dissemination in PCIT and cultural applications of PCIT.

This article addresses the cultural adaptation of Parent-Child Interaction Therapy (PCIT) to Native American and Alaska Native families. PCIT was one of three therapies adapted within the Indian Country Child Trauma Center (ICCTC). The program was designed to implement the basic components of PCIT in a framework that supports American Indian and Alaska Native traditional beliefs. Cultural considerations embedded into the ICCTC’s model transformation process and specific applications for PCIT within the model are discussed. The authors explain that PCIT is compatible with traditional beliefs in several ways including 1) the belief that children need caring, concern and encouragement from parents and extended family, 2) the belief that each child possesses qualities needed to develop into a worthwhile human being, and 3) the belief in caregivers’ responsibilities to nurture the positive nature of a child with respect and honor. A review of eight facets of practical application of PCIT to Native American and Alaska Native families is provided. Engagement: It was important for therapists to communicate to...
families that all caregivers were encouraged to attend and observe. Coaching: It was important to remember that within these cultures listening and watching are not seen as passive, but ways to learn, understand and incorporate new behaviors. Verbal responses: Careful attention was needed to attending to the comfort level of caregivers. Language cadence: Attention had to be given to the potential need for adjustment in coding time. The importance of play: Reinforcement of the concept of the child at the center of the circle was needed. Questioning: A strong tradition of storytelling was found to reduce parents’ questions. Praise: Special attention was given to parent’s using culturally appropriate words such as “honor” and “respect”. Bug in the ear: The device was framed as a “helper”, a concept embraced by Native American and Alaska Native cultures. The authors summarized the process by stating that tension can arise between adhering to the fidelity of an Evidence-Based Practice while respecting the unique aspects of a cultural group. Furthermore, they warn against a provider’s familiarity with a cultural group causing the assumption that extensive adaptations may be required when this is not always the case. They caution that cultural adaptation of PCIT should be regarded as a conceptual approach applied case by case while maintaining the integrity of the evidence-based treatment.


Mark S. Friedman, PhD, Michael P. Marshal, PhD, Thomas E. Guadamuz, PhD, Chongyi Wei, DrPH, and Ron Stall, PhD, are with the Department of Behavioral and Community Health Sciences and the Center for Research on Health and Sexual Orientation, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, PA. Carolyn F. Wong, PhD, is with the Children's Hospital Los Angeles, University of Southern California, Los Angeles. Elizabeth M. Saewyc, PhD, RN, is with the School of Nursing, University of British Columbia, Vancouver. This study sought to compare the likelihood of childhood sexual abuse, parental physical abuse, and peer victimization based on sexual orientation. Previous studies have suggested that sexual minority youths compared with sexual nonminority youths are more likely to experience these victimizations. These studies have varied in effect sizes, measurement of abuse and sexual orientation, group comparison, sampling, and decade of study. The authors of the current study emphasized that relying upon any one study to determine risk factor for victimization was problematic. They undertook a meta-analysis of previous studies while also including the possible moderating roles of bisexuality, decade of study, and gender. Criteria for studies included in the meta-analysis included: comparison of the likelihood of self-reported childhood sexual abuse, physical abuse perpetrated by parents or guardians, or peer victimization between sexual minority and sexual nonminority individuals; and report abuse occurring prior to age 18 years. Only school-based studies conducted in North America were included in the meta-
analysis. Four of the authors coded the relevant articles for independent variables: sexual orientation, childhood sexual abuse, parental physical abuse, and peer victimization. Moderator variables were bisexuality status, decade of survey, and dimensions used to assess sexual orientation. Analysis of data revealed that compared with sexual nonminority adolescents, sexual minority adolescents were on average 2.9 times more likely to report childhood sexual abuse. Compared with sexual nonminority adolescents, sexual minority adolescents were on average 1.3 times more likely to report parental physical abuse. Compared with sexual nonminority adolescents, sexual minority adolescents were on average 1.7 times more likely to report being threatened or injured with a weapon or otherwise assaulted. Sexual minority youths were also 2.4 times more likely to miss school because of fear. Analysis also showed that gender moderated the relationship between sexual orientation and childhood sexual abuse in that the disparity in sexual abuse between sexual orientation groups was greater for males than females. The study authors identified limitations including, data were collected through retrospective self-reports, which may be biased; it was not possible to test for ethnic and racial differences; studies did not collect data or test possible factors such as disclosure of one's sexual orientation, gender role nonconforming behavior and other sexual minority-related factors that may be associated with childhood abuse. The authors assert that the study results have implications for prevention efforts. In conclusion, the authors list ten relevant research questions for further examination.


Dr. Fontes earned a Ph.D. in Counseling Psychology from the University of Massachusetts, Amherst. She has written numerous articles and chapters on cultural issues in child maltreatment, violence against women, and cross-cultural research. Fontes teaches at the University Without Walls at the University of Massachusetts. She has worked as a family, individual, and group psychotherapist and has conducted research in Chile, and with Puerto Ricans, African Americans, and European Americans in the United States.

Fontes presents many of the challenges and possible obstacles to interviewing children who are immigrants or who are children of immigrants. Information is presented concerning biases, cultural differences, and linguistic issues that can potentially interfere even when interviewers have the best intentions. Some issues presented as problematic when approaching the interview include the possibility that caregivers may feel they are being accused of less than adequate care of the child, which may result in loss of custody, prosecution, or deportation. A second consideration is the fact that in many cultures, children are expected to keep family secrets within the family or community. Another issue of concern is language barriers. Fontes states that professionals who speak a little bit of a language may be tempted to conduct the interview without using an interpreter, a practice that is inadvisable unless the interviewer is truly
proficient in the language. Fontes provides several guidelines for interview preparation. These include preparing the physical setting, gathering information on the child’s cultural background, and assessing the child’s level of acculturation to the extent possible. Fontes then provides information on the important aspects of rapport building and conveying respect to both child and caregiver. These critical aspects include interviewer demeanor and interviewer voice. Other important aspects on the interview Fontes includes as critical are the pace and time of the interview and assessment of the child’s development. The author provides analysis of issues and suggestions for approaching each one successfully. This article provides practical, hands on information to the forensic interviewer regarding cultural considerations.


Lisa Aronson Fontes, PhD, is a Professor in the University without Walls, at the University of Massachusetts at Amherst. She holds a Doctorate in Counseling Psychology and is a noted author on cultural issues in child maltreatment and violence against women. Dr. Fontes regularly trains social workers, psychologists, attorneys, law enforcement personnel, physicians, educators, women’s crisis workers, parents, and others in cultural competence and family violence issues. Carol Plummer, PhD, is an Associate Professor in the Myron B. Thompson School of Social Work and a Research Affiliate at the Consuelo Foundation, University of Hawaii at Honolulu. She holds a dual Doctorate in Social Work and Psychology. She is a noted author and researcher in the field of child sexual abuse.

This article examined cultural issues as they apply to disclosure of child sexual abuse. The article was divided into three sections. Section one reviewed the seminal literature to date on disclosure. Section two reviewed the literature on the ways culture plays a role in disclosure and reporting. Section three provided guidelines for culturally sensitive interviewing. The conclusions drawn emerged from both the empirical literature and the clinical experiences of both authors. The results of studies focusing upon cultural influences overall, is unclear. Therefore, Fontes and Plummer focused upon ten distinct issues that they believe may silence disclosures in some cultures. The literature showed that shame was a central issue which can inhibit disclosure in many cultures. Studies also showed that shame “may also be a strong predictor of postabuse adjustment.” The second cultural factor affecting disclosure as identified by the literature was taboos and modesty. Some cultures prohibit even speaking of any topic related to sexuality or the body. Therefore, disclosure is often met with severe anger or punishment toward the victim. Sexual scripts in some cultures make disclosure more difficult. In many cultures “the view of sex as a gender battlefield” makes it more difficult for boys to disclose victimization by females because disclosure would seem to imply that the boy is not as manly as he should be. In many cultures virginity for girls and even the hint of loss of virginity is considered a dishonor. In some
cultures girls who have been victimized are seen as having disgraced the family and may suffer punishment. This is a deterrent to disclosure. Lower status of females in some cultures often causes a report of assault to be discounted. African American women and girls are often expected to keep silent because their complaint would be seen as illegitimate. Further deterrents to disclosure in some cultures exist in the strong values of honor and respect toward older males in society. Religious beliefs may often inhibit disclosure.

Two additional categories of deterrents to disclosure have been found in the literature. The first category was reporting costs, which vary by ethnic group and may inhibit disclosure. Reporting costs may include loss of privacy and family support as well as financial loss. The second issue was structural barriers to disclosure. These included linguistic barriers, lack of document in native languages, immigration laws, racism, and economic barriers. The literature also revealed positive effects of culture on disclosure. Strong mother-child relationships, intolerance of adult sexual practices with children, high value placed on women and children, strong social sanctions against abuse, and extended family supervision of children are some of the positive effects on probability of disclosure. The literature also showed that people within the United States from different cultures may differ in how child sexual abuse is defined and understood. Studies found that African American and Hispanic adults were more likely to report suspected abuse by a stranger but were less likely that Caucasians to report abuse by friends or family members. Section three of this article examined the ways professionals should address cultural issues in child sexual abuse. Fontes and Plummer state, “Professionals must make special efforts to become competent to interview, assess, and work with children and families from racial, cultural, and socioeconomic groups that differ from their own”. The authors developed a set of guidelines based upon empirical evidence and their own clinical experiences. The guidelines on considerations for enhancing cultural competence in interviews were divided by planning for the interview, during the interview, and after the interview. An additional recommendation from the authors was the practice of employing more diverse professionals and assuring high quality community and agency training in cultural issues.


Carol J. Evans, PhD, is research associate professor and director of the Child and Family Mental Health Services Research Division of the Missouri Institute of Mental Health. She has over twenty years of experience in program evaluation and project management, and has worked with diverse cultural groups in both rural and urban settings. Dr. Evans has expertise in consumer and family issues related to mental health, substance use prevention for children/youth, youth and young adult transitions in mental health and program evaluation. Robyn S. Boustead, MPA, was
project director of the Child and Family Mental Health Services Research Division of the Missouri Institute of Mental Health. Her research interests and expertise included developing trauma-informed systems that work to decrease and address issues related to chronic, toxic stress and history of traumatic events, especially with veterans and their families. Christine Owens, PhD, is research assistant professor in the Child and Family Mental Health Services Research Division of the Missouri Institute of Mental Health. Dr. Owens conducts research in the areas of rural mental health and mental health services.

This article reviews results from a cross-site demonstration project on the integration of behavioral health services. The authors include a review of the literature on inclusion of spirituality considerations in treatment programs, implications for services regarding practice and policy, including training for service providers on spirituality. The review of the literature led to the conclusion that inclusion of spirituality in treatment assisted families with coping skills. Data was gathered from the Starting Early, Starting Smart (SESS) and Family Strengths Institute, 2002. SESS was a 3-year evaluation of programs for at-risk children. Participants were from 13 diverse sites across the U.S. The institute included a response panel of participants as well as follow up interviews. Participants in the Institute expressed their desire to include spirituality in treatment. The authors assert that although the literature provides a sufficient amount of evidence that inclusion of spirituality issues should be considered, integrating spirituality into practice is difficult. Implications for policy include the inclusion of families in policy making decisions. The authors posit that administrative barriers to including spirituality such as personal discomfort and resistance to change need to be addressed if system level change can occur. Training for practitioners in inclusion of spirituality has traditionally been excluded. The authors maintain that more emphasis is needed in training programs on the importance of spirituality in families and family life. The assertion is made that because spirituality is important to some families, it should be taken into consideration when working with families in treatment or at-risk.


Nancy Chandler, MSW, the editor for these Guidelines, is the past Executive Director of NCA and is currently CEO of the Georgia Center for Child Advocacy. She is a well-known presenter and advocate on child sexual abuse. Cindi Cassady, PhD, is currently the Clinical Director of Mental Health Services at Deaf Community Services in San Diego, California. Dr. Cassady’s Doctorate is in Clinical Psychology and she has worked in the field of mental health and deafness for over 18 years as a court-approved psychologist providing forensic testing,
psychological evaluations, and clinical treatment for hearing impaired clients. Nancy D. Kellogg, MD, is a Professor of Pediatrics at the University of Texas Health Science Center, San Antonio. She is the Medical Director of the Alamo Children's Advocacy Center and a consultant and trainer for the Texas Department of Protective and Regulatory Services and the San Antonio Police Department. Dr. Kellogg is also part of the medical staff at Christus Santa Rosa Medical Center and University Hospital. She is a member of the Ray Helfer Society and has authored over 70 publications on child maltreatment. Morag MacDonald, RN, MSW, MSN, Head Nurse of Capital Region Mental Health, has been profoundly deaf since birth. She is a nurse/therapist for the Deaf who struggle with chronic mental illness or have Post Traumatic Stress Disorder. Judith Mounty, EdD, MSW, holds a Doctorate in Psycholinguistics as well as a Masters in Social work, an MED in Deaf Education, and a BS in Elementary Education. She is a Research Scientist at the Language Planning Institute/Center for ASL English Bilingual Education and Research. She was the first woman who is deaf to hold the Powrie Vaux Doctor Chair of Deaf Studies at Gallaudet University and served as the Director of the Center for American Sign Language Literacy. Dr. Mounty also provides mental health intervention for hearing impaired individuals and their families. Karen Northrop, MSW, has worked in the field of sexual abuse prevention, response, and administration since 1987. She is Coordinator of Public Programming and Development at the Aetna Foundation Children's Center, a child advocacy organization at St. Francis Hospital and Medical Center in Hartford, Connecticut. She coordinated the CAC Outreach to the Deaf Project, whose purpose was to disseminate information nationwide on equal access to CAC services for hearing impaired victims of child sexual abuse and produced the film Do? TELL! Kids Against Child Abuse, which informs hearing impaired children about child sexual abuse.

These guidelines were prefaced by introductory material including statistics about the community of deaf and hard of hearing (HoH). The authors also included a list of NCA standards for accreditation to which these guidelines pertain. These include (1) Child-Focused Setting (2) Cultural Competency and Diversity, (3) Interviewing, (4) Medical Evaluation, and (5) Mental Health Services. The focus here is upon Cultural Competency and Diversity as it relates to serving maltreated children who are deaf or hard of hearing. The authors looked to the literature to develop these guidelines. Statistics for the deaf report that as many as two million people in the United States are profoundly deaf while as many as 90% of children who are deaf or HoH grow up in families with parents who do not sign, or who learn minimal sign language, or who use gestures or “home signs” to communicate with their child. Furthermore, English is understood only 30-40% of the time by lip-reading according to the literature. Additionally, there is quite limited sign language vocabulary for emotions. Depth of emotion is not often understood through sign language. The research also revealed that “there is a lack of appropriate culture and linguistic resources related to education about safety and sexual abuse.” One study reported that trauma experienced by a child with hearing impairment may be intensified by additional trauma related to communication isolation.
The authors believed that knowledge of all these factors plays a critical role in helping professionals avoid stereotypes and generalizations about subgroups within the population of those with hearing impairment. They asserted that “cultural competence in working with this population includes sensitivity to factors contributing to increased vulnerability to sexual abuse.” Several factors affect work with persons who are deaf or HoH. First, persons with hearing impairment often do not have adequate access to education and information. Teachers may not be adequately prepared to instruct them, therefore, those with hearing impairment may not realize that being touched or forced to participate in an activity that makes them uncomfortable is wrong. Another factor influencing work with this population is that often they are not believed by professionals or family members when they report abuse. Further aggravating this situation is the fact that they often have limited ability to counter the arguments of those who do not believe them. The authors of the guidelines provided thorough background and discussion of use of interpreters as well as the desired qualifications of interpreters including Certified Deaf Interpreters (CDIs) and Oral interpreters. They suggested that prior to scheduling an evaluation, a CAC should acquire as much information as possible about the child or parent’s preferred form of communication and skill level.

The next section of the guidelines dealt directly with communication. The authors stated that often young children with hearing impairment do not have enough experience to know that they should ask an interviewer to slow down or repeat something. The child will often nod in agreement to a question they do not understand instead of asking for clarification or repetition. The authors concluded with an admonition that professionals working with children who are hearing impaired, not only must they have adequate understanding of cultural considerations, but they must also be aware of the oppression, stigmatization, and isolation that often are a part of the child’s life. The additional trauma of sexual abuse may be dramatically increased when combined with these issues related to hearing impairment.


Willi Horner-Johnson, PhD, is Research Assistant Professor of Public Health and Preventive Medicine at the Oregon Health & Science University (OHSU). She completed a postdoctoral fellowship in disabilities and health at OHSU. Dr. Horner-Johnson is also a Research Scientist for OHSU's Center on Community Accessibility (CCA), a program of the Oregon Institute on Disability and Development. One of her research interests is prevention of maltreatment of people with disabilities, and she is the Principal Investigator of a study for the Rehabilitation and Research Training Center (RRTC) on Health and Wellness that involves detailed analysis of the performance of the Behavioral Risk Factor Surveillance System (BRFSS) health-related quality
of life items among respondents with disabilities. She was recently honored by the American Public Health Association (APHA), receiving the Disability Section's New Investigator Award for her significant contributions to the field of disabilities. Charles E. Drum JD, PhD, is Assistant Director for Public Health, Community Outreach and Policy at the Child Development and Rehabilitation Center at OHSU. He is the founding Director of the Center on Community Accessibility (CCA) and the Director of the RRTC on Health and Wellness at the Oregon Institute on Disability & Development, and an Associate Professor of Public Health and Prevention Medicine at OHSU. In addition to his law degree, he holds an M.S. in Public affairs and a PhD Social Policy and Management. His research focuses on health, health-related quality of life, community development, and accessibility issues for persons with disabilities. He is a well-known author in the disability literature and training curricula and has received appointments to many state and federal committees and task forces which address disability issues. In October 2009, Dr. Drum received The National Distinguished Disability Research Award from the Southwest Conference on Disability.

The position of the authors presented in this article was that data on the prevalence of maltreatment in persons with intellectual disabilities (ID) was both outdated and derived from studies that were methodologically weak. Most literature addressing the issue was prior to 1994. To strengthen and update the knowledge and understanding about the prevalence of maltreatment of persons with ID, a review of the literature (English only) published between 1995 and 2005 was conducted. The review focused upon three questions: (1) what is the estimated prevalence of maltreatment among people with ID based on studies published 1995 to 2005? (2) how does prevalence differ between maltreatment of persons with ID and persons without ID? and (3) how does prevalence differ between persons with ID and other types of disabilities? To locate the published literature on this topic the researchers conducted searches of three bibliographic databases: MEDLINE (1986-2005) PsychINFO (1985-2005), and CINAHL (1982-2005). Articles which did not include original data were excluded.

A total of 38 articles were found to be relevant. Analysis of the articles revealed for question one, prevalence of maltreatment among those with ID, in studies of children and adolescents, lifetime prevalence estimates ranged from 11.5 to 28%. In studies which included adults, prevalence estimates ranged from 25 to 53%. For question two, prevalence of maltreatment in persons with ID compared to persons without ID, one study found prevalence at 7.6 times higher while a second study found prevalence at 3.1 times higher for those with ID. Addressing the third question, prevalence differences between those with ID and those with other disabilities, one study found that maltreatment was more prevalent among children with behavior disorders and speech/language disorders than among children with ID. The study also found that children with health-related disabilities such as asthma or arthritis had the same prevalence as children with ID. Maltreatment was less prevalent among children with other types of disabilities such as hearing, physical, and visual disabilities. The authors concluded from analysis of all the studies
that due to the use of convenience samples and the wide variance among results, the state of “knowledge regarding the proportion of people with ID who experience maltreatment has advanced relatively little in the past decade”. They suggested a clear need for more population-level data to better define the scope of this problem.


Elizabeth B. Lightfoot, PhD, is an Associate Professor and Doctoral Program Director at the School of Social Work at the University of Minnesota. She is a frequent co-author in the literature with Traci LaLiberte, PhD, the Executive Director of the Center for Advanced Studies in Child Welfare in the School of Social Work at the University of Minnesota. Dr. LaLiberte focuses on child welfare practice and policy with special interests in comprehensive family assessment, system change, permanency for children in out of home care, and work with children and parents who have disabilities. She has served as principal investigator on studies of comprehensive assessment, evidence-based practice in treatment foster care settings, child welfare leadership, and the intersection of child welfare and disability.

The researchers conducted an exploratory study to answer two research questions. Question one asked what policies, plans and/or procedures county Child Protective Services (CPS) agencies follow to address the needs of children and family members with disabilities and what do county CPS agencies view as their barriers and strengths in serving people with disabilities. The article provided background material covering the data on maltreatment of children with disabilities. The 2003 data for maltreatment of children with disabilities ranged from 1.7 times greater to 3.4 times greater than children without disabilities. This study gathered data from the 66 rural and 21 non-rural county CPS agencies in the state of Minnesota from December 2002 to March 2003. Telephone interviews were conducted with directors of the agencies using semi-structured interviews to obtain information on the agency’s approaches to cases involving individuals with disabilities. 53.3 % reported having no knowledge of any such policies related to disability. Only five counties reported that they had a written policy. 40% reported an awareness of a county policy pertaining to accommodations such as providing sign language interpreters. The directors were asked about their approaches to child protection cases with a child and/ parent with a disability. Eighteen different approaches were recorded. The authors grouped them into six categories: formal case management, informal case management, collaborative approaches, training and information, systems-related approaches, and practice approaches. Each approach was described by the authors and results are displayed in a table. The next section looked at barriers to providing adequate services to people with disabilities. The respondents listed multiple barriers. Thirty-five were listed in both rural and non-rural settings. Factors contributing to these barriers included communication challenges, and the
chronic nature of some disabilities. The next section addressed strengths of the agencies working with persons with disabilities. Twenty-five strengths were described and displayed in a table by rural and non-rural. Strengths included ability to collaborate well, good relationship with clients and families, creativity and innovation of CPS workers, and the presence of well-developed services.

The authors drew several conclusions from the study. First, they found that there was no standard approach to managing cases involving people with disabilities. Second, both formal and informal collaboration was happening at the case worker level. Very few agencies had specialists who were experts in both child protection and disability issues. The researchers noted the limits to the study including that it focused only on Minnesota’s CPS agencies. The results were not generalizable to other states. Second, because the respondents were administrators, they may not have had direct knowledge of actual agency practices. Lastly, respondents may have presented a better picture than what actually occurs in the field. The authors suggested that a follow-up study using standardized questions instead of open-ended questions “should be conducted with both front-line workers and administrators”. They concluded that the study indicated a need for more attention to disability issues with child protection, including more training of workers and the development of models for collaboration and the removal of systemic barriers to service.


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The purpose of this study was to compare the prevalence of sexual and physical abuse experienced by bisexual youth compared to gay, lesbian and heterosexual youth. The authors hypothesized that bisexual youth report greater numbers of sexual and physical abuse than their heterosexual peers, but not necessarily greater numbers than their gay or lesbian peers. A literature review was conducted which found some studies from the U.S. and Canada documenting the angry and violent responses LGB youth experience from family, at school, and the community. Some studies have shown that the disclosure is not the only trigger for maltreatment of sexual minority youth. Most studies were conducted with convenience samples, however, some population-based studies also have revealed higher incidence of physical abuse by family members of sexual minority youth compared to their heterosexual peers. The current study method was secondary analysis of data from seven population-based high school health surveys in the U.S. and Canada. Questions regarding the gender to which the students were attracted were asked. Data analyses were conducted separately for boys and girls. In six of the
seven surveys girls were more likely to report abuse than boys, but the differences between orientation groups among boys was more significant in boys. Sexual abuse reported by heterosexual boys was under 10%, while bisexual boys reported a rate of over 25% and homosexual boys reported a rate of over 20%. Lesbian and bisexual girls reported a rate of 25% in some surveys to as much as 50% in other surveys of sexual abuse. The prevalence for heterosexual girls ranged from just under 10% to just over 25%. Four of the seven surveys assessed physical abuse. Girls in every orientation group reported higher rates of physical abuse than did boys. Gay, lesbian and bisexual boys and girls report higher prevalence of physical abuse than do their heterosexual peers.

Because the seven studies were conducted over a period of six years, the researchers examined rates over time. They concluded from this analysis that the trend was that the disparity between heterosexual abuse and abuse of sexual minorities is growing. They suggested that further studies over time are needed to determine whether the trend continues. The authors noted a limitation of this study due to no indication of timing of physical or sexual abuse. No indication could be drawn from the data as whether abuse took place before or after the self-identification of sexual orientation. Nor was there any indication as to whether the abuse was a direct consequence of disclosure. However, the researchers concluded that regardless of the timing or reason for abuse, higher prevalence of abuse in sexual minority youths suggests a higher incidence of runaways, homelessness, and crime-related issues among this population. Implications for professionals were the need to respond to sexual orientation disclosure in helpful, not harmful ways. They also suggested the need for organizations and caseworkers to raise awareness of the level of violence directed toward this population.


Lynn Clark Callister, PhD, RN, FAAN, is a Professor in the Brigham Young University College of Nursing. Her research and humanitarian efforts have received international recognition, including the highest honor bestowed from the Association of Women's Health, Obstetric and Neonatal Nurses - the Distinguished Professional Service Award.

This article was a review of the literature about culturally competent care for women and children. The audience for this article was those in the nursing and related professions, however, many of the findings translate to other fields. A synopsis of several sources provided the following definition: cultural competence includes cultural awareness and cultural knowledge (cognitive domain), cultural skills (behavioral domain), cultural sensitivity (affective domain), and cultural encounter (environmental domain). Callister divided the literature covering cultural
competence into four categories: descriptive, world view perspectives, cultural brokering, and transcultural world view. She then listed the many scholarly articles which appeared between 1990 and 2003 in the nursing literature. An outcome of culturally competent care as determined by the studies has identified gaps in healthcare outcomes between mainstream individuals and minorities have been identified. Culturally competent care generates a larger percentage of healthcare-seeking behaviors among cultural and ethnic groups. Several studies found that cultural competence helps to reduce disparities in healthcare when it includes respect for cultural practices that are protective of health and well-being. Callister provided a list of suggestions for culturally competent care based upon findings from several studies. The list included: examine personal cultural attitudes and knowledge, use culturally sensitive interviewing tools, foster an open, sensitive approach to beliefs, demonstrate comfort with cultural differences develop cultural communication techniques, demonstrate willingness to relinquish control, and demonstrate respect.


Anna R. McPhatter, PhD, is the Dean of the School of Social Work at Morgan State University, the only School of Social Work at a historically Black University in Maryland. Her research interests are Child Welfare; African American Families, particularly in urban settings; Cultural Competence; Maternal and Child Health; and Adolescent Health. Traci L. Ganaway, PsyD, LICSW, LCSW-C, is the President/CEO of GANT Consulting, LLC. She holds a Master’s degree in Social Work and a doctorate in Clinical Psychology, and has over 17 years of professional experience in the areas of community mental health, health care, human services and corrections within the context of direct practice work, management, administration, clinical supervision and training.

The authors’ aim was to present a model for moving practitioners beyond thinking about and discussing cultural competence and into implementation and sustainability. The article began with a guiding definition and principles. Principles include “Culturally competent social work is a mandate”, and “Cultural competence is proactive”. The theoretical framework for the model derives from several questions the authors pose. They asked, “How does one become culturally competent, and how does an agency ensure that it provides culturally appropriate services?” and “When do we arrive at an acceptable level of competence?” The change model McPhatter and Ganaway used to apply to cultural competence is a five-stage model proposed by Prochaska and DiClemente (1992) developed for therapeutic interventions, but has been applied to several psychosocial issues. The five stages of the change model are Precontemplation, Contemplation,
Preparation, Action, and Maintenance. Prior to explaining the stages and how they apply to cultural competency in agencies, the authors discuss three barriers to change and how they affect agencies. The barriers are organizational barriers, interprofessional barriers, and individual barriers. The five stage model was then applied to each of the three barriers. The model strategies are presented in narrative and chart form and include implementation tasks for completion during each stage. In the discussion section the authors stated that the goal of the model is to change the conception of achieving cultural competence into one of “ongoing process” with a realistic plan. The suggestion was made that organizations must ask, “What will be the payoff for culturally competent practice and service delivery?” The answer, the authors concluded, will be in context of benefit and value for children, families, and communities.


Phillippe B. Cunningham, PhD, holds a Doctorate in Clinical Psychology. He is an Associate Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, in Charleston. He is a noted author in the literature, particularly in the area of multisystemic therapy. Sharon L. Foster, PhD is a Professor in the Clinical PhD Program at the California School of Professional Psychology and an Associate Provost for Research and Scholarship at Alliant International University in San Diego, California. Her research interests are: peer relations and mechanisms of peer influence in childhood and adolescence, aggression among girls, and research methodology. Scott W. Henggeler, PhD, holds a Doctorate in Clinical Psychology. Currently, he is Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina and Director of the Family Services Research Center (FSRC), which has received the Annie E. Casey Families Count Award, GAINS Center National Achievement Award, and the Points of Light Foundation President's Award in recognition of excellence in community service directed at solving community problems. Dr. Henggeler is a noted author in the literature and is on the Board of the National Association of Drug Court Professionals. He has received grants from NIMH, NIDA, NIAAA, OJJDP, CSAT, the Anne E. Casey Foundation, and others.

This study was introduced with citations of previous studies defining cultural competence. The point of view of the authors was that there was concern in the professional community that mental health professionals are not meeting the needs of ethnic minorities. The purpose of this study was to examine the relevance of the content of therapy processes for treating African American children and their families. The authors held three beliefs supporting the need for cultural competence in serving this population. 1) African Americans are disproportionately represented in the most vulnerable populations, 2) African American teens comprise the highest
risk group for criminal offending, and 3) Public health problems are associated with long-term social and economic costs.

The working definition for cultural competence in the field of mental health services used for purposes of this study is “the ability to understand and function effectively in meeting the needs of minority populations” (Cross, Bazron, Dennis, & Isaacs, 1989). The researchers questioned whether there is agreement on how to operationalize the construct of cultural competence in terms of specific therapist behaviors. They sought to determine whether therapy process measures used to assess family treatment of teenagers could be used to build a model to operationalize cultural competence in mental health services to African Americans. To evaluate agreement of experts on the operationalization of cultural competence with African Americans, a group of peer-nominated experts and a group of therapists with high level of experience working with African Americans were recruited. The experts completed surveys rating process measures. Following data collection, because answers to the open-ended questions were so varied, a focus group was conducted. From this a set of nine core skills or processes was produced. The list of nine core processes was included in a questionnaire to the experienced therapists. The therapists were asked to evaluate in relation to three therapy process scales. A comparison was made of the consensus of the focus group of experts with the coding of the therapist experts. The analysis revealed the agreement between the two expert groups was significantly greater than chance, but fell far short of standards of agreement level acceptable in research involving human judgments.

The study’s findings were consistent with those of Fortier and Shaw-Taylor (2000). The peer-nominated experts and the therapist experts “demonstrated little consensus regarding the specific operationalization of the construct in the treatment of African American families.” However, despite the lack of consensus, both groups that a subset of process items was relevant to cultural competency. The items were displayed in a table. The items focused upon mutual understanding of the goals of therapy and the recognition of family strengths. Limitations to the study were the small sample size and the items used in the existing scales were not developed specifically for assessing cultural competence. The researchers concluded that the list core processes might provide a starting point for a definition of culturally competent therapy process with African Americans. The researchers suggested that further study was needed to develop instruments identifying clinical skills and practices that improve mental health services to ethnic minorities.

Judith A. Cohen, MD, a Child and Adolescent Psychiatrist, is Medical Director of the Center for Traumatic Stress in Children & Adolescents at Allegheny General Hospital in Pittsburgh, PA, and Professor of Psychiatry at Drexel University College of Medicine. Since 1983 she has been funded by more than a dozen federally-supported grants to conduct research related to the assessment and treatment of traumatized children. With her colleagues, Anthony Mannarino, PhD and Esther Deblinger, PhD, she has developed and tested Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based treatment for sexually abused and multiply traumatized children and their non-offending parents. Dr. Cohen has served on the Board of Directors of the American Professional Society on the Abuse of Children (APSAC), and received its Outstanding Professional Award in 2000. She is currently a member of the Board of Directors of the International Society for Traumatic Stress Studies, and is Associate Editor of its Journal of Traumatic Stress. She also served as the first author of the ISTSS published guidelines for treating childhood PTSD. Dr. Esther Deblinger is Professor of Psychiatry, co-founder and co-director at the of the CARES (Child Abuse Research Education and Service) Institute at the University of Medicine and Dentistry of New Jersey - School of Osteopathic Medicine. Anthony P. Mannarino, MD, is currently Chairman, Department of Psychiatry, and Director of the Center for Traumatic Stress in Children and Adolescents at Allegheny General Hospital, Pittsburgh, Pennsylvania. He is also Professor of Psychiatry at the Drexel University College of Medicine. Dr. Mannarino has been a leader in the field of child traumatic stress for the past 25 years. He has been awarded numerous federal grants from the National Center on Child Abuse and Neglect and NIMH to investigate the clinical course of traumatic stress symptoms in children and to develop effective treatment approaches for traumatized children and their families. Dr. Mannarino has received many honors for his work, including the Betty Elmer Outstanding Professional Award, the Most Outstanding Article Award for papers published in the journal, Child Maltreatment, given by the American Professional Society on the Abuse of Children (APSAC), and the Model Program Award from the Substance Abuse and Mental Health Services Administration for “Cognitive Behavioral Therapy for Child Traumatic Stress”. Michael de Arellano is a Professor and a Licensed Clinical Psychologist at the National Crime Victims Research and Treatment Center (NCVC), Department of Psychiatry at the Medical University of South Carolina.

This article reviewed the extent to which cultural issues have been included literature on treatment outcomes for abused children. A thorough review of the literature was conducted. Limitations reviewed and suggestions for both practice and future research are provided. Conclusions from the literature were divided into three major areas. First, for the area of cultural effect on psychiatric symptoms following child abuse, the literature provided some evidence that
ethnicity may have an impact on the types and severity of symptoms children display. Some studies found that minority children experience more severe combination of symptoms and more lasting detrimental effects than do Caucasian children. The second area for literature examination was cultural effect on treatment preference and accessibility. A number of studies suggest that African American and Hispanic children may respond better to “brief, goal-directed, problem-oriented treatment” as rather than to other types of treatment. The research has also shown that in minority populations mental health interventions are more accepted if they are recommended by the family’s regular pediatrician and provided by in the primary care setting. Additionally, several studies have found that Asian American and Hispanic children are less likely to receive mental health intervention than Caucasian children regardless of socioeconomic status. There was further evidence that cultural factors may impact length of treatment as well. The third area of examination was cultural effect on treatment outcome in abused children. Some studies in this area have found that race does not significantly affect treatment outcomes while other studies have found that it has a very minimal effect.

The authors emphasized that all of the treatment studies examined used samples which may not have completely represented the broader population of children from each ethnic group. The authors suggested that studies using larger and more representative samples should be conducted for examination of ethnic, racial and religious factors that may influence treatment preferences and/or responses. They further suggested that all treatment research should include the effects of race and ethnicity as part of data analysis. The researchers concluded that it is critical that therapists “develop cultural sensitivity in treating abused children and their families.” They further asserted that regardless of the evidence obtained from empirical studies, it is essential that clinicians develop cultural competence, understanding and respect for each child “within the context of family and cultural group.”


Dr. John F. Knutson, PhD, is a Professor in the Department of Psychology at the University of Iowa. Dr. Knutson received his PhD in Clinical Psychology and began researching child maltreatment in the late 1970’s. Dr. Knutson has published more than 100 journal articles and book chapters on aggression, child maltreatment, and the association between abuse and disabilities, cochlear implants, and methodology pertaining to the assessment of child maltreatment. He served on two federal committees focused on research definitions of child maltreatment and he was a member of the Technical Advisory Group for the Fourth National Incidence Study (NIS-4) of the Office of Child Abuse and Neglect. Patricia M. Sullivan, PhD, is a licensed psychologist who obtained her Doctorate in Pediatric Psychology. She is a Professor
of Psychiatry and Psychology at Creighton University where she is the Director of the Center for the Study of Children’s Issues. She has written many articles in the literature concerning child maltreatment and disabilities, particularly with hearing impaired children. She has provided numerous presentations to guardians ad litem, county attorneys and to juvenile, county and district court judges on psychological evaluations. Dr. Sullivan is an NIH funded researcher and most recently studied the long-term effects of violence exposure, including child abuse, domestic and community violence, in childhood.

This study was supported by a research grant from the National Center on Child Abuse and Neglect. The researchers reported on the prior research on maltreatment and disabilities. They stated that little scholarly work had been conducted that focused upon the association between child maltreatment and disabilities. The Westat (1993) study had provided support for the link, however the study was limited to opinions of CPS workers to determine presence or absence of disabilities. Similarly the Sullivan and Knutson (1998) also provided strong support for the link between disabilities and maltreatment; however, it was limited to a hospital-based sample. The present study was a replication of the hospital-based study with the addition of using an entire school-based sample. Additionally, the definitions of disabilities were school-based criterion.

The study examined the electronic data base records of a population of school children including children eligible for various special education programs. Thus the sample ranged in age from 0 to 21. Demographic data such as race, gender, and age were also retrieved from the school database records in order to examine data across various categories. For each child identified from the records as maltreated, a detailed record review was completed. Examination was also conducted of law enforcement agencies’ records. Results of the data analysis and record examination revealed that the overall rate of maltreatment among children who had a disability and were receiving special education services was 31% or more than three times the rate for children without educationally relevant disabilities. The most prevalent form of abuse was neglect for both disabled and nondisabled children. Children with disabilities were 3.67 times more likely to suffer neglect than children without disabilities. Children with disabilities were 3.88 times more likely to be emotionally abused than children without disabilities. Most children were victims of multiple forms of abuse; however, significantly more children with disabilities suffered multiple forms than did children without disabilities. Children with disabilities also tended to be maltreated multiple times and in multiple ways. The study found no association between type of disability and type of maltreatment. To assess the role of age in maltreatment, the children were grouped by ages 0-5, 6-9, 10-13, and 14-20. For both disabled and nondisabled children, significantly more children were maltreated for the first time in the age 6-9 group than in other age groups. Children with disabilities make up close to one-third of the maltreated children between ages 0 and 9. Among maltreated children with disabilities, significantly more girls than boys were victims of sexual abuse. For all types of abuse boys with disabilities were more likely to be abuse than were girls. Risk for maltreatment was also examined by type of
disability. Deaf or hard-of-hearing children had twice the risk for neglect and emotional abuse and almost four times the risk for physical abuse children without disabilities. Children with visual impairments were twice as likely to suffer emotional abuse as children without disabilities.

In the discussion section of the report, the authors discussed the findings in relation to the previous studies. They posited that the significant differences in findings from the Westat study and this study was likely due to different methodological approaches. The Westat study used only CPS agency records and therefore, was limited to a great deal to intrafamilial abuse. In addition, the CPS records were used to establish disability, while in the present study school-based records were used. However, similarly to the Sullivan and Knutson (1998) study, perpetrators of maltreatment of children with and without disabilities were “overwhelmingly immediate family members”. Also consistent with the earlier study, children with disabilities tended to be maltreated at younger ages. The findings of the present study for dominant forms of abuse were also congruent with the findings of the National Incidence Studies and the Westat study. The authors conclude with the recommendation that because this study did not address cause and effect, future studies should examine disabilities as either a risk factor or an outcome.
Forensic Interviews


Yee San Teoh, PhD, earned a doctorate from the University of Cambridge and is now in the department of psychology at Brooklyn College, City University of New York. Michael E. Lamb, PhD., is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment.

This research examined the relationships between child age and interviewer demeanor and children’s verbosity and informativeness. Interviewer demeanor was measured by support, verbosity, and authoritarian manner. While previous research on effects of interviewer support had been mixed, there had been very little examination of other aspects of interviewer demeanor. This study builds upon previous research showing that children’s memory reports are often more complete and accurate and less suggestible when questioned by highly supportive interviewers. This study was conducted in Malaysia using an approach that would distinguish between supportive and unsupportive interviewer comments. Interviewer nonverbal behavior was excluded. Interviews examined in this study (N=75) were conducted with children ages five to 15, including 67 girls and eight boys. The interviews were conducted by British and locally-trained law enforcement officers from the Child Protection Unit in Kuala Lumpur. Transcripts of the interviews were coded for interviewer demeanor and number of details in children’s accounts and level of informativeness. Similar to previous studies, the researchers found a positive link between interviewer support and children’s informativeness. However, it was also determined that the interviewers used proportionally fewer supportive comments with younger children during the interview substantive phase. Another finding was that interviewer support only during the substantive phase seemed to influence children’s informativeness during the substantive questioning. This affect was greater for older children since interviewer support was more evident among older children. Another significant result was that interviewers were more talkative while interviewing the younger children in both pre-substantive and substantive phases. Contrary to prediction, the researchers did not find a significant relationship between interviewers’ authoritarian manner and children’s verbosity and level of informativeness. The findings of this study support the need for interviewers to be socially supportive even when this may be more difficult with younger children. The authors assert that for future research it is important that examination of individual differences in children’s responsiveness to social support manipulations be conducted. The researchers acquired no personal gain from this research because no interview protocol was used during the interviews studied.

Thomas D. Lyon, PhD, JD, is the Judge Edward J. and Ruey L. Guirado Chair in Law and Psychology at the University of Southern California and researches child abuse and neglect, child witnesses, and domestic violence. He is the past-president of the American Psychological Association’s Section on Child Maltreatment (Division 37) and a former member of the board of directors of the American Professional Society on the Abuse of Children. Elizabeth C. Ahern, MA, is a PhD candidate in developmental psychology at the University of Southern California. She researches children’s disclosure of maltreatment, truth induction methods, and emergent lie-telling ability. She is also a child interviewing specialist and conducts trainings on child interviewing. Nicholas Scurich, MA, is a PhD candidate in quantitative psychology at the University of Southern California. He studies normative and descriptive models of juridical decision making.

Lyon and colleagues determined to accomplish five tasks in this article. First, they argued that children’s disclosures of abuse can be highly probative, especially when obtained using techniques supported by research. They present an overview of the Bayesian approach and agree that it is an excellent framework for understanding difficulties in evaluating abuses allegations. Subsequently, they critique the information presented by Faust and colleagues in the first three chapters of Kuehnle and Connell (2009) on the limited probative value of sexual abuse indicators. They assert that the examples used by Faust et al may lead to underestimation of the probative value of disclosure. Second, the authors refer to Brown and Lamb’s (2009) review of the evidence that the NICHD protocol increases the quantity and quality of information that children provide. Lyon and colleagues then elaborate on interview methods than can increase the diagnosticity of disclosures. The third section of the article discusses the probative value of children’s disclosures of genital touch, and argues that these disclosures often have high probative value. The discussion takes into account age of the child and type of questions employed. This is followed by a discussion of innovations in interviewing that can increase probative value. The final section of the article is a discussion of Herman (2009), who argued that the NICHD protocol does a poor job of distinguishing between true and false allegations. The authors argue that Herman was incorrect in his assessment of the poor probative value of children’s disclosures of abuse, as well as the advantages of using the NICHD protocol. Following this critique, the authors suggest that including instructions, narrative practice, rapport building, and open-ended questions will lead to more accurate reports, and additionally these methods may be improved by use of instructions with counterexamples and a promise to tell the truth. This article adds to the body of knowledge on the value of evidentiary findings from disclosures by promoting further discussion and research.

Margaret Ellen Pipe, PhD, holds a joint appointment in the Interdisciplinary Children's Studies Center and the Department of Psychology at Brooklyn College. Her research is in the field of applied developmental psychology with a focus on child witnesses, interviews of children, and memory development. Yael Orbach, PhD, is a researcher and staff scientist at the National Institute of Child Health and Human Development, and one of the developers of the NICHD interview protocol. Michael E. Lamb, PhD., is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment. Craig B. Abbott is a Senior Research Assistant and Statistician in the Comparative Behavioral Genetics Section at the National Institute of Child Health and Human Development. His research interests are in the effects of family violence on the social and emotional development of children and adolescents and the development and assessment of techniques for interviewing child witnesses and victims. Heather Stewart is an Assistant Program Manager at the Children’s Justice Center in Salt Lake City, Utah. She has collaborated with the National Institute of Child Health and Human Development on child forensic interview research since 1997.

The purpose of this research was to determine whether the use of evidence-based practice for interviewing child witnesses would cause changes in disposition of cases including numbers of arrests, charges filed, cases prosecuted and guilty pleas or convictions. This study adds to the literature by focusing on the investigative interview as a predictor of outcomes. Previous literature had examined temporal and procedural aspects of the case flow through the system. The article reviews case flow in child abuse cases, previous research examining predictors of case outcomes, as well as review of the NICHD Interview Protocol. Three outcomes of the research were expected. It was expected that use of the interview protocol would reduce ambiguous accounts and increase the amount of central information. Second, it was expected that use of the protocol would be associated with higher numbers of arrests, filing of charges, convictions and pleas. Third, it was expected that use of the protocol would decrease the number of cases declined by prosecutors during screening. The research method was a comparison of case outcomes from cases before-NICHD Interview protocol cases with cases after the protocol was implemented. Both before -protocol cases (N=350) and protocol cases (N=410) involved the same detectives, prosecutors and judges and had no changes in leadership or formal policy during the study period. Case characteristics and outcomes were compared. Case outcomes were represented at all decision points between initial referral and court disposition. Results for numbers of cases declined by prosecution at screening were 28% of pre-protocol cases and 17.6% of protocol cases. Forty-two percent of pre-protocol cases resulted in arrests and charges...
filed while 52.9% of protocol cases resulted in arrests and charges filed. Fifty-two percent of pre-protocol cases resulted in a guilty plea, while 56% of protocol cases resulted in a plea of guilty. Of the cases that went to trial, 50% of pre-protocol cases resulted in conviction, while 91% of protocol cases resulted in conviction. As in previous studies, the outcomes at screening seemed to be critical. Also similar to previous studies, cases involving victims between ages 2.8 and 4 years were least likely to result in charges filed in both pre-protocol and protocol cases. Similar to previous research, cases involving the most severe abuse were more likely to have charges filed regardless of protocol condition. Lastly, similar to previous studies, only a small percentage of cases went to trial in both protocol conditions. Limitations to the study included: 1) outcome data were collected during different time periods, 2) missing data with respect to case characteristics, and 3) all cases were conducted in the state of Utah and thus outcomes may not be generalizable to other areas. The researchers suggest the need for further research and replication of comparison between pre-protocol and protocol cases.


David LaRooy, PhD, holds a research lectureship funded by the Scottish Institute for Policing Research (SIPR) based at the University of Abertay Dundee with research focusing on forensic interviews with children and guidelines for interviewers. Carmit Katz, PhD, is Research Associate in Applied Developmental Psychology at the University of Cambridge, UK. Lindsay Malloy, PhD, is Assistant Professor in the Department of Psychology at Florida International University with research addressing children’s and adolescents’ disclosure of negative or traumatic experiences. Michael E. Lamb, PhD., is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment.

The authors argued that interviewing children more than once is potentially valuable for a number of reasons. The authors state that although interview guidelines discourage multiple interview sessions, many also acknowledge that it is often appropriate to do so. The article provides a brief review of the psychological research and forensic implications of additional interviews. The method for analyzing effects of repeated interviews was the analysis of transcripts of four cases of multiple interviews. The four cases involved children and adolescents of various ages and diverse circumstances. All interviews were conducted using the National Institute of Child Health and Human Development (NICHD) Interview Protocol. All cases had independent external evidence of abuse. The article presents the conditions and transcripts of the interviews with notation of both repeated and new information from second interviews. The first two cases showed the value of additional interviewing when there were practical reasons for
doing so. The remaining two cases showed how the results of experimental research on repeated interviews is relevant and how one interview is often unlikely to result in a complete account of remembered events. The second interviews involving two adolescents and two young children (ages 5 and 6) resulted in substantial amounts of new information. The authors posit that perhaps the reminiscence effect should be considered sufficient grounds for another interview. Additionally, there were no contradictions found from first and second interviews in all four cases. There was no evidence that additional interviews caused inaccuracies as is commonly assumed. The researchers remind the reader that inaccurate information results when suggestive questioning or interviewer bias occur, whether in a single or repeated interview. They further caution that the cases analyzed do not represent all situations in which multiple interview sessions might be conducted. However, they assert that the findings are consistent with what would be expected based upon previous psychological research. They further submit that repeated interviews are most likely to be advantageous in jurisdictions that have high-quality training, regular peer review, and continued professional development. The authors conclude with the suggestion that future research should examine the effects on children’s accounts when more than two interviews are conducted.


Amy Russell, MSED, JD, NCC, currently serves as deputy director for the National Child Protection Training Center, located in Winona, Minnesota, and provides professional training on a national and international level. Russell has worked with victims of violence and trauma in several capacities, including extensive counseling and support work with child victims of abuse; director of victim services and counselor for survivors of homicide victims; victim/witness coordinator in a U.S. Attorney’s office; and executive director of two children’s advocacy centers.

Russell addresses two areas of concern regarding investigative interviews of child victims and witnesses. The first area of concern is the importance of documentation of the interview. Secondly, Russell reviews the evidence for several elements used to assist in assessing internal reliability of children’s statements. Russell begins with a thorough review of the literature examining electronically recorded interviews. The literature reviewed reveals the benefits and controversies of recorded interviews. Benefits determined through research have included 1) reduction in children’s court appearances, 2) playing of recordings that may encourage a plea by offender, 3) use in court when interval between interview and court date is months or years. Criticisms of electronic recordings have been based upon the lack of training and expertise of interviewers and the possibility for misuse or exploitation of recordings. Russell asserts that both
of these issues can be and are commonly overcome by adequate training and acquisition of skills and knowledge. Russell emphasizes the fact that the advantages of electronic recordings are well documented to include decrease in number of interviews and court appearances. Additional advantages include the use of recordings for witness corroboration or witness impeachment, the use of recordings in lieu of children’s testimony in grand jury proceedings, and reduction in errors that often occur during interviewer hand note taking. Russell subsequently presents the judicial and statutory support for electronic recordings of child interviews. Statutory support includes 15 states having legislation specific to this topic, while other states have similar laws. Twenty states have legislation addressing the admissibility of recorded pre-trial statements and 28 states have a variety of hearsay exceptions permitting use of children’s out-of-court statements. Russell discusses several cases which lend support to the use of recorded interviews. In the next section of this article, Russell reviews and presents arguments she believes to be critical for judicial officials’, juries, attorneys, and others to understand about how interviews are conducted and assessed for reliability. These factors include medical evidence, timing and circumstances of disclosure, identity of alleged perpetrator, existence of a motive to fabricate, appropriate language for developmental level, quantity and quality of details, appropriate level of sexual knowledge, consistency of report, description of alleged perpetrator’s behavior, plausibility of description of abuse, and emotional reaction of child during interview. Russell concludes by emphasizing the need for training and knowledge in a variety of areas including, normal sexual and linguistic development, familiarity with suggestibility research, and awareness of best practices and protocols for interviewing children. She further suggests that ongoing training for attorneys, judges, and other legal professionals in recognition of the signs of abuse should be encouraged.


Karen J. Saywitz, PhD, is a developmental and clinical Psychologist who currently serves as Professor in the Department of Psychiatry and Associate Director of TIES for Families in the Department of Pediatrics, UCLA School of Medicine. TIES provides multi-disciplinary services to families adopting children with special needs from the foster care system. She is an international expert on children involved in the legal system and has received awards for her pioneering research, teaching, and advocacy on children's mental health. Thomas D. Lyon, JD, PhD, is a Professor of Law and Psychology at the University of Southern California and past-president of the American Psychological Association’s Section on Child Maltreatment. He is a well-known author, presenter and researcher in the field of child maltreatment, particularly in the area of child witnesses. Gail Goodman, PhD, is a Distinguished Professor of Psychology at the University of California, Davis, and her research involves memory development and children's
abilities and experiences as victim/witnesses. Her research has been cited in Supreme Court decisions.

The authors’ focus in this chapter was on child interviewing principles based on the best available science, understanding that such principles keep changing as new evidence accumulates and that there are gaps in the knowledge base where guidance is limited. They emphasized the fact that interviewers, like professionals in any field, need to stay abreast of new developments. The focus was upon empirically based evidence behind interview structure, setting, interviewer demeanor, children’s reluctance and suggestibility, rapport development, narrative practice, introducing the topic of abuse, avoiding concepts that confuse children, instructions to children, phrasing of questions, evidence-based strategies for eliciting details, and multiple interviews. Conclusions were drawn from review of the research base for each area. They determined that studies show totally unstructured interviews are “ill-advised” and that even when “interviewers are well-trained, it is difficult for them to abide by best practice recommendations without following a structured or semi-structured format”. Structured protocols are shown to help prevent defective interviewing while standardization increases adherence to evidence-based practices. Addressing the topic of setting for interviews, the studies examined confirm that distractions can have adverse affects on children’s ability to focus on the interview. Private interviews are recommended to avoid the possible contamination from parents or others. The authors suggested that even without obvious pressure, children may be reluctant to speak in the presence of another person as well as reluctant to accuse someone of wrongdoing in their presence. Review of the scientific evidence suggests that interviewers are more successful “when they provide a supportive yet non-suggestive atmosphere”. The authors explained that while there is little scientific data available on the best methods for developing rapport with children, studies do suggest maltreated children can have more difficulty establishing rapport with professionals than nonmaltreated children with mental health problems (Eltz, Shirk, & Sarlin, 1995). Numerous studies were found to demonstrate the value of phrasing questions in grammar and vocabulary children can understand. Review of the literature shows that communication breakdowns occur when young children are asked long, overloaded questions using complex grammar and vocabulary (Brennan & Brennan, 1988; Carter, Bottoms, & Levine, 1996; Perry, McAuliff, Tan & Claycomb, 1995; Saywitz, Jaenicke & Camparo, 1990).

The authors determined that children are often reluctant to say “I don’t know”. Several studies suggest that telling children that saying “I don’t know” is acceptable reduces their suggestibility to misleading questions. On the topic of warning children about misleading questions two studies were found that showed positive effects from warning children that questions might mislead them and then giving permission for them to correct the interviewer (Saywitz & Moan-Hardie, 1994; Warren, Hulse-Trotter, & Tubbs, 1991). Several studies found that repeated interviewing of young children while using suggestive techniques can be detrimental to the accuracy of their reports (e.g., Ceci, Loftus, Leichtman, & Bruck, 1994; but see Quas et al., 2007). However, repeated non-leading interviewing tends to uncover new details (Hershkowitz & Terner, 2007;
see review in LaRooy, Lamb, & Pipe, 2009). Researchers have not found a detrimental effect of repeating open-ended wh- questions (who, what, where, when, how). Repetition of yes/no questions, however, can be problematic, especially those with embedded information that came from sources outside the child (see review in Lyon, 2002).


Irit Hershkowitz, PhD, is a professor in the School of Social Work at the University of Haifa, Israel. She was a research fellow in the Section of Social and Emotional Development, National Institute of Child Health, National Institutes of Health. Since 1995 she has conducted field studies of young alleged victims, witnesses and suspects of abuse and has mainly published on investigative interviewing of children.

Dr. Hershkowitz completed an in-depth look at two socioemotional factors associated with children’s provision of forensic information during sexual abuse investigations: rapport building and interview’s support. The research tested to what extent the length and questioning style of the rapport-building session and the level of support interviewers provided, correlated with the amount of forensic details children provided. A thorough review of the literature is provided. This research was approached with the following two expectations: (1) a positive association between shorter rapport-building sessions and rapport-building attempts comprising open-ended questions and the production of forensic details during the substantive part of the interview and (2) that higher levels of interviewers’ support would cause more details in the substantive part of the interview. The interviews for this research followed the National Institute of Child Health and Human Development (NICHD) investigative protocol. Results included a finding that (1) larger amounts of forensic details followed shorter rapport-building sessions and (2) larger amounts of supportive comments interviewers addressed to the child in the interview, were followed by more details obtained. The author suggested that the findings help define what form of rapport building is associated with more detailed forensic statements. The findings also imply that short sessions of open-ended invitations aimed at establishing child–interviewer rapport are associated with richer information. The author noted a limitation to the study due to the sample consisting of cooperative children who voluntarily disclosed abuse and who were likely to perceive the investigator as helpful. The finding may not hold for interviews with reluctant children. A previous study (Davies et al., 2000) also found the negative association between the length of rapport building and children’s production of detail. Sternberg et al., 1997, also found the apparent advantage of child investigators using open-ended strategies when attempting to develop rapport with alleged abuse victims.

Karen J. Saywitz, PhD, is a developmental and clinical Psychologist who currently serves as professor in the Department of Psychiatry and Associate Director of TIES for Families in the Department of Pediatrics, UCLA School of Medicine. TIES for Families provides multidisciplinary services to families adopting children with special needs from the foster care system. She is an international expert on children involved in the legal system and has received awards for her pioneering research, teaching, and advocacy on children’s mental health. Lorinda B. Camparo, PhD., is an Associate Professor of Psychology at Whittier College. Her research interests include the efficacy of techniques for interviewing children, adolescent friendships, and the development of prejudice and stereotypes in children and adolescents.

The authors identified and discussed improvements in child forensic interviewing from the previous two decades including protocols designed to accommodate children’s developmental levels. Also described were the advances in the infrastructure of interviewing for the same period. Finally, they ended with a discussion and suggestions for moving into a holistic approach to research and practice. The authors’ approach to the topic was from a more therapeutic standpoint as clearly seen in the suggestions for further research. A comprehensive overview of the trends in interviewing based on empirical research for the period was provided and followed by a discussion of how the research derived protocols have been put into practice. The protocols covered in depth included the Step-Wise Interview, the Cognitive Interview, the National Institute of Child Health and Human Development (NICHD) investigative interview, the Narrative Elaboration procedure, and Finding Words. The next section covers some core components of community response to child abuse allegations that have affected the context and infrastructure of forensic interviewing over the previous 20 years. The authors found from both the research and the clinical literatures the clear value of differentiating between forensic interviews and clinical efforts. From their review of the literature the authors also found that during the 1980s, it was common during pretrial investigations for child witnesses to be repeatedly interviewed by multiple interviewers from various agencies such as law enforcement child protection, juvenile law, and mental health, each unaware of the other's activities and with no single agency taking responsibility for coordinating the process. Many interviewers were unaware of the dangers of using suggestive interviewing techniques with young children. Interviews occurred in a wide range of uncontrolled settings (e.g., schools, hospitals, courthouses, police stations, homes, cars, and cafeterias), lacking safeguards and objectivity necessary to minimize potential for false accusations. The authors completed this article with suggestions for a more holistic approach, not merely treating children as witnesses or victims of
crime, including moving beyond just getting the facts and striving to meet mental health needs without tainting reports.


David La Rooy, PhD, holds a research lectureship funded by the Scottish Institute for Policing Research (SIPR) based at the University of Abertay Dundee and is responsible for the Forensic Psychobiology Degree. Michael E. Lamb, PhD., is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment. Dr. Lamb is internationally recognized for his fundamental contributions to our understanding of early family relationships and child care, and for his groundbreaking work at the intersection of developmental science and public policy. His scholarship has significantly advanced developmental psychology while also having a major impact on legal authorities, forensic investigators, policymakers, and others concerned with the well-being of children. Margaret Ellen Pipe, PhD, holds a joint appointment in the Interdisciplinary Children's Studies Center and the Department of Psychology at Brooklyn College. Her research is in the field of applied developmental psychology with a focus on child witnesses, interviews of children, and memory development.

The authors reviewed previous studies of effects of repeated interviewing in child abuse investigations including many studies undertaken in the previous decade, some shedding light on issues that were not addressed adequately, if at all, in earlier reviews. The authors’ decision to conduct a narrative review of all experiments in which children were repeatedly interviewed about a personal experience or event allows the presentation and evaluation of a large amount of evidence examining widely held beliefs about the effects of repeated interviewing. This examination also identified forensically relevant questions to which there are as yet no empirically validated answers. In a previous field study (Hershkowitz and Terner, 2007) reported that children provided many new details in a second interview, suggesting that repeated interviewing might be of considerable value. This review of the empirical research focused upon three major issues: (1) what happens to the amount and accuracy of information reported in response to free recall and open-ended questioning across repeated interviews? (2) how should information that is consistently reported across repeated interviews, and that which is newly reported in repeated interviews, each be characterized? and (3) what is the relationship between repeated interviewing and suggestibility? The following conclusions resulted from this extensive review of the research. Skepticism about repeated interviewing is unjustified because there were
some conditions in which repeated interviews seemed advantageous because the amount and accuracy of information in free and open-ended recall was partly determined by both the length of the delay between the event and the repeated interviews and the delay(s) between the interviews.

Concerns about repeated interviewing were reinforced by the fact that children often provide different information about the same event across different interviews (Steward et al., 1996). The resulting ‘inconsistency’ may detract from the perceived credibility of witnesses and raise doubts about the accuracy of the information they provide (Brock, Fisher, & Cutler, 1999; Cassel & Bjorklund, 1995; Poole & Lamb, 1998, Poole & White, 1995). Doubts about credibility can take the form of natural skepticism (e.g., “If that’s true, why didn’t she report it when first questioned?”), or more serious concerns that, over successive interviews, children can be deliberately or unwittingly influenced to report false information (Ceci & Bruck, 1993; Loftus, 2005). Studies also suggest that although new information reported across successive interviews is generally more inaccurate than information that is consistently recalled, accuracy may vary depending on the delay between interviews or between the event and interviews. Of the 30 studies examining repeated interviewing and suggestibility, most reported that repeated interviewing leads to increased suggestibility, used highly suggestive techniques, multiple suggestive techniques, and more frequent suggestive interviews. The authors suggested that further systematic studies were needed before conclusive practical lessons can be drawn.


Margaret Ellen Pipe, PhD, holds a joint appointment in the Interdisciplinary Children's Studies Center and the Department of Psychology at Brooklyn College. Her research is in the field of applied developmental psychology with a focus on child witnesses, interviews of children, and memory development. Yael Orbach, PhD, is a researcher and staff scientist at the National Institute of Child Health and Human Development, and one of the developers of the NICHD interview protocol. Michael E. Lamb, PhD., is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment. Craig B. Abbott is a Senior Research Assistant and Statistician in the Comparative Behavioral Genetics Section at the National Institute of Child Health and Human Development. His research interests are in the effects of family violence on the social and emotional development of children and adolescents and the development and assessment of
techniques for interviewing child witnesses and victims. Heather Stewart is an Assistant Program Manager at the Children’s Justice Center in Salt Lake City, Utah. She has collaborated with the National Institute of Child Health and Human Development on child forensic interview research since 1997.

The authors examined whether improved interviewing procedures increase the likelihood that a suspect would be prosecuted. They further examined decision points to determine whether the use of the NICHD protocol led to a reduction in the time for case processing. This study examined case outcomes in 551 cases before the NICHD interview protocol was implemented and 729 cases after the protocol was implemented. The 1,280 interviews were conducted by police interviewers at a Children’s Justice Center in the United States. Each case was coded for case characteristics and case outcomes which included each point of decision making during the case flow in the criminal justice procedures from case referral for investigation to disposition. There was no significant difference between the pre- and post-protocol cases with respect to number of counts per suspect. Analysis of records showed that cases using the protocol resulted in charges filed at a rate of 1.5 times higher than pre-protocol cases. Results indicated that charges filed for cases involving children age 7-9 were most affected by use of the protocol, with 22% more cases filed than with pre-protocol interview cases. For the small number of cases that went to trial, a guilty verdict was found in 16 out of 17 (94%) of the protocol cases, while a guilty verdict was found in seven out of 13 (46%) of pre-protocol cases. Further analysis found that with regard to speed of case processing, the delay from date of interview to date of suspect being arrested and/or charged was longer for the cases before the protocol was implemented. Previous research had indicated that protocol interviews elicited higher quality information. Therefore, the researchers predicted that use of the protocol would have a positive effect on case outcomes. The authors reasoned that children’s narrative accounts are more compelling and accurate than those heavily contaminated by interviewer input. The researchers indicate a strength of the study as the fact that the same detectives conducted the pre-protocol interviews and the protocol interviews. A study limitation indicated is that the outcome data are collected in different time periods, pre and post training on the NICHD interview protocol. From the results of this study and previous research, the authors contend that interview protocols implemented and training in forensic interviewing, should be evidence based. It should be noted that two of the authors of this paper have worked with development of the National Institute of Child Health and Human Development interview protocol.

Michael E. Lamb, PhD, is Professor and Head of the Department of Social and Developmental Psychology at University of Cambridge. His research focuses on forensic interviewing; non-parental childcare, and parent-child relationships and the development of psychological adjustment. Dr. Lamb is internationally recognized for his fundamental contributions to our understanding of early family relationships and child care, and for his groundbreaking work at the intersection of developmental science and public policy. His scholarship has significantly advanced developmental psychology while also having a major impact on legal authorities, forensic investigators, policymakers, and others concerned with the well-being of children. Yael Orbach, PhD, is a researcher and staff scientist at the National Institute of Child Health and Human Development, and one of the developers of the NICHD interview protocol. Irit Hershkowitz, PhD, is a professor in the School of Social Work at the University of Haifa, Israel. She was a research fellow in the Section of Social and Emotional Development, National Institute of Child Heath, National Institutes of Health. Since 1995 she has conducted field studies of young alleged victims, witnesses and suspects of abuse and has mainly published on investigative interviewing of children. Phillip W. Esplin, EdD, specializes in forensic psychology. He was a Senior Research Consultant with the National Institute of Child Health and Human Development, the Child Witness Project, from 1989 through 2006. Dvora Horowitz, PhD, is with the Israeli Ministry of Labour and Social Affairs and a lecturer in the Beit Berl Academic College.

The authors approached this research from the point of view that in many cases of alleged child sexual abuse, inappropriate interview techniques have to potential of compromising and contaminating children’s testimony as found in (Bruck, 1999, and Ceci and Bruck, 1995). The goals of this study were twofold: first, summarizing research designed to translate findings regarding children’s memory, communicative skills, and social understanding and tendencies into specific interview strategies and techniques that should help prevent such notorious errors and problems in the future, and second, to review studies demonstrating that the use of such techniques in over 40,000 interviews has dramatically improved the quality of investigative interviewing in a number of locations already. Following a review of the literature, the authors emphasize that for purposes of this study, the focus was upon the interviewer’s ability to elicit information and the child’s willingness and ability to express it, rather than the child’s ability to remember it. An overview of the structured NCHID Protocol was provided, followed by an evaluation of what the authors referred to as ‘in the real-world’.
The authors reviewed the empirical research in light of issues such as, the protocols suitability for interviews with young children and the importance of training. Conclusions drawn from review of the research include: (1) how much researchers and interviewers have collectively learned about children’s communicative and memory retrieval capacities and (2) that this information can be used by interviewers to maximize the value of their investigative interviews with alleged victims of abuse. The authors emphasize that the protocol is not a panacea for all interview situations. A short discussion of other interview protocols was provided.


Theodore P. Cross, PhD, was the director of the Multi-Site Evaluation of Children’s Advocacy Centers in the Crimes Against Children Research Center at the University of New Hampshire (CRCC). He is now a visiting research specialist in quantitative analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. Lisa M. Jones, PhD, is a Research Assistant Professor of Psychology at the CRCC. She has over 10 years of experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Dr. Jones has authored or co-authored several influential papers on national trends in sexual victimization of children and youth. She helped to direct a five-year, quasi-experimental Multi-site CAC Evaluation Project, funded by OJJDP. Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent internet safety prevention programs. Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology at the CRCC. Monique Simone, MSW, is research associate at the CRCC. David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. His current research is devoted to dissemination and implementation efforts designed to adapt and then transport effective interventions for these clinical problems to various community settings or systems serving children, youth, and families, including pediatric primary care, juvenile justice, child welfare, public health/safety, and mental health.

The focus of this study was a comparison of CAC and non-CAC outcomes by analyzing investigative or forensic interviews by police, child protective services and other professionals to assess the truth about a suspicion of child abuse following an official report. They discuss several practice problems that affected interviewing and the ways in which CACs are considered to solve
these problems. They sought answers to three major questions: Do CACs promote interagency coordination? Do CACs reduce the number of child interviews and forensic interviewers? Do CACs improve the interview setting? The biggest objection to redundant interviewing is that it could make children re-live the trauma of the abuse in the retelling. In limited research, a greater number of interviews have been associated with more child distress (Berliner & Conte, 1995; Henry, 1997; Jaudes & Martone, 1992; Tedesco & Schnell, 1987). Repeated interviewing could make children think that people do not believe them or are unwilling to help. Children could change their answers because they think they got it “wrong” the first time (Ceci & Bruck, 1993), or may become frustrated and recant their statements to stop the interviews. This study was a segment of the larger study: The Multi-Site Evaluation of Children’s Advocacy Centers. Four communities with CACs were compared to four within-state communities lacking CACs. Two types of data gathered between December 2001 and December 2003 from both CAC and comparison communities were used for this study: descriptive, site-level data and case file data.

Results suggested that the CACs had a noticeable impact on investigations and forensic interviewing in child sexual abuse cases. Team interviews, videotaping of interviews, joint CPS-police investigations, and police involvement in CPS sexual abuse cases were all more common in the CAC cases than in the non-CAC cases. Some results such as greater police involvement for CACs than for comparison communities seemed to duplicate results from Smith et al. (2006). Findings also suggested that the CACs in the study appeared to offer a more thorough and child-oriented response to child sexual abuse reports, and families appeared to have a more positive experience on average, however, the authors pointed out that the advantages pertained to coordination and not number of interviews.


Lindsay E. Cronch (Asawa), PhD, is a licensed clinical psychologist. She was a research team member at the Child Maltreatment Lab, Department of Psychology, University of Nebraska-Lincoln, where her primary research projects related to the assessment and treatment of families in which child maltreatment is identified. She recently completed a postdoctoral fellowship at the Children’s Hospital of Dallas. Jodi Viljoen, PhD, is an Assistant Professor in the Department of Psychology, Simon Fraser University. Her research interests include youth violence, mental health and treatment of adolescent offenders, adolescents’ legal rights and competencies, youth forensic assessment, and treatment of adolescent offenders. David J. Hansen, PhD, is a Professor and Department Chair, University of Nebraska Psychology Department. He co-directs the Family Interaction Skills Clinic and directs Project SAFE (a clinical research and treatment...
program for sexually abused children and their families) through the Psychological Consultation Center. Dr. Hansen has published extensively on maltreatment, clinical assessment and intervention, child and adolescent social competence and adjustment, among other topics.

The authors examined the research and trends in forensic interviewing such as structured interview protocols, the extended forensic evaluation model and the child advocacy center model established to prevent repeated interviewing. Limitations of the research as well as discussion of empirically based recommendations were provided. Major points from the research literature reviewed include factors influencing disclosure during interviews, techniques used in forensic interviews, and new directions in forensic interviewing. Review of the research on the child advocacy center model provided these conclusions: (1) that repeated interviewing and repeatedly asking similar questions have both been associated with inaccurate reporting and recanting allegations, particularly if early interviews are conducted inappropriately and (2) that the CAC model approach to interviewing best serves the interests of the child, reduces number of interviews, and provides the victim with support. Limitations to the research included the fact that much of the research on certain interviewing techniques was limited to the developers of these techniques. Few studies have been conducted by researchers who were not involved in the development process.


Erna Olafson, PhD, is an Associate Professor of Clinical Psychiatry at the University of Cincinnati and Director of the Program on Child Abuse Forensic and Treatment Training at Cincinnati Children’s Hospital. She has conducted forensic interviewing training programs across the United States. Cindy S. Lederman, JD, is the presiding judge of the Miami-Dade Juvenile Court in Miami, Florida. She is a member of the Board on Children, Youth and Families of the National Research Council and Institute of Medicine. She recently completed a fellowship from Zero to Three, the National Center for Infants, Toddlers and Families in their Leaders of the 21st Century Initiative. Judge Lederman serves on the board of the Florida Infant Mental Health Association.

The purpose of this review was to update criminal, juvenile, and domestic relations court judges about current areas of agreement and disagreement among scientific researchers about the disclosure patterns of CSA victims. The authors reviewed six questions surrounding the disclosure and non-disclosure patterns of known to have been victims of sexual abuse. Two sources of information which the authors consider to be imperfect are surveys of adults who report having been sexually abused during childhood and examination of children’s statements.
during evaluation and treatment in cases with corroborative evidence that is independent of their statements. To provide judges with a thorough overview of the issues, the review of the research was divided into nine categories: child sexual abuse disclosures delayed until adulthood, child sexual abuse disclosures delayed within childhood, children’s gradual disclosures during formal interviews, non-disclosure or denial by children when interviewed about child sexual abuse, studies of disclosure patterns in cases without selection bias, studies of child sexual abuse cases that avoid only substantiation bias, recantations, variables that affect disclosure patterns, and bizarre disclosures.

Conclusions drawn from the literature concerning forensic interviewing include, (1) prior disclosure predicts disclosure during formal interviews, (2) gradual or incremental disclosure of child sexual abuse occurs in many cases, so that more than one interview may become necessary, (3) when both suspicion bias and substantiation bias are factored out of studies, and when external corroborating evidence of child sexual abuse is present, 42% to 50% of children do not disclose sexual abuse when asked during formal interviews. The authors suggested that further research is needed about recantation rates, which range in various studies from 4% to 22%, and children’s disclosure patterns which warrant further multivariate research.


Alison R. Perona, JD, is the Inspector General, Chicago Transit Authority, Chicago, Illinois Bette L. Bottoms, PhD, is a Professor in the Department of Psychology, Vice Provost for Undergraduate Affairs and Dean of the Honors College at the University of Illinois at Chicago. Her research areas have included the accuracy of children's eyewitness testimony, techniques to improve children's reports of past events, and jurors' perceptions of children's testimony. She is the author of numerous scholarly articles and the co-editor of five books on children's eyewitness testimony. Erin Sorenson, MA, is the Chief Programs Officer at the BeCause Foundation in Chicago, IL, and former Director of the Chicago Children’s Advocacy Center.

The authors presented the basic principles of forensic interviewing as well as review of currently used protocols. They provided a detailed, practical blueprint for conducting a structured forensic interview emphasizing how the components of the interview are based upon empirical research. Also discussed were special considerations for interviews with children of different age groups and children with special needs or circumstances. The authors followed with suggestions for legal and social service professionals in accessing the social science research literature that should inform forensic interview techniques. The authors emphasized that it is impossible to apply exact techniques to use with children of certain ages due to differences in development.
even of children of the same age. A review of the literature on wording questions was provided including question suggestiveness, negative and positive questions, closed ended questions, style and tone of questioning, and more. A review of the literature examining the use of interview aids and the various components of the interview process was provided. This is followed by a discussion of the empirical evidence covering individual differences among children in special victim populations.

The authors concluded that determinations about the effects of individual differences on memory and suggestibility are “somewhat speculative”, but becoming more definitive as the research base expands. Addressed also was the topic of repeated interviewing. The researchers concluded from the literature that pre-adolescents and adolescents, like younger children, should not be subjected to repetitive interviews. They concluded that being asked to repeat statements to interviewers might cause them to re-experience trauma-related emotional difficulties, such as shame and embarrassment. If repeated interviews are unavoidable, at the second and subsequent interview, prior interviews should be discussed and the purpose for the current interview (e.g., additional investigation, trial preparation) should be explained. The child should be allowed to express his or her feelings about being asked to repeat information. In the discussion of understanding and using the research, the authors pointed out that forensic investigators have different professional training than the social scientists who conduct the research. They offered several suggestions for interpreting and applying research to the field. They also suggested that it is important to consider how generalizable research findings are to the real world of child abuse investigations.


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The authors explained that most professionals agree that following guidelines of best practices when conducting investigative interviews in the field should be done, that interviews should be completed as soon as possible after the alleged offenses by interviewers who introduce as little information as possible using open-ended prompts, and that open-ended questions are more likely to produce more accurate responses. This suggested however, that although research-based recommendations are widely endorsed but are seldom followed. The researchers compared interview quality over 96 interviews conducted by 21 interviewers who were trained according to professionally recommended practices to interview quality of the same 21 interviewers in the six months prior to this training. Conditions examined included validation, rapport building, victims’ protocol, and suspects’ protocol. Findings from the study suggested that benefits of training in interview best practices are obtained when steps are taken to ensure the maintenance of these same practices. The results further suggested that systematic evaluations of programs consistently reveal effects on the trainees’ knowledge but no significant impact on the quality of their interviewing behavior. Results also suggested that meaningful, long-term improvement in the quality of information obtained from alleged child victims of sexual abuse are observed only when well-established principles are operationalized clearly and concretely and when training is distributed over time. The results of this study mirrored previous studies by both Orbach, et al. (2000) and Sternberg, Lamb, Orbach, et al. (2001) which revealed that the quality of interviewing improved when forensic interviewers were trained to implement a protocol that operationalized the consensus recommendations of diverse professionals and scholars, practiced using that protocol, and received written and verbal feedback on their interviews.


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The authors cited several studies which have found the value of narrative responses elicited using open-ended prompts rather than information elicited using more focused prompts. The researchers posit that the research-based recommendations replicated in these studies are “widely endorsed, but seldom followed”. Additionally, earlier studies suggested that both the use of a detailed protocol and ongoing supervision and feedback were absolutely crucial to the quality of forensic interviews. This study examined two sets of interviews. The first set of interviews was conducted using the NICHD protocol by experienced forensic investigators who received regular supervision and feedback on their interviews. The second set of interviews was conducted by the same investigators immediately following termination of the supervision-and-training regimen. Results included that the number and proportion of invitations declined significantly when supervision ended, while the proportion of option-posing and suggestive prompts increased. Results also showed that withdrawal of supervision was associated with a decline in the quality of information obtained from alleged victims, as well as a decline in the amount of information elicited. The authors concluded that when supervision was removed, interviewers adhered less to best practice guidelines and thus affected their performance. Several previous studies (Lamb, Hershkowitz, Sternberg, Esplin, et al., 1996) and (Sternberg et al., 1996) showed similar results.


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The authors reviewed the literature relevant to questioning in forensic interviews. The research showed that regardless of age, responses to open-ended questions are more likely to be accurate than responses to more focused questions. However, some practitioners (e.g., Bourg et al., 1999; Hewitt, 1999; Saywitz & Goodman, 1996) contend that open-ended questions usually fail to elicit forensically valuable information from young children, especially preschoolers. Therefore, this study was conducted with two primary goals: (1) to determine whether alleged victims of child sexual abuse can provide high-quality information when investigators adopt recommended practices and (2) to characterize and compare investigative interviews with younger and older children to clarify the capacities of young alleged victims to describe their experiences when properly interviewed. The researchers entered into the study with the expectation that older children would provide more details than younger children, and that use of the NICHD protocol would increase the amount of information produced by all alleged victims from all age groups.

The method was the examination of 100 first forensic interviews of alleged sexual abuse victims by six experienced police officers. Half of the children were interviewed using the National Institute of Child Health and Human Development's structured interview protocol while half were interviewed using standard interview procedures. Results included that protocol interviews were more likely than standard interviews to include an explanation of the ground rules, the recommended rapport-building techniques, and a practice narrative about a neutral event. Another result was that protocol interviews were better organized and were more likely to shift focus to the alleged abuse in a nonsuggestive manner. A third finding was that nonprotocol interviews were more likely to obtain information about the child’s family. Also, the number and proportion of details elicited using open-ended prompts were greater in the protocol interviews than in the standard interviews 48out of 50 times. Similar to the findings of Orbach, et al. (2000) interviewers in the protocol condition introduced option-posing and suggestive questions later
than in the standard interviews, including interviews with very young children. The researchers concluded that a major contribution of this study is the demonstration that alleged victims age six and younger can provide substantial amounts of information when open-ended questions are used in well-structured interviews.


At the time this article was written, both authors were affiliated with the Department of Clinical Medicine, University of Leeds, UK. Jan Aldridge, PhD, is a Senior Lecturer in Clinical Psychology and Director of Child Forensic Studies at the University of Leeds and is Consultant Clinical Psychologist at Martin’s House Children’s Hospice, Wetherby, West Yorkshire. She has written academic and general articles as well as making parenting programs for TV. Sandra Cameron, MA, MSC, is a Clinical Psychologist in Leeds, UK.

The central focus in this study was the efficacy of interview training. They designed a study to address two interrelated issues. The first issue was the effect of a one-week intensive, research-driven training course on subsequent interviewer performance. The second issue was the actual types of questions used by police and social worker interviewers in their investigations of child abuse cases. The study examined 27 interviews using a series of rating scales. Second, a content analysis of the interviews was conducted to record the frequency of use of five question types. Of the 27 interviews examined, eight progressed only to the rapport building stage; therefore 19 were used to examine question types. Following the one week intensive interviewing training course, half-day follow-up sessions were arranged every three months. The follow-up sessions were to reemphasize the main points of the training in relation to subsequent interviews and to review issues which had arose in the participants’ workplaces. To examine the effect of the training course on interviewer behavior, trained interviewers were compared to “untrained” interviewers for a nine month period following the course. Nineteen videotaped interviews were examined and rated with a rating scale. The following areas were rated: rapport building, free narrative, open-ended questions, and specific questioning. The rating scale ranged from one (very poor) to eight (excellent). The highest single mean rating for both groups was 5.7. The researchers concluded results demonstrated that in order to affect a behavioral change in interviewers, there must be a “number of experiences of interviewing with different children, in different types of situations, together with ongoing supervision encouraging reflective practice.” The results of this study echo those of Davies, et al (1995). Similarly to (Gagne & Briggs, 1974) this research showed that the kind of capability and competency needed for child interviewing develops over “fairly long periods of time”.

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Kay M. Stevenson, PhD, was an Associate Professor at the Graduate School of Social Work, University of Denver. Patrick Leung, PhD, is a Professor and Coordinator of the Office for International Social Work Education, University of Houston, and is currently coordinating the Social Work Research Center there as well. He is editor of the *China Journal of Social Work*.

The authors posited that a criticism of many training programs was that evaluation of the impact on actual performance is inadequate or nonexistent. The authors assert that “rigorous evaluation of competency not only enhances accountability, but also increases the credibility of CPS in court and community.” This study identified existing methods of evaluating training efforts, examines the development of evaluation using videotaped simulated interviews, and discusses practice implications. The authors identified one method of determining the success of learning is measuring performance improvement. The results from knowledge tests given before and after training can provide information about mastery of training content while pre and posttests of simulated interviews can determine trainees' mastery of practical skills. Stevenson and Leung pointed out that the ability to demonstrate new knowledge in interviewing situations requires time for integration into existing worker styles and agency protocols. They also suggested that practice and feedback over time are requisite for the development of skill in comprehensive coverage of complex content.

Review of the literature by the researchers revealed that following training, trainees “may identify critical content in an initial assessment without necessarily demonstrating how that content might be translated into actual interviews.” In order to evaluate trainees’ competence in conducting initial assessment interviews with alleged child victims of sexual abuse a video-based evaluation procedure and a rating instrument were created. A standardized case scenario was constructed and role played by adults, simulating an initial interview with a victim of child sexual abuse. Trainees completed a videotaped, 30-minute interview to evaluate skills both immediately before and after training. Results of the study strongly suggested that interviewing competency requires an increase in conceptual knowledge, but also time and practice to integrate skills into ongoing practice. It was also determined that it is necessary but insufficient to evaluate competency in skill development immediately on completion of a training period. The results of the study also suggested that competency in conducting initial child sexual abuse interviews requires both a knowledge base and training in key interviewing processes and behaviors, and practice and feedback from supervisors in the workplace following training.
Victim Support and Advocacy


Jennifer Cole, PhD, is an assistant professor in the University of Kentucky with appointments in the College of Social Work in the Center on Trauma and Children and in the College of Medicine in the Department of Behavioral Science. Her research interests are in the areas of victimization, substance use, and in particular the intersection of victimization and substance use among youth and young adults.

The purpose of this research was to examine how professionals in Sexual Assault Response Teams (SARTs) understand and work through the various professional statutory requirements for victim confidentiality. Through an examination of the literature and the statutory differences, Cole found evidence suggesting that conflicts may arise between advocates, medical providers, and law enforcement. Within many SARTs, team members are operating under different statutory requirements for privileged communications with victims. The method for the study included a telephone survey of 78 professionals on SARTs in two metropolitan areas and one site covering four counties. All three sites served victims age 14 and over. Participants were asked two questions. First, they were asked to agree or disagree with this statement, “Maintaining the confidentiality of victims poses particular challenges to coordinating care between professionals.” The second question was based upon participant answers to question one. An open-ended question asked participants to discuss challenges or to talk about why maintaining confidentiality was not a challenge. Fifty-eight percent of participants disagreed with the statement that maintaining confidentiality created a challenge to collaboration with the team, while 10% were neutral, and close to 32% agreed with the statement. Responses to the open-ended question regarding why confidentiality was not seen as an impediment fell into two categories; 1) everyone on the team understands the importance of victim confidentiality, and 2) maintaining confidentiality does not limit information shared among the team members. However, no victim advocates gave this response, while over 28% of medical and 23% of criminal justice professionals gave this response. Of the 32% of respondents who agreed that maintaining confidentiality did pose problems with team collaboration, close to 67% were victim advocates. The reason most frequently reported for why this posed a challenge was the belief that information sharing was limited. These results showed a difference in opinion between many advocates and those from the medical and law enforcement professions. Differences among professionals in the understanding of statutory obligations of maintaining victim confidentiality were found. Some medical and law enforcement professionals did not understand the statutory requirement of privileged communication between victims and advocates, as well as the requirement of a signed waiver allowing advocates to share victim communication with SART members. This finding is similar to those of previous smaller studies showing that maintaining
confidentiality was a potential obstacle to team collaboration. Cole suggests that regular team meetings could be used as an opportunity to discuss these differences. A second suggestion is involvement of an outside person or agency to help mediate conflict regarding information sharing. Implications for practice suggested by Cole include the need for both initial and ongoing joint training for professionals and paraprofessionals on SART teams. Trainings should address the benefits of the team response, roles, conflict resolution skills, and statutory obligations of confidentiality. Cole notes three limitations to this study including selection of the three SARTs in one state, which may not be representative of those in other states, use of purposive sampling, and the possible influence of social desirability on participant responses. The author declared no conflicts of interest with respect to this research.


Each of the authors of this article is affiliated with the Indiana University of Pennsylvania. Kathryn Bonach, Ph.D., L.S.W., L.P.C., N.C.C. holds a MSW/PhD joint degree in Social Work and an MA in Sociology, and is an Associate Professor of Sociology. She is a past recipient of Program Development and Training grants from the National Children’s Alliance. J. Beth Mabry, PhD, holds a Doctorate in Sociology and is also an Associate Professor of Sociology. Candice-Potts Henry, MSW, was a McNair Scholar and presented the findings from this study at the annual national McNair Research Conference in 2008.

This article begins with a history of the Children’s Advocacy Center (CAC) movement and points to the differences in service provision to victims of child sexual abuse before and after the advent of CAC’s. The authors point out that it is not clear, however, how nonoffending caregivers perceive the parts of the investigative and prosecutorial processes and the performance of various members of the Multidisciplinary Team (MDT). The objective of this study was to examine nonoffending caregiver perceptions of whether CAC and MDT members accomplish their functions satisfactorily and how these perceptions relate to overall satisfaction with the CAC experience.

The authors employed three strategies in the development of the survey: (1) The executive director and program coordinator at the CAC were consulted on program goals, objectives and desired outcomes; (2) they studied similar surveys that had been used by other CAC’s and resources in the field; and (3) they reviewed the evaluation literature on CAC’s with regard to nonoffending caregivers’ perceptions of the different MDT entities singularly, and how they these perceptions affect overall satisfaction. The authors make the salient point that consumer
satisfaction plays a potential role in (1) generating referrals to CACs by clients and other agencies, (2) determining the reputation of CACs across various constituent groups, and (3) cultivating donors and organizational resources.

The nonoffending caregivers surveyed for this study were served by a two-year-old CAC program in a rural community in the eastern United States. All cases had already passed through the forensic interview and investigative process. The methodology is explained thoroughly, with emphasis on the measures taken to insure anonymity. One hundred and twenty nonoffending caregivers were mailed surveys, those who had more than one child victimized received only one survey, and cases in which child welfare held guardianship were not surveyed. Due to the sensitive nature of the respondent’s connection with the CAC, the authors only had two mailings of the survey. The final sample of 26 who responded represents a 24.1% response, and they were compared with nonrespondents on key characteristics using the data provided by the CAC to help identify differences that might contribute to bias in the results. All the questions on the survey were quantitative except for the final question, which asked respondents if there was anything else they would like to share about their experiences with the CAC.

Each of the Tables in the article is explained thoroughly and the data is illustrated in an easily comprehensible manner. Table 1 illustrates the sociodemographic and case statistics for the sample, and shows the comparison between those who did respond versus the nonresponders. The victims were slightly older (10.9 vs 9.0 years of age), and were more likely to have been referred by law enforcement and less likely to have been referred by child welfare in the sample respondent group as compared to the nonrespondent group. Table 2 reports the distribution of the study variables in the sample. For satisfaction with CAC services, three aggregates were measured: (1) information and logistical coordination; (2) responsiveness and providing for clients’ comfort; and (3) staff courteousness and helpfulness. Satisfaction with MDT entities was measured for (1) child welfare services, (2) law enforcement services, (3) district attorney services, (4) medical evaluation services, and (5) victim advocacy services. The final quantitative measure of overall satisfaction with CAC experience is also provided. Table 3 shows the correlations among study variables. Caregivers’ overall satisfaction with services received through the CAC is significantly and positively related to the three individual CAC satisfaction measures as well as satisfaction with child welfare services, law enforcement, and victim advocacy. Overall satisfaction with CAC services was not related, however, with either satisfaction with the district attorney’s office or with medical evaluation services. Table 4 reports the results of two regression models of overall satisfaction with services received through the CAC on other indicators of satisfaction.

In the authors’ discussion they point out the fact that their findings are consisted with other studies which found satisfaction with the coordinated services provided by CAC’s. However, they emphasize that insufficient communication from the district attorney’s office after the
forensic interview left nonoffending caregivers feeling frustrated and uninformed about the prosecution of the case. With the CAC studied, the district attorney’s office made changes based on this finding. Implications for practice were provided, with recommendations for other researchers and CAC’s to consider when assessing caregiver satisfaction with not only with the CAC as a whole, but also each entity of CAC services. The authors also devote a section of the article describing the “study driven” changes in protocol that occurred at the CAC researched. This is very useful information, particularly for the Victim Advocate at a CAC. Overall, this article provides a valuable addition to the literature as it provides insight from the consumer’s point of view in predicting their overall satisfaction with a CAC, based not only on the separate entities of the MDT, but also the interrelation among these various entities.


Timothy Fortney, PhD, is a licensed psychologist at the University of Central Florida’s Counseling Center, where he is also a liaison to the Athletic Department. He is the Group’s Coordinator for the Substance Abuse Treatment Team. In his practice, he specializes in the treatment of PTSD and utilizes CBT, EMDR and Hypnotherapy. He has co-authored several articles in the literature about sexual offenders. Juanita N. Baker, PhD, is a Professor Emeritus in the Psychology Department at the Florida Institute of Technology. Jill Levenson, PhD, is an Associate Professor of Human Services at Lynn University in Boca Raton, Florida. She is a licensed clinical social worker and maintains a small psychotherapy practice. Dr. Levenson is also a nationally recognized expert in sexual violence and has testified in front of many state legislatures and has contributed to an Amicus Brief submitted to the U.S. Supreme Court in the 2002 case of CT v. Doe, which addressed the constitutionality of Megan's Law. She is actively engaged in several research projects funded by the National Institute of Justice.

Do professionals who work with sexual offenders or victims of sexual abuse hold many of the same misperceptions as the general public concerning sexual abuse? The authors posited that it is very important for these professionals to be aware of these misperceptions for the following reasons: (1) inaccurate information and attitudes may impact their effectiveness in therapeutic and psycho-educational interventions with clients, (2) professions will not be as strong or effective advocates for their clients if they have false beliefs, (3) professionals may misrepresent research and facts when educating the public, thereby strengthening attitudes and core beliefs that lead to injustice, discrimination, inefficient laws, and compromised community safety, and (4) the credibility of the field of mental health is harmed when professionals do not correct myths which are the basis for core beliefs and thus do not advocate for rationality and justice.
This study investigated the knowledge and perceptions of professionals who work with sexual offenders or their victims in five areas: (1) who commits sexual offenses, (2) the rate at which offenders come to the attention of authorities, (3) the rate at which offenders were sexually victimized in childhood, (4) recidivism rates, and (5) treatment efficacy. A brief review of the literature was provided for these five areas, with particular emphasis given in the areas where public perceptions contrast with empirical evidence.

Sexual abuse professionals attending four different conferences during the summer of 2007 were surveyed. Details of these conferences are provided, and Table 1 illustrates the demographic characteristics of the sample as well as whether they worked with offenders or victims. The professionals who worked with victims were more likely to be female and more likely to work with adolescents and children than those who work with offenders. Details of the survey utilized are explained and the procedure for survey distribution at the conferences as well. Table 2 lists seven of the survey questions and how the professionals’ responses compared to published data. This table also illustrates the differences in the responses of the professionals who work with offenders versus those who work with victims. Table 3 illustrates the responses to survey questions pertaining to beliefs about sex offender treatment, again illustrating the differences between the two groups of professionals. The authors also provide a narrative which references published data concerning the areas between questioned.

In the closing discussion, the authors pointed out how the professionals’ responses differ from the general public, and highlight the differences found between those who work with offenders and those who work with victims. They provided possible explanations including empathy, desensitization, and cognitive dissonance. The limitations of the study were discussed and the authors call for professionals working in this area to also examine their own core beliefs, to insure that their perceptions and attitudes are based upon evidence-based practice and prevention policies, not misperceptions held by the general public. This article is very relevant for victim advocates, since they have a responsibility to understand the misperceptions held by the general public and professionals working with sexual offenders and victims of sexual abuse, as prepare victims for their encounters with the criminal justice system.


Haig Kouyoumdjian, PhD, graduated from the clinical psychology program at the University of Nebraska-Lincoln, where he was part of the Child Maltreatment Research Team. This article was based on his doctoral dissertation. He completed his post-doctoral fellowship at Kaiser Permanente in Martinez, CA, and is currently an Assistant Professor at Mott Community College.
in Flint, Michigan. He co-authored the well-known textbook *Introduction to Psychology*, currently in its 9th edition. Dr. Kouyoumdjian's primary areas of research focused on child maltreatment and Latino mental health, resulting in several publications in the literature.

Andrea R. Perry, PhD, received her doctorate in clinical psychology from the University of Nebraska-Lincoln where she was a member of the Family Violence and Injury Lab. She completed her predoctoral internship at the Palo Alto Veterans Affairs Health Care System in Palo Alto, California. She has co-written several articles in the literature, contributed to the Encyclopedia of Domestic Violence and co-authored the chapter on Child Physical Abuse and Neglect in the *Comprehensive Handbook of Personality and Psychopathology*. David J. Hansen, PhD, is Chair of the Department of Psychology. His primary research area is child maltreatment (sexual abuse, physical abuse, neglect, and witnessing domestic violence), including factors related to identification and reporting, assessment and intervention with victims and families, and the correlates and consequences of maltreatment. An additional area of research is social-skills assessment and intervention with children and adolescents. His research emphasizes procedures for enhancing the effectiveness of clinical interventions, through assessing and improving adherence, generalization, maintenance, and social validity. Dr. Hansen is the Co-Director of the Family Interaction Skills Clinic (with Dr. Mary Fran Flood) and Director of Project SAFE, a clinical treatment program for sexually abused children and their families. Dr. Hansen’s teaching interests include clinical psychology, psychological assessment and intervention, clinical supervision, and family violence.

The first goal of this study was to examine the impact of parental expectations to account for variance in children’s emotional and behavioral functioning as children presented for treatment after sexual abuse. The second goal was to investigate the ability of parental expectations at pretreatment to account for variance in children’s emotional and behavioral functioning at posttreatment. Participants in this study included 67 sexually abused children (16 boys and 51 girls) and 63 nonoffending caregivers who participated in Project SAFE (Sexual Abuse Family Education), a curriculum-led cognitive-behavioral group treatment program. All children were between 7 and 16 years of age and Child Protective Services has substantiated the abuse. Parent-Report measures utilized were a demographic questionnaire designed specifically for this study which sought relationship status, ethnicity, employment status, family income, educational level, and age; the Child History Form (CHF); Child Behavior Checklist (CBCL); Parental Expectancies Scale (PES); and the Post Sexual Abuse Expectations Scale (PSAES). Child-Report Measures utilized were Children’s Depression Inventory (CDI) and Revised Children’s Manifest Anxiety Scale (RCMAS). The authors explain the methodology well and also provide detailed demographical information on nonoffending parents and victims. The first two tables illustrate the alleged perpetrator’s relationship to the child and abuse characteristics categorized by pre- and posttreatment. Then three tables were given which illustrated (1) Parental expectations measures (pretreatment) predicting Children’s Internalizing Problems Scale,
externalizing problems scale, and total problems scale on CBCL (Pretreatment), (2) Changes in Children’s Mental Health Functioning between Pre- and Posttreatment, and (3) A summary of hierarchical multiple regressions with CBCL internalizing problems scale and total problems scales (posttreatment) as the criterion variables. The authors provided a narrative which explains the various relationships studied and results found. In their discussion they emphasized that parental expectancies of children’s future functioning were not predictive of children’s functioning scores, either pre or post treatment, yet parental expectations of how sexual abuse will affect children were predictive of children’s functioning scores at pre and post treatment. Thus, the influential role that the sexual abuse label has on shaping parental perceptions of children’s functioning cannot be overlooked. Also, the positive changes in the children’s mental health symptoms from pre to post treatment suggest that Project SAFE was effective.

The authors address the limitations of this study, including the homogenous nature of the sample, and the assessment measures and analyses utilized. They provide areas for further research and point to three specific areas where interventions can be improved: (1) provision of psychoeducation for children, parents, and professionals about CSA associated symptoms, (2) encouragement of the child to engage in rewarding activities or helping parents provide optimal support the child, and (3) teach adults to acknowledge their bias and behaviors on an ongoing basis. Victim support and advocacy services at a CAC play an integral role in successful implementation of each of these suggestions.


Each of the four authors was affiliated with the Crimes against Children Research Center (CCRC) at the University of New Hampshire, when this article was written. Lisa M. Jones, PhD, is a Research Assistant Professor of Psychology at the CCRC. She has over 10 years’ experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Dr. Jones has authored or co-authored several influential papers on national trends in sexual victimization of children and youth. She helped to direct a five-year, quasi-experimental Multi-site CAC Evaluation Project, funded by OJJDP. Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent Internet safety prevention programs. Theodore P. Cross, PhD, was the director of the Multi-Site Evaluation of Children’s Advocacy Centers at CCRC. He is now a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology and Monique Simone, MSW, is Research Associate at the CCRC.
This research has relevance for established CAC’s interested in improving service delivery; developing CAC’s interested in further clarification of the model; MDT members; CAC funders; other researchers and evaluators. While there is tremendous value in assessing satisfaction with the services provided at a CAC this particular research posed that question but in a limited context. The questions were almost exclusively restricted to the investigation component; questions referred to the interview, the actions of law enforcement and CPS investigators and the physical setting for the interview. One question seemed to venture outside the investigation/interview realm: “Was it clear to you who you were supposed to go to if you had questions about the investigation?” In their interpretation of the data, the researchers considered some of the reasons why children and caregivers might have indicated a high level of satisfaction with their experiences; these statements alluded to the involvement of other CAC staff but as previously mentioned, the interview questions did not explicitly seek information about experiences with other team members or CAC staff. Some significant findings included (1) As with children, parental satisfaction with investigations appears to increase with the perceived supportiveness of the involved professionals and when they have good access to information about what is happening with the investigation, and (2) “Caregivers reported higher rates of satisfaction when their case was investigated through a CAC compared to cases investigated in communities without a CAC. The difference was not due to the number of interview or a specific case outcome per se, but was based on more intangible aspects of investigations, such as support from investigators and a greater sense of comfort and safety during interviews.” The research on client satisfaction and the discussion it generates clearly helps programs to evaluate their current practices and make adjustments when warranted, however, this research should not be considered the definitive source on client satisfaction. Based upon the findings, the researchers pointed to the need for further inquiry that is broader in scope and explores other components of the CAC model.


David Finkelhor, PhD, is Director of the Crimes against Children Research Center, Codirector of the Family Research Laboratory, and Professor of Sociology, University of New Hampshire. He has been studying the problems of child victimization, child maltreatment, and family violence since 1977. He is a noted author and researcher in the field of child maltreatment and received the Distinguished Child Abuse Professional Award by APSAC in 1994 and the Significant Achievement Award from the Association for the Treatment of Sexual Abusers in 2004. Theodore P. Cross, PhD, is a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. He was Director of the Multi-Site Evaluation of Children’s Advocacy Centers in the CCRC at the University of New Hampshire when this article was written. Elise Cantor Pepin, PhD, received
her Doctoral degree in Developmental Psychology at the University of New Hampshire and is now an Associate Professor in Psychology at Southern New Hampshire University.

In addition to CAC staff and team members, this article could be used to draw attention to the need for increased funding for advocacy and crisis intervention. The authors conducted a literature review and review of statistics and laws to offer a new perspective on the overlapping systems that they call the “juvenile victim justice system” suggesting that the fragmented system is not widely understood by professionals working with child victims. The authors offered a case flow model that integrated the child protection system and the criminal justice system, identifying key points on the continuum where child victims interact with the various agencies and institutions of the juvenile victim justice system; the case flow model also attempted to highlight those points in time when intervention and support are critically important for child victims. Figure one provided an excellent visual description of the flow of the juvenile victim justice system, including a timeline which illustrates the process from investigation to disposition. Narratives were also provided for each of the steps in the process.

From the analysis, the authors argued that more professionals are needed who understand the system in its entirety, not just their own agency role. It is important to know who can help guide victims, families and other professionals through the system. The authors identified several areas for improvement, including the need for professionals to recognize how stressful certain aspects of the system can be for child victims. In making these recommendations, the authors were again painting a vastly different picture of what occurs in the CAC model, suggesting that each child victim would greatly benefit from the services provided by someone who stays connected to a case for the duration of the child's involvement with the system. This article is also a good primer on the legal system for persons new to the child maltreatment field.


Shelly L. Jackson, PhD, is an Assistant Professor in the Department of Psychiatry and Neurobehavioral Sciences and Director of Grants and Program Development at the Institute of Law, Psychiatry and Public Policy at the University of Virginia. She holds a doctorate in developmental psychology and completed a NIMH Postdoctoral Fellowship in Law and Psychology. She developed *A Resource for Evaluating Child Advocacy Centers* while a Fellow at the National Institute Justice. Her work over the past 13 years has focused on family violence.

This research was one of the earlier efforts to evaluate the CAC model and based on the anecdotal information available at that time regarding compliance with the NCA standards.
Interviews were conducted with 117 CAC directors to assess the variations in the application of the NCA standards for accreditation. When the interviews took place, the CAC’s were still operating under the original standards. Jackson developed survey questions that focused on the eight standards that she felt directly impacted child victims (Organizational Capacity was omitted because it primarily addresses operations and board functions). In her introduction, Ms. Jackson stated that as a community develops a CAC, they may make adjustments to the model to meet the unique needs of their community. The goal of this research was to assess the extent of these variations without any judgment on the efficacy of these variations. Valuable information in this article included the author’s conclusion that at the point in time of publication, no one had produced any data that examined which CAC components are “absolutely necessary for reducing child stress and facilitating prosecution” (p. 420). This may open the door for research on the role victim advocates play in reducing trauma for child victims and their non-offending caretakers. This research draws attention to some concerns that bear further review. First, the author’s depiction of the role of the advocate was somewhat narrow and minimized the rather extensive scope of responsibilities generally assigned to the CAC advocate.


The authors are all clinical social workers. Lorie Elizabeth Anderson, MSW, is in private practice in Cheektowaga, NY. Elisabeth A. Weston, PhD, is a Professor of Human Services at Niagara County Community College, Sanborn, NY. Howard J. Doueck, PhD, is a Professor and Associate Dean of Academic Affairs at the University of Buffalo in the School of Social Work. Denise J. Krause, MSW, is a Clinical Professor at the University of Buffalo in the School of Social Work and Associate Dean for Community Engagement and Alumni Relations.

The intended audience of the article was most likely students considering working with sexually abused children. Due to the absence of any mention of the CAC model, this article did not reflect how most children experience the criminal justice system though many of the roles assigned to the “child-centered social worker” are very similar to those of a CAC advocate. Additionally, most CAC advocates are not clinical social workers. It is also noteworthy that the majority of the articles reviewed by these authors were written in the 80’s and 90’s, prior to any evaluation or studies of CAC’s. Had they explored the CAC model the authors might have discovered that the “generalist” approach is very much the practice of victim advocates working in a CAC. Through their literature review, the authors explored the role of the social worker in child sexual abuse cases, offering support for the expansion of the role to better assist children navigating the criminal justice system. This expansion, the authors proposed, would ideally integrate the
traditional clinical role of the social worker (treatment provider) with the victim witness social worker, creating a generalist approach to advocacy. The authors suggested that the current practice results in a gap in services for child victims; it is their perception that there can be a significant delay from the point when a child begins working with a clinical social worker to the point when the victim witness social worker is introduced to the family. The authors’ efforts to improve the system’s response to child victims are commendable but they may be missing key information which would have provided a more accurate picture of current practices. The child-centered social worker concept is indeed a more victim-sensitive approach but the authors are proposing a model that already exists in many communities. This article was useful in its description of the complexity of child sexual abuse cases and the importance of providing a client-centered approach when working with child victims and their non-offending caretakers. The suggestion to combine multiple roles is efficient but not realistic in a CAC; therapists are often called as expert witnesses and therefore, excluded from the courtroom. Victim advocates have historically served in the “court advocate” role, providing primary support for the child throughout the court process.


Jacqueline Corcoran, PhD is professor in the School of Social Work at Virginia Commonwealth University. Her research efforts are focused upon family treatment, evidence-based practices, and solution-focused therapy. Dr. Corcoran’s practice experience has been in family treatment, sexual abuse, and crisis intervention.

This article reviews both the Transtheoretical Stages of Change Model and Motivational Interviewing (MI) and suggests the use of these in conjunction with one another to motivate ambivalent mothers of sexually abused children to become supportive. The paper begins with review of literature establishing the importance of maternal support following a child’s disclosure of abuse. This support is composed of both belief and protection. The author selected mothers as the focus of this study because they are, for the most part, the main non-offending caregiver of abused children with the understanding that other persons may be serving in this capacity. Corcoran posits that a problem occurs when mothers themselves are suffering from severe distress as a result of the disclosure. Corcoran reviews the Transtheoretical Stages of Change Model as it was developed for use in the areas of smoking or substance abuse. The stages of the model include levels of motivation in this order: precontemplation, contemplation, determination, action, and maintenance. Corcoran explains that at each stage, mothers are at risk for becoming stuck and not moving forward to the next level. Therefore, the CPS worker or other
professional provides motivation to continue and advance through the stages while strategies for coping and action are taught at each stage. If relapse occurs, the cycle begins again. Motivational Interviewing is proposed to motivate mothers as they progress through each stage. Corcoran provides support from the literature of the efficacy of MI when used in interventions for substance abuse and dependence. Techniques employed in MI include listening reflectively, eliciting self-motivational statements, and implementing strategies to handle resistance. A section of the paper describes a case example in which MI was used. A transcript of interactions between a social worker and a mother is provided as an example of how the mother moved through stages of problem recognition, concern, intention to change, and optimism. The author asserts that the transcript demonstrates how the worker’s handling of client resistance, as well as the client’s motivation to move forward. Corcoran concludes by stating that further research is needed to examine how the Transtheoretical Stages of Change Model and Motivational Interviewing works with non-offending caregivers of abused children.


Candace A. Grosz, LCSW, is the Women’s Health Director of the Colorado Department of Public Health and Environment. Ruth S. Kempe, M.D., recently deceased, was Emerita Professor of Psychiatry and Pediatrics at the University Of Colorado School Of Medicine. She and her husband, C. Henry Kempe, M. D., are recognized for their efforts in bringing child abuse into the national spotlight, and promoting prevention and treatment programs. The C. Henry Kempe Center is known internationally for its groundbreaking work in the field of child maltreatment. Michele Kelly, PsyD, is a psychologist on the child protection team at the Kempe Center.

The foundation of the program under consideration in this article was the belief that a crucial element in recovery for a child victim is his or her family’s response to the disclosure and their ability to provide ongoing support. Through individual treatment and support groups, parents revealed how they felt about what had occurred, often blaming themselves. The results of the pilot project can be useful for CAC’s in general and victim advocates in particular as an educational tool that underscores the array of emotions experienced by families and the child victims following a disclosure.

The goal of this research was to better understand the effects of extrafamilial sexual abuse on child victims and their families. Child victims and their families were evaluated following investigative interviews by law enforcement. Based on clinical assessments to determine the most effective treatment modalities, families participating in the ReCap Program (Recovery for Children and Parents) were offered crisis counseling, individual treatment for the child victim
and/or the parent, treatment groups for children and support groups for parents. The pilot project was conducted in an outpatient child abuse center affiliated with a university medical facility. The authors indicated that the pilot program was developed in response to numerous phone calls from parents seeking counseling for their children following an incident(s) of extrafamilial sexual abuse. Children under age seven were considered the priority demographic based on the lack of community resources for this age group. Key findings from the interviews including (1) The betrayal by the perpetrator was felt sharply by both the parents and children. They had trusted someone who had tricked them and abused them. The betrayal of trust left parents and children blaming themselves, doubting their judgment in choosing caretakers and friends, and questioning their competence in many areas, (2) Child victims wanted the sexual abuse to stop but they were not prepared to deal with the upset of their families and the stress of the investigation and prosecution that followed disclosure, and (3) It seemed as if the disclosure by the child victim was the problem rather than the sexual abuse by the perpetrator. Child victims worried that they were to blame for the distress of their parents and siblings, the disruption of the family routines and relationships, and “trouble” for the perpetrator.

Although the emphasis of the research was upon crisis intervention and treatment, there are several key points which support the victim advocacy standard. In the follow up survey with families, Grosz, Kempe and Kelly asked for feedback regarding the experience in the ReCap program. Parents were asked to identify the three most important factors in recovery for child victims and themselves. The authors indicated that a significant factor in recovery was the parents’ capacity to diminish their own distress and provide ongoing support for the child victim. To achieve this type of outcome, the authors suggest that a Child Advocacy Center is an ideal setting for intervention that extends beyond the ReCap program; families receive supportive services throughout their involvement in the system, all within a child friendly environment.


Howard J. Doueck, PhD, is a Professor and Associate Dean of Academic Affairs at the University of Buffalo in the School of Social Work. Elisabeth A. Weston, PhD, is a Professor of Human Services at Niagara County Community College, Sanborn, NY. Lynda Filbert, MSW, is Filbert is now director of Child Welfare Services at Family and Children’s Services Niagara (FACS) in Ontario, Canada. Ruth Beekhuis is president of the Ontario Association of Social Workers, and was a Social Worker with Family and Children Services in St. Catharine’s when this article was written. Heidi F. Redlich Epstein, JD, MSW, was the staff attorney for the Child Advocacy Unit of the Legal Aid Bureau of Baltimore, and is now part of the ABA Permanency
Barriers Project, which helps children move through the foster care system into permanency and helps states save foster care dollars.

The authors conducted a qualitative evaluation of a child witness advocate program established in 1988 in Ontario, Canada. Similar to CAC’s, the program was developed to improve the judicial system’s response to child victims by coordinating the efforts of child protection, law enforcement and the Crown Attorney’s office (the equivalent of the prosecuting attorneys in the US). Unlike the CAC model, the services are not provided within an agency setting but rather in direct contact with the victim and victim’s nonoffending caretakers (usually within the child’s home). Using a “psycho-educational model” the victim advocate provides case information and support as needed. The authors indicate that the goal of their research was to examine the “salient” issues that are common for children and families who are involved in the criminal justice system. Identifying that information would be useful for front-line workers, team members and specifically, victim advocates. The day-to-day activities of the advocates involved in the study were very similar to the functions within a CAC setting: court prep, court accompaniment, assistance with transportation when necessary, and most importantly, assessing the child’s ability to testify, both emotionally and cognitively. CAC directors could also benefit from the insights gained from the insights and feedback provided by families who participated in the study.

This was a very small sample size of 12 caretakers, representing 14 children; and 14 professionals: five law enforcement from the child abuse unit, five prosecuting attorneys and four judges). In their interviews, the caretakers identified five sources of “system induced trauma”: (1) The abuse investigation, (2) The child facing the accused in court, (3) The inadequate provision of protective devices for the child, (4) The process of providing testimony, and (5) The eroding emotional effect of the overall court process. It is conceivable that the five system-induced traumas identified by the Canadian survey participants would be similar to those experienced by families involved in our criminal justice system. Therefore, it could be advantageous and instructive for CAC staff to examine these considerations when developing a new advocacy component or strengthening an existing program. The authors also provided comments from the nonoffending caretakers, prosecutors, and team members, and they indicate that in most cases, the child’s advocate was considered a “protective device” and this was considered by families as helpful. They did note that the local law enforcement unit specializing in child sexual abuse cases, the child victim witness program, and the attorney assigned to the cases had worked together for a significant amount of time and their history of coordination could have increased the likelihood that the families’ experiences were more often positive than not.
Medical Evaluation


Joyce A. Adams, MD, is a Clinical Professor of Pediatrics, University of California, San Diego, School of Medicine, and she is also affiliated with the Chadwick Center for Children and Families, and Rady Children's Hospital. Suzanne P. Starling, MD, is a Professor of Pediatrics, Eastern Virginia Medical School. She is the Division Director of Child Abuse Pediatrics at the Children's Hospital of The King's Daughters in Norfolk, Virginia, and a member of the Ray E. Helfer Society. Lori D. Frazier, MD, is the Medical Director, Child Protection Team Center for Safe and Healthy Families Primary Children's Medical Center in Salt Lake City, and a member of the Ray E. Helfer Society. Vincent J. Palusci, MD, is the Medical Director of the Children's Protection Team at DeVos Children's Hospital, Grand Rapids, Michigan, and an Associate Professor at the Michigan State University College of Human Medicine in East Lansing. Robert A. Shapiro, MD, is the medical director of the Child Abuse Team at Children's Hospital Medical Center and director of the Child Abuse and Forensic Pediatrics Fellowship and Professor of Clinical Pediatrics, University of Cincinnati College of Medicine. Martin A. Finkel, D. O., FACOP, is affiliated with the Child Abuse Research, Education and Service Institute, of New Jersey-School of Osteopathic Medicine and Dentistry. He is also a Professor of Clinical Pediatrics and Medical Director and Founder of the Center for Children's Support at the University of Medicine and Dentistry. Ann S. Botash, M. D., is a Professor of Pediatrics and Vice Chair for Educational Affairs at the State University of New York Upstate Medical University. She is Director of the University Hospital's Child Abuse Referral and Evaluation (CARE) program in Syracuse, New York.

The first purpose of this study was to assess abilities of medical professionals to recognize normal and abnormal examination findings, ability to interpret medical and lab findings by using published guidelines, and to apply knowledge from research. The second purpose was to determine which factors in education, experience and expert review are associated with greater accuracy in recognition and interpretation of findings. Previous studies have found that persons with little experience in performing examinations were more likely to mistake normal variations as signs of abuse. Other studies have found that when shown photographs of findings in girls, interpretations of medical findings changed when a clinical history was provided. Other research has shown that physicians in training programs performed poorly at recognizing normal preperbutal genital anatomy from labeled photographs. Still further research has found that physician knowledge of genital anatomy increases with additional training. A survey was constructed by a panel of ten physicians with expertise and extensive experience in medical evaluation of children for suspected sexual abuse. The panel also chose the photographs to be used with the questions. The survey contained images and information for 20 cases and 40
questions. Invitation to complete the survey was sent via several professional listservs. A total of 197 complete surveys were returned from 118 physicians, 43 SANEs, 33 Advanced Practice Nurses (APN), two nurses and one physician’s assistant. Results showed that; 1) Similar to previous research, the total number of sexual abuse evaluations performed and the average number of evaluations performed monthly was significantly associated with higher scores, 2) Other factors that were associated with higher scores were having cases reviewed by an expert at least quarterly, self-identification as a Child Abuse Pediatrician, and reading The Quarterly Update, a newsletter summarizing and reviewing research in child abuse medicine, 3) Similar to previous research, Pediatric Emergency Medicine Physicians scored significantly lower than Child Abuse Pediatric Specialists, while the two groups had very low agreement on identification and interpretation of findings suggestive of abuse, 4) Scores across disciplines were higher for those who had review of cases at least quarterly by a recognized expert in child sexual abuse medical evaluation. The last finding has not previously been shown to increase diagnostic accuracy. The authors noted that scores on an examination such as used in this study may not reflect actual clinical proficiency. They further noted that although this study reinforced the importance of correct interpretation of physical findings, the obtaining of the detailed medical history in a developmentally appropriate manner is also of importance. In this study, training, clinical experience, and discipline were significantly associated with accurate identification of medical findings and ability to apply medical knowledge to correctly interpret findings. Furthermore, expert case review, keeping up with the medical literature, and ongoing practice appeared to render additional accuracy.


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This research is the first to examine impact of follow-up examinations in the diagnosis and treatment of children and adolescents evaluated for sexual abuse. The authors noted that previous research on injury and infection have been reported from initial examinations, and had not been collected from follow-up examinations. The purpose of this study was to determine whether follow-up examinations affect medical diagnosis or treatment. Data was collected by
retrospective chart review of charts of patients who were initially examined by a trained pediatric SANE in a children’s hospital emergency department and who had follow-up examinations conducted by an experienced SANE of child abuse physician at a CAC. Two of the study authors independently reviewed the documented findings for initial and follow-up examinations for all patients (N=727, 13% male, 87% female). Changes between the two examinations were classified. Changes that were expected such as healing were classified as “no change in likelihood of trauma.” Change classifications were: change in likelihood of trauma, increased likelihood of trauma, and decreased likelihood of trauma. Results of the chart review showed that 598 (82%) of the sample had no change, 82 had findings that reduced the likelihood of trauma, and 47 (6.5%) had findings that increased the likelihood of trauma, and 82 (11%) had findings on follow-up exam that decreased the likelihood of trauma. There were 24 patients who had new findings that either increased or decreased likelihood of trauma. There were 130 STIs diagnosed from examination 1, while there were 47 STIs diagnosed from follow-up examinations. The researchers summarized these results as: follow-up examinations changed the interpretation of trauma likelihood in 129 (17.7%) of cases and identified STIs in 47(6.5%) of cases, thus 23.2% of the study population was affected. The authors noted that similar results have been found in studies of follow-up examinations for physical abuse cases. The researchers state that the results suggest that there is an important role for follow-up examinations in confirming treatment and completing assessment for STIs resulting from sexual abuse. Limitations of the study are lack of generalizability to other programs conducting pediatric sexual abuse evaluations and the study group may have differed in results from victims who did not have follow-up examinations.


Joyce A. Adams, MD, is a Clinical Professor of Pediatrics, University of California, San Diego, School of Medicine, and she is also affiliated with the Chadwick Center for Children and Families, and Rady Children's Hospital. She specializes in adolescent medicine and child abuse evaluation and expert case review and has been involved since 1986 in providing health care to children with suspected sexual abuse. She is a member of the Ray E. Helfer Society and has testified in over 250 court cases, both in the United States and internationally.

This article contributes a review of the approach to interpreting medical findings and suggestions for further needed research. Adams provides a review of the evolution of the list of findings for child sexual abuse over the previous 20 years, beginning with the first publication in 1992 by Adams, Harper, and Knudson, as well as subsequent revisions based upon newly published research. Adams describes the 2001 publication including the “Overall Assessment of the Likelihood of Sexual abuse” with category ratings from no evidence to definitive evidence.
Adams further describes how the overall assessment section came to be used in many instances as a checklist approach replacing a more thorough clinical assessment. Upon consultation with medical colleagues to clarify the instruments purpose, it was subsequently decided that the table should be removed. Adams explains that there was still disagreement among physicians with medical expertise in child sexual abuse upon the list of findings. Research data was not sufficient to justify some diagnoses as diagnostic of trauma. At the same time, Adams explained that some experts remained skeptical of any approach that did not emphasize the importance of the child’s statement in the overall medical examination. After a process of review of research findings, a consensus among experts developed and resulted in the publication (Adams et al., 2007) providing guidelines on medical evaluation including a table describing an approach to interpretation of findings. In 2010, Adams published a review of new studies and made suggestions for updating the interpretation of findings table. In the next section of this article Adams reviews more recent studies published after the 2007 publication of guidelines. Major topics include healing of acute trauma in prepubertal girls, importance of the child’s history, evaluating data from research, conditions mistaken for abuse, herpes simplex virus and genital warts, and the importance of accurate interpretation of medical findings. Adams then examines the issue of how well experts agree on the list of findings published in 2007. A survey of experts found no consensus as to the interpretation of findings with respect to trauma or abuse. Adams concluded with the suggestion that a systematic review of published research and expert opinion are still called for to help determine the diagnostic significance of specific acute and nonacute findings as well as specific sexually transmitted infections. Adams stated that following the completion of further studies and reviews of previous studies, further revisions of the approach to interpretation table may be necessary.


Cindy W. Christian, MD, is Attending Physician and Director of Safe Place: The Center for Child Protection and Health at The Children's Hospital of Philadelphia. Christian also works as Associate Professor of Pediatrics at The University of Pennsylvania School of Medicine.

Christian presents the arguments for both immediate medical examination and delay of examination. She posits that proper timing is dictated by several factors including forensic evidence implications, acuity of most recent assault, age and medical condition of victim, and other factors. Discussed is the fact that some argue that not all sexually abused children require a physical examination while others may argue that all sexually abused children should have a medical exam immediately following disclosure. Christian presents arguments for both immediate and delayed examination. Listed in chart form and reviewed as reasons for immediate examination include; 1) the need for forensic evidence collection, 2) identification of genital
injury as a corroborator of disclosure, 3) pregnancy testing and prophylaxis, and 4) evaluation and prophylaxis for sexually transmitted diseases. Listed in the chart and discussed as reasons for delaying a medical examination are; 1) unavailability of a qualified examiner, 2) the child’s emotional state (fear or anxiety) argues against conducting the exam, and 3) in cases of delayed disclosure, conducting the exam would have limited value in proving abuse. Following presentation of these arguments including the research base for each argument, Christian concludes with the statement that the medical examination rarely proves that sexual abuse has occurred, yet it does often provide reassurance to children and families, and occasionally identify problems that require medical attention.


Martin A. Finkel, D. O., FACOP, is affiliated with the Child Abuse Research, Education and Service Institute, of New Jersey-School of Osteopathic Medicine and Dentistry. He is also a Professor of Clinical Pediatrics and Medical Director and Founder of the Center for Children's Support at the University of Medicine and Dentistry. Randell Alexander, MD, PhD, is professor of pediatrics in the Division of Child Protection and Forensic Pediatrics at the University of Florida-Jacksonville, College of Medicine. He is chief of the Division of Child Protection and Forensic Pediatrics.

Finkel and Alexander present in-depth discussion of issues regarding taking the medical history or sexually abused children. They also present suggested scripts and examples of best practice for asking questions and addressing issues. This article contributes a very practical guide to medical history taking. Their primary premise is that careful questioning about all aspects of the child’s medical history should be conducted by skilled, compassionate, and objective clinicians who understand how children are abused as well as their reactions to it. The authors suggest that many clinicians feel ill-equipped to obtain thorough medical histories from children alleging sexual abuse. They suggest that this is due in some part to the dearth of publications on taking the medical history of children at various developmental ages. They further argue that physicians who allow their involvement to be focused solely upon the physical examination, they diminish their therapeutic value for the child and family. They stress that the medical examination should be therapeutic for the child and family because it should address any concerns or worries about the child’s body. Finkel and Alexander emphasize that a physician’s understanding of sexual victimization is essential to ability to form age and developmentally appropriate questions and to facilitating continuing dialogue. From this perspective, the authors present a series of six steps of sexual victimization. This is followed by a discussion of several important aspects involved with medical history taking including relevance of the medical history, timing of the history taking, purpose of the physical examination, addressing immediate concerns such as trauma and disease,
and assuring the child and family with regard to any fears. They provide a list of examples of bodily concerns expressed by children. The authors also discuss other aspects related to the medical examination. These include areas of concern to address during the history taking with the caregiver, the detailed review of the child’s systems, and the history of alleged sexual contact, and the consideration of alternative explanations for physical complaints. The paper concludes with an emphasis upon the reasons for detailed documentation of the medical history that will resolve a possible claim of physician bias. This paper contributes practical, hands-on approaches to understanding of child sexual victimization and developing skills and confidence in conducting medical examinations and history taking.


Cris Finn, MS, PhD, is assistant professor of nursing at Loretto Heights School of Nursing at Regis University in Denver Colorado. Dr. Finn’s areas of research include child abuse, violence, and community health. Her clinical expertise is in forensic and emergency nursing.

This study contributes to the literature an examination of experiences of expert forensic nurses receiving child abuse disclosures. The author posits that the human connection between the nurses and the child victims seemed to be the major stimulus resulting in disclosures. This research adds to the body of knowledge concerning circumstances of children’s disclosures. The primary focus of the study was to describe the forensic nurses’ perceptions of the contexts in which children disclose to them. The method of study was face-to-face interviews with 30 expert forensic nurses attending a professional conference in 2007. The context of the interviews focused only upon initial/first time disclosures. Five major themes were identified from the interviews: child friendly environment, connecting with and rapport building, engaged listening, believing the child unconditionally, and the potential for false disclosure. In depth examination of the interviews found that all participants felt that the child friendly environments created a feeling of comfort and safety for the children. Finn cites research emphasizing the importance of this issue. All participants also placed great emphasis on building rapport which included trust, empowerment, age-appropriate communications and unconditional acceptance. Building rapport was the factor most emphasized by the participants. Also emphasized by the participants and supported by the research cited by Finn was the concept of engaged listening. The nurses discussed the use of open-ended questions and the concept of limitless time. Finn reports that this concept of the child having limitless time to talk is missing from the literature. Finn emphasized that there is very scarce literature on unconditional belief in what the child is saying however, the study participants believed that this aspect was quite important to the process. The participants did express their concern about false disclosures and the need to be mindful of this potential.
Finn noted limitations to the study including the fact that most participants had completed higher degrees of education than most registered nurses and the fact of potential biases, selective memory, and recall issues. Finn suggests that further study should include both initial and secondary subsequent disclosures received by nurses. The author reported no actual or potential conflicts of interest.


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The major goal of this research was the determination of the time period after child sexual assault that specimens may provide evidence using DNA amplification. Two secondary goals were to determine laboratory yields of body swabs versus other specimens (clothes and linens), and to determine the correlation between physical findings and laboratory test findings. This research adds to the research literature concerning length of time after assault that specimens taken from child victims may yield evidence. The researchers noted that the American Academy of Pediatrics recommends that forensic evidence be considered for up to 72 hours after assault. However, since the use of DNA amplification has increased in recent years, some jurisdictions have requested that evidence be collected in sexual assault cases beyond 72 hours. The authors cited a previous study that found that for children under 10, no evidence was found after 13 hours after assault. A second study cited also found no evidence in young victims 24 hours after incident. In both studies the majority of evidence was found on clothing or linens. The researchers emphasize the point that both of these previous studies were conducted with pre-
DNA amplification methods. The data for the current study was collected from a retrospective review of case information and laboratory results from evidence-collection kits. The study analyzed results from 277 kits from children age 13 and under and processed according to standard laboratory protocol. Of the kits examined, time from assault to evidence collection was within 24 hours for 40% of cases, between 25 and 48 hours for 9% of cases, between 49 and 72 hours for 3% of cases, and beyond 72 hours for 3% of the cases. Time interval was not known in 45% of cases. 55% of all cases were children under the age of 10. A full explanation of all results is provided and displayed in tables, including proportion of cases with positive DNA within age groupings, and number of cases with positive DNA from a body source according to site and age, findings according to type of laboratory test. 56 (20%) of kits tested positive by DNA. For these 56 that tested positive, 30 (54%) were from the before 24 hour interval group, 9 (16%) were from the between 25 and 48 hours interval group, 3 (5%) were from the between 49 and 72 hour interval group, and 2 (4%) were from the beyond 72 hour interval group. Twelve (21%) were from the unknown interval group and thus were not considered for analysis. The majority of the children with positive DNA result had normal, non-specific or indeterminate acute anogenital findings. The results of this study are congruent with previous studies finding that the majority of children with positive biological findings are examined within 24 hours of assault. The second finding similar to previous studies is that the majority of evidence is found in clothing and linens. However, in this study it was found that five children under age 10 had a positive DNA test collected between 7 and 95 hours. Another important result according to the researchers was the high proportion of cases with normal or on-specific anogenital findings among those who had had DNA evidence from a body swab. The researchers point to the significance that the collection of forensic specimens after a disclosure is appropriate even when a physical finding is normal or nonspecific. The study was limited by the retrospective design, and by the fact that the time interval from assault to examination was unknown in 45% of the cases studied. There are no apparent conflicts of interest or possible gain from the researchers due to study results.


Alice Whittier Newton, MD, is a pediatrician on the Child Protection Team at Massachusetts General Hospital for Children. Her clinical interest is in child abuse and neglect. Andrea Marie Vandeven, MD, is Director of Ready, Set, Grow, and Assistant Professor in the University of Missouri-Kansas City School of Medicine. Her specialty is child abuse.

This paper reviews the changing roles of physicians and nurses over the past few decades in care and treatment of suspected victims of child sexual abuse. The contribution to the literature includes an historical overview, comments on the major literature, and consideration of major issues and the research literature on them. Issues evolving and covered include the response and
changes due to research showing that the majority of victimized children have no definitive medical findings. Another area of important change reviewed by the authors is the understanding of long-term consequences of abuse upon physical health. Newton and Vandeven devote attention to how and where children present with possible sexual abuse. Issues and concerns related to presentation at primary care offices, emergency departments, and hospital-based child protection teams. The third section is devoted to covering the literature supporting the need for medical experts in child sexual abuse as well as the response to the literature among child maltreatment practitioners. The following section reviews how clinicians conduct sexual abuse evaluations and the role of the medical provider in the forensic interview. Review of and commentary on many issues related to the medical evaluation of prepubertal children and adolescents is covered. The final sections touch on medical evaluation concerns in child advocacy centers and with regard to cultural issues. This review provides a broad review of the literature and how it has affected evolving consensus and disagreement among professionals who conduct medical evaluation of suspected victims of sexual abuse.


Stina Syrjänen is a Professor of Oral Pathology and Head of the Department of Oral Pathology and Oral Radiology at the Institute of Dentistry and MediCity Research Laboratory, University of Turku, Finland. Internationally recognized for her work on the human papillomavirus infection (HPV), she has co-authored over 300 articles and six books, and presented at conferences around the world on this subject.

In this invited review, Syrjänen summarized what was in the literature on HPV infections in children, their risk factors, natural history and potential modes of transmission (peri-conceptual, prenatal, perinatal, horizontal, autoinoculation and sexual abuse). Skin and anogenital warts, oral papillomas, and recurrent respiratory papillomatosis are discussed, as well as asymptomatic HPV infections in the genital tract, oral mucosa, and tonsils. While sexual abuse may cause childhood genital warts, sexually abused children usually have other signs of abuse, and the medical evaluation should include identification of other physical indications of abuse and microbiological assessment of other sexually transmitted diseases. However, the predictive value of HPV for possible sexual abuse does increase with age, 36% among children 4 to 8 years of age, and 70% in children over eight years of age.

This report provided an overview of the Health Insurance Portability and Accountability Act (HIPAA) regulations with regard to the role of the medical professional worker releasing or reviewing patient health information when the patient is a child who is a suspected victim of abuse or neglect. The review stated that medical professionals who are employed by covered entities, including governmental organizations, but who work at a facility that may not be a covered entity, such as a Children’s Advocacy Center, may still be required to comply with HIPAA regulations. The report discussed some specific exceptions to HIPAA regulations related to child abuse, stating that in general, HIPAA allows disclosure of information without legal guardian authorization in matters which affect the treatment of and medical intervention for, the child and the investigation of matters that relate to abuse or neglect. If a medical professional suspects abuse or neglect, as it is defined within state statutes, then he is required to disclose information to the appropriate investigative agencies (usually CPS and law enforcement agencies). However, section 164.512(f) puts limitations on the information released to law enforcement but not to CPS agencies. When the medical professional is not the reporter, he may still disclose information about a suspected child victim without parent authorization if: (1) the information is permissible by state law in order to conduct the investigation; (2) the information is deemed to be necessary to prevent further harm to the child or others; and (3) the information is limited to that relevant only to the case. HIPAA does permit disclosure either under court order or by subpoena, or other legal processes. In cases where state laws do not override HIPAA, the medical professional is required to receive a written notice from the party sending the subpoena information that the child’s guardian has been informed that the physician will be disclosing information. Disclosure of a child’s health information during child fatality reviews is an allowable HIPAA exception relating to public health matters. Such information may also be disclosed to multidisciplinary teams.


Joyce A. Adams, MD, is a Clinical Professor of Pediatrics, University of California, San Diego, School of Medicine, and she is also affiliated with the Chadwick Center for Children and Families, and Rady Children's Hospital. She specializes in adolescent medicine and child abuse evaluation and expert case review and has been involved since 1986 in providing health care to children with suspected sexual abuse. She is a member of the Ray E. Helfer Society and has testified in over 250 court cases, both in the United States and internationally.
This article describes the results of research, and systemic reviews of older studies that have occurred since the Adams, et al, paper appeared in 2007. The “Approach to Interpretation of Medical Findings in Suspected Child Sexual Abuse” Table is revised to reflect this new information. Eight conditions mistaken for abuse have been added. Two revisions regarding genital and anal lesions are made in the “Indeterminate Findings” section. Also discussed were the findings that many injuries to the hymen and other genital tissues heal very quickly, often leaving no sign of the previous injury on follow-up examination. The importance of a complete medical history and call for more research and review of published research studies reporting medical examination findings where other types of injury have occurred, not just those involving the hymen, is made by the author. Photo-documentation is recommended as the standard of care and the author stresses the importance of peer review. Description of the TeleHealth Institute for Child Maltreatment’s (THICM) is given, with the disclaimer that it is not intended for initial diagnostic or treatment purposes or to serve as a second opinion. THICM is strictly for educational and quality improvement purposes. The author conducted a short survey of 100 members of the Ray E. Helfer Society, physician experts in child sexual abuse medical evaluation. The results were displayed in tabular form; they show that there is still a consensus among physicians about the indeterminate findings listed in the Table “Approach to Interpretation of Medical Findings in Suspected Child Sexual Abuse” in 2007. The author closed with an invitation for medical providers to contact her with comments and suggestions.


Kirsten Bechtel, MD, is an Associate Professor of Pediatrics in the Department of Pediatrics at Yale University School of Medicine, New Haven, Connecticut and Attending Physician, Department of Pediatric Emergency Medicine, Yale-New Haven Children's Hospital.

In this article, Bechtel reviewed the demographics of sexual abuse, the prevalence of specific sexually transmitted infections (STIs) and which children and adolescents are at highest risk for contracting such infections. The review covered the findings of studies collecting information on children with STIs including human papillomavirus (HPV), HIV, and herpes simplex virus. Review of the studies for HPV found that vertical transmission (mother-child) is uncommon while the best way to identify possible sexual abuse as the cause of horizontal transmission is by the history, family assessment, and physical examination. Studies concluded with varying results including a finding that 31% of children with HPV reported a history of sexual abuse with risk of sexual abuse increasing with age. Studies found that victims with possible exposure to HIV should be given preventative treatment within 72 hours of the abuse with one hour being the
optimal time for treatment. This research looked at five studies which found that just over half of reported cases of genital herpes in children had evidence suggesting a sexual mode of transmission. Evidence of sexual transmission increased with age. Among the conclusions of this research were that a careful history should be obtained to exclude sexual abuse as the mode of transmission of STIs.


Each of the authors of this article is affiliated with the Yale Child Sexual Abuse Clinic (YCSAC). John M. Leventhal, M.D. is a Professor of Pediatrics and Medical Director of YCSAC. His research interests include child abuse prevention; distinguishing accidental from abusive injuries; and epidemiology of child maltreatment. He is a member of the Helfer Society and a noted author in child maltreatment literature. Janet L. Murphy, MSN, APRN, is the Associate Medical Director of YCSAC, and Andrea G. Asnes, MD, MSW is an Assistant Professor of Pediatrics and Medical Associate Director of YCSAC and was previously the Medical Director of the Child Protection Team, The Children's Hospital at the Cleveland Clinic. Cumulatively, the authors of this article have had over 50 years of clinical experience in treating children who are suspected victims of child abuse.

This article sought to address the special concerns of child victims and their parents and how clinicians should respond to these concerns based on their professional experiences, particularly through peer review. The authors’ premise was that since sexual abuse can have potentially damaging long-term psychological effects, medical examiners need to address the concerns of parents and children, and not only focus on the forensic aspect of the evaluation. Ten major concerns, six for parents and four for children, are given. The authors then offered suggestions regarding a clinical approach for each of these concerns. These suggestions are given in context of five variables: (1) the child’s age; (2) intra-vs. extra-familial sexual abuse; (3) a parent’s own experience of sexual abuse; (4) support of the non-offending parent(s) to the child; and (5) the family’s strengths and weaknesses and previous involvement with Child Protective Services. Also, to address these special concerns of the parents and children, the authors suggested expansion of the normal scope of the medical history that would be obtained during the medical evaluation to include the following: (1) how the family has responded to the child’s statements; (2) whether the parents have discussed the allegations with each other; (3) who is most upset with what has happened with the child; and (4) what are the parents’ and child’s concerns; (5) what the parents have discussed with the child; and (6) what the parents’ plans for counseling are. By addressing these concerns, families can focus on important issues, including ensuring the
safety of the child, acknowledging family members’ feelings, and arranging counseling for the child and parents.


Jim Anderst, MD, MSCI, is an Assistant Professor, Section on Child Abuse and Neglect in the Department of Pediatrics, University of Missouri, and an attending physician at the Children’s Hospitals and Clinics, University of Missouri-Kansas City School of Medicine. His research interests are child abuse pediatrics and diagnosis, evidence based medicine, and physician-child protective services relations. Nancy D. Kellogg, MD, is a Professor of Pediatrics at the University of Texas Health Science Center, San Antonio. She is the Medical Director of the Alamo Children's Advocacy Center and a consultant and trainer for the Texas Department of Protective and Regulatory Services and the San Antonio Police Department. Dr. Kellogg is also part of the medical staff at Christus Santa Rosa Medical Center and University Hospital. She is a member of the Ray Helfer Society and has authored over 70 publications on child maltreatment. Inkyung Jung, PhD, is an Assistant Professor in the Department of Epidemiology and Biostatistics, University of Texas Health Science Center at San Antonio.

The objective of the authors was to evaluate the association of definitive hymenal findings with the number of reported episodes of penile-genital penetration, pain, bleeding, dysuria, and time since assault for girls presenting for nonacute, sexual assault examinations at a Children’s Advocacy Center during 2004-2007. The medical evaluations were conducted by a physician, nurse practitioner, and a sexual assault nurse examiner, each with experience in more than 500 child sexual assault interviews and examinations. Charts of all girls 5 to 17 years of age who provided a history of nonacute, penile-genital, penetrative abuse were reviewed. Characteristics of the histories provided by the subjects were examined for associations with definitive findings of penetrative trauma. Although 960 charts were identified, 454 of the patients were unable to quantify the number of penetrative events, leaving 506 patients for inclusion in the study. Of the 56 children with definitive examination results, 52 had no history of consensual penile-vaginal intercourse and all were at least ten years of age. All of the definitive findings documented were healed hymenal transections.

The authors’ methodology was thoroughly explained, and outside reviewers, each having more than 20 years of experience in evaluating pediatric sexual abuse victims and each having performed more than 2,500 sexual abuse examinations, were used to verify their findings. Numerous tables which show the characteristics of the study population and agreement of outside reviewers were provided. Photographs illustrating hymenal transaction and deep notch in prone knee-chest position are provided with detailed verbal descriptions. Analysis was unable to
detect an association between the number of reported penile-genital penetrative events and definitive genital findings. Eighty-seven percent of victims who provided a history of ten penetrative events had no definitive evidence of penetration. A history of bleeding with abuse was more than twice as likely for subjects with definitive findings. Children less than ten years of age were twice as likely to report more than ten penetrative events, although none had definitive findings on examination. Definitive findings of penetration for 10.7% of the subjects with no history of consensual were identified in the study. The authors discussed how their results compared to findings from previous studies and note that few previous studies have included expert review of colposcopic photographs. They noted the many limitations of this study: sample size, retrospectivity, and exclusion of children who did not disclose the number of penetrative events. They concluded that most victims who reported repetitive penile-genital contact that involved some degree of perceived penetration had no definitive evidence of penetration on examination of the hymen. Similar results were seen for victims of repetitive assaults involving perceived penetration over long periods of time, as well as victims with a history of consensual sex.


Wendy G. Lane, MD, is Clinical Assistant Professor in the Department on Epidemiology and Preventive Medicine at the University of Maryland, School of Medicine. Her research is focused primarily on child maltreatment, with specific interests in abusive abdominal trauma, child abuse prevention, physician identification and reporting of maltreatment. Howard Dubowitz, MD, is Professor and Head of the Division of Child Protection in the Department of Pediatrics at the University of Maryland, School of Medicine. His research interest is in child abuse and neglect, with a special interest in child neglect and prevention.

This study provides additional evidence supporting the need for expertise in the evaluation and management of suspected child abuse and neglect. Lane and Dubowitz sought to fill a gap in the research on child maltreatment experts. They found that although the evidence to date supporting this need, focused on the pediatrician’s role in medical evaluation and reporting of suspected abuse, there was little about general pediatricians’ experience, comfort with and sense of competence in providing opinions of the likelihood of abuse, nor in providing testimony. They list reasons found in previous studies for physician discomfort as mandated reporters, including having to go to court, fear of losing patients, and misperceptions about the level of certainty necessary for reporting, and inadequate training in management of child physical and sexual abuse cases. This exploratory study sought to assess experience, comfort and competence of
primary care pediatricians in evaluating and managing child maltreatment cases and second, to assess pediatricians’ need for expert consultation in such cases. The method of research was administration of a questionnaire to pediatricians randomly selected from the AAP membership list. The questionnaire contained three sections. The first section focused on pediatricians’ experience with child abuse cases over the previous year. The second section used statements on a Likert scale examining knowledge, attitudes, level of comfort, and perceived confidence in handling child abuse cases. Section three reported collection of demographic information. One hundred forty-seven returned questionnaires were eligible for analysis. Years in practice of respondents averaged 14 years. Results showed that respondents generally had very little experience evaluating and reporting child abuse or neglect. Results also showed that the physicians reported about three fourths of suspected abused and about half of neglect cases to CPS. There was strong support for expert consultation among participants who had evaluated at least one patient for suspected maltreatment. The pediatricians who had evaluated at least one patient for physical abuse, referred an average of 64% of patients to an expert, while among those who had evaluated at least one patient for sexual abuse, 73% referred all patients to an expert. Pediatricians who had no expert available for referral expressed the desire to refer on average, 92% of patients suspected of sexual abuse. Length of time in practice was negatively associated with referral of cases to an expert. When asked about their feelings of competence in evaluation of child maltreatment, 76% felt competent about evaluation of physical abuse, 47% felt competent about evaluation of sexual abuse, and 69% felt competent about evaluation of neglect. Overall, the majority of respondents had little experience evaluating and reporting suspected child abuse. They felt competent in conducting the medical examination but much less competent in giving a definitive opinion or testifying in court. The results are similar to previous studies finding that primary care pediatricians have little training and experience in conducting examinations for child maltreatment. Previous studies also found that feelings of discomfort and lack of competence were common among primary care physicians. The study was limited by the fact that the AAP membership list from which participants were drawn did not supply information about physicians’ subspecialty practice. A second limitation was the reliance upon self-report data and therefore, verification of data supplied by participants could not be verified. The significance of this study is the additional evidence supporting the need for expertise in the evaluation and management of cases of suspected child abuse and neglect.


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The authors published literature from 1966 through 2008 addressing this topic and identified ten research studies of prepubertal children selected for non-abuse and one case control study of girls ages three to eight with and without a history of penetration. The review was completed to determine the diagnostic utility of the genital examination in prepubertal girls for identifying nonacute sexual abuse. The authors suggested that many studies have shown that inexperienced examiners should have abnormal findings confirmed by an experienced examiner and all findings should be photodocumented, if possible. Due to the rate of normal examinations in victims, the study found that each case requires a thorough history with attention to recent behavioral problems and a complete physical examination. The studies found among the children having been recently sexually abused (less than 72 hours) and have had forensic evidence collected, up to 25% may have had acute anogenital injury. Therefore, the agency should be prepared to evaluate for symptoms of illness, administer emergency prevention against infection, and collect forensic evidence. The authors suggested that care should be made to avoid multiple
interviews by different medical professionals; preparation should be in place to refer children for
an interview by a professional trained and experienced in the evaluation of child abuse. The
researchers pointed out that previous research has determined that the majority of girls with a
history of abuse will have a normal examination. Further conclusions drawn from this review
suggested the accuracy of most genital findings used in isolation to predict nonacute sexual abuse
among prepubertal girls is poor; therefore, allegations made by a child should not be disputed,
allowing for a careful investigation by law enforcement and child protection agencies.

Hibbard, R. A., Desch, L. W., and the Committee on Child Abuse and Neglect and Council on

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This article updated the 2001 policy statement from the American Academy of Pediatrics
Committee on Child Abuse and Neglect and Committee on Children with Disabilities. The
authors noted that because states use different definitions of child abuse and neglect as well as
disability, it is difficult to determine how much more disabled children are likely to be
maltreated. However, they listed studies which occurred after The Child Abuse and Prevention,
Adoption, and Family Services Act of 1988, which mandated the study of the incidence of child
maltreatment among children with disabilities. Not only did these studies show that disabled
children were more likely to be maltreated, but also that maltreatment can also cause disability.
Other limitations of research in this area are described, with calls for more research and
collaborative team-approach training of CPS workers in the area of maltreatment of children
with disabilities. The authors provided a detailed narrative describing the many factors that make
children with disabilities be at a higher risk for maltreatment. These included the higher
emotional, physical, economic, and social demands on their families; lack of support for the
additional child care responsibilities that may be involved; and inappropriate medical care or
education. Foster parents may not be sufficiently or educated or prepared to deal with a child
with special needs. Children with disabilities often have no access to sexual prevention
information and they may be more accustomed to adults touching them as they depend on them
for their physical needs and may not know how to discriminate or be able to communicate that they have been abused.

The pediatrician’s role in caring for children with disabilities is to be aware of the natural history of disorders that may mimic child abuse to prevent the misdiagnosis of child maltreatment and to be aware of injury patterns from inflicted versus noninflicted trauma. Reporting to the appropriate CPS agencies when child maltreatment is suspected must occur, as well as a structured interview with the child, if possible, and consultation with other pediatric specialists as indicated. Treatment should include a multidisciplinary team plan, which involves both the child and family. Pediatricians should be educators for all those involved in providing care for children who are maltreated. This includes CPS workers, law enforcement and health care professionals, early childhood educators, teachers, judges, parents, medical residents and students, and their peers. Pediatricians should also recommend parenting skills programs and support groups, and other resources which are important in preventing maltreatment. Finally, the pediatrician should be a strong advocate for influencing public policy which protects children with disabilities from maltreatment. Ten items for guidance for pediatricians treating children with disabilities who have been maltreated are given:

1. Be capable of recognizing signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities.
2. Be familiar with disabling conditions that can mimic abuse or pose an increased risk of accidental injury that can be confused with abuse.
3. Because children with disabilities are at increased risk of maltreatment, remain vigilant not only in assessment for indications of abuse but also in offerings of emotional support and provision of equipment and resources to meet the needs of children and families.
4. Ensure that any child in whom maltreatment has been identified is evaluated thoroughly for disabilities.
5. Advocate for all children, especially those who have disabilities or special health care needs, to have a medical home. (Medical Homes Initiatives for Children with Special Needs Advisory Committee & American Academy of Pediatrics, 2002) If a child is hospitalized and does not have a medical home, the inpatient attending physician can help the family secure one before discharge, preferably as early as possible in the hospital course. (Perceelay & American Academy of Pediatrics, 2003)
6. Be actively involved with treatment plans developed for children with disabilities and participate in collaborative team approaches.
7. Use health supervision visits as a time to assess a family's strengths and need for resources to counterbalance family stressors and parenting demands.
8. Advocate for changes in state and local policies in which system failures seem to occur regarding the identification, treatment, and prevention of maltreatment of children with disabilities.
9. Advocate for the implementation of positive behavioral supports and elimination of aversive techniques and unnecessary physical restraints in homes, schools, and other educational and therapeutic programs (both public and private), institutions, and settings for children who have disabilities.

10. Advocate for better health care coverage by both private insurers and governmental funding.


Joyce A. Adams, MD, is a Clinical Professor of Pediatrics, University of California, San Diego, School of Medicine, and is also affiliated with the Chadwick Center for Children and Families, and Rady Children's Hospital. She specializes in adolescent medicine and child abuse evaluation and expert case review and has been involved since 1986 in providing health care to children with suspected sexual abuse. She is a member of the Ray E. Helfer Society and has testified in over 250 court cases, both in the United States and internationally. Rich A. Kaplan, MD, is the Medical Director of The Center for Safe and Healthy Children, the University of Minnesota Children's Hospital Child Abuse Program. He is an Associate Professor of Pediatrics at the University of Minnesota School of Medicine and the Associate Medical Director at Midwest Children's Resource Center, a regional medical child abuse evaluation program at Children's Hospitals and Clinics in St. Paul and Minneapolis. First, as a social worker and then as a pediatrician, he has been working with child abuse victims for over 30 years and was a 2003 recipient of the United States Department of Health and Human Services Commissioner's Award for Outstanding Service in the Prevention of Child Abuse and Neglect. He is a member of the Ray E. Helfer Society. Suzanne P. Starling, MD, is a Professor of Pediatrics, Eastern Virginia Medical School. She is the Division Director of Child Abuse Pediatrics at the Children's Hospital of The King's Daughters in Norfolk, Virginia, and a member of the Ray E. Helfer Society. Dr. Starling is also a founding member, American Board of Pediatrics Subboard on Child Abuse Pediatrics and was also awarded Outstanding Professional by the American Professional Society on the Abuse of Children. Her research includes analysis of child abuse training and knowledge among pediatric, emergency medicine and family medicine residents and analysis of child abuse medical knowledge among professionals involved in child abuse investigations. Neha H. Mehta, MD, is a practicing pediatric emergency medicine physician at Sunrise Hospital and Medical Center, Las Vegas, Nevada. She was the first Insuring the Children Fellow at Cincinnati Children’s Medical Hospital. Martin A. Finkel, D. O., FACOP, is affiliated with the Child Abuse Research,
Education and Service Institute, of New Jersey-School of Osteopathic Medicine and Dentistry. He is also a Professor of Clinical Pediatrics and Medical Director and Founder of the Center for Children's Support at the University of Medicine and Dentistry. Dr. Finkel was the first clinician to introduce colposcopy on the east coast for the evaluation of the sexually abused child and authored the first paper in the medical literature on the healing chronology of acute anogenital trauma as a result of sexual abuse. He is a member of the Ray E. Helfer Society.

Ann S. Botash, M. D., is a Professor of Pediatrics and Vice Chair for Educational Affairs at the State University of New York Upstate Medical University. She is Director of the University Hospital's Child Abuse Referral and Evaluation (CARE) program in Syracuse, New York, and a founder and Medical Director of the McMahon/Ryan Child Advocacy Site. Dr. Botash created and is Director of the Child Abuse Medical Provider (CHAMP) Network to educate healthcare professionals in the identification and management of child sexual abuse cases. She has authored a primer for medical providers, *Evaluating Child Sexual Abuse: Education Manual for Medical Professionals* (Johns Hopkins Press; 2000), and many research articles. Dr. Botash is a recipient of the Ambulatory Pediatric Association's award for Public Policy and Advocacy and President of the Ray Helfer Society. Nancy D. Kellogg, MD, is a Professor of Pediatrics University of Texas Health Science Center, San Antonio. She is the medical director of the Alamo Children's Advocacy Center and a consultant and trainer for the Texas Department of Protective and Regulatory Services and the San Antonio Police Department. Dr. Kellogg is also part of the medical staff at Christus Santa Rosa Medical Center and University Hospital. She is a member of the honorary Ray Helfer Society. Dr. Kellogg has authored over 70 publications. Robert A. Shapiro, MD, is the medical director of the Child Abuse Team at Children's Hospital Medical Center and director of the Child Abuse and Forensic Pediatrics Fellowship and Professor of Clinical Pediatrics, University of Cincinnati College of Medicine. He is Board Certified in Pediatric Emergency Medicine and does research in the area of child abuse diagnostics. He is a member of the Ray E. Helfer Society.

These guidelines were developed collaboratively over a four-year time period by some of the most well-known physicians involved in the child sexual abuse field. The intended audience was organizations, communities, and individuals who are responsible for the provision and oversight of medical care provided to children presenting with suspected sexual abuse. Groups of 10-40 physician experts met at child abuse conferences from January 2002-2005 to revise the table summarizing the interpretation of physical and laboratory findings in suspected child sexual abuse and to develop guidelines for medical care of child victims of sexual abuse. Then, additional literature reviews were completed and input from other physicians, nurse practitioners, and nurses who are involved in examining and treating abused children was requested through Cornell University’s Special Interest Group on Child Abuse electronic mailing list. Under Results and Guidelines, the following topics were covered: medical evaluation; medical history; timing of the examination; documentation, examination techniques; sexually transmitted infections; interpretation of physical and laboratory findings; and medical testimony. Baseline
professional standards for the Child Sexual Abuse Medical Provider or Nurse Examiner were also given, addressing training, experience, continuing education, and relationships with consultants. A detailed table provided guidance for interpreting physical laboratory findings in suspected child sexual abuse. This table listed findings documented in newborns or commonly seen in non-abused children and commonly caused by other medical conditions as well as indeterminate findings, where insufficient or conflicting data from research studies exists. The authors noted that while the medical evaluation is only one component of the overall assessment of child sexual abuse, it can provide important reassurance to the child and family that may assist in the child’s recovery, or be instrumental in establishing that a problematic physical sign or symptom was actually caused by something other than abuse.


Carole Jenny, MD, MBA, is a professor of pediatrics at Brown Medical School and is a member of the expert faculty of the International Society for Prevention of Child Abuse and Neglect. She is past chair of the Section on Child Abuse and Neglect of the American Academy of Pediatrics (AAP). She currently serves on the Academy's Committee on Child Abuse and Neglect. She has served on the FBI working group on the Online Investigation of Children. Her research interests include fatal neglect, abusive head trauma and factitious disorders by proxy. She was a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania, and received an MBA in Health Care from the Wharton School. She was the country's first endowed chair in child abuse pediatrics, at Hasbro Children's Hospital, and an internationally known expert in child abuse prevention and treatment. Since joining the hospital in 1996, Jenny has developed ChildSafe, a comprehensive child protection program. Jenny is a member of the Ray E. Helfer Society.

While medical neglect accounts for only 2.3% of all substantiate cases of child maltreatment in the United States, it is noted that this probably only the “tip of the iceberg” because only the most egregious and intractable cases are likely to be reported to authorities. The authors suggested that the child must be seen as the center of an ecological framework within which lack of medical care may result from interactions among a variety of interdependent factors, including patient, parent and physician. Medical neglect usually occurs when caregivers fail to heed obvious signs of serious illness or they are non-compliant with a physician’s orders after medical advice has been sought. Five factors must be considered necessary for a diagnosis of medical neglect: (1) A child is harmed or is at risk of harm because of lack of health care; (2) The recommended health care offers significant net benefit to the child; (3) The anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over nontreatment; (4) It can be demonstrated that access to health care is
available and not used; and (5) The caregiver understands the medical advice given. Often “net benefit” may be disagreed upon by parents and physicians; this should be discussed and documented in the record. A hospital’s ethics committee might be helpful in resolving these types of conflict. Ten suggested intervention options were listed, ranked from least restrictive to most restrictive. There is also a discussion of medical neglect in children with special health care needs and the added responsibilities that treatment of these children place upon the physician.

Concerning religiously motivated medical neglect, the authors refer to the US Supreme Court Case, Prince v Massachusetts. Parents do not have the right to deny their children necessary medical care based on their religious convictions. The authors summarized by emphasizing the several important roles of the physician in working on behalf of medically neglected children: engaging the family, understanding the family’s circumstances, explaining the need for therapy, and collaborating with other professionals and utilizing resources within the community to ensure that the best care is provided for the child.


Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology at the Crimes Against Children Research Center (CCRC) at the University of New Hampshire. Theodore P. Cross, was the director of the Multi-Site Evaluation of Children’s Advocacy Centers at the CCRC; he is now a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. Lisa M. Jones, PhD, is a research assistant and professor of psychology at the CCRC and has over 10 years of experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent Internet safety prevention programs. Monique Simone, MSW, is also affiliated with CRCC. David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. His current research is devoted to dissemination and implementation efforts designed to adapt and then transport effective interventions for these clinical problems to various community settings or systems serving children, youth, and families, including pediatric primary care, juvenile justice, child welfare, public health/safety, and mental health.
The analysis utilized in this article was part of the quasi-experimental study, the Multi-Site Evaluation of Children’s Advocacy Centers, which evaluated four CAC’s relative to within-state non-CAC comparison communities in South Carolina, Pennsylvania, Texas and Alabama. The article began with a brief introduction of the research supporting the importance of forensic medical examinations. A review of 1,220 case records was conducted for the purpose of determining which sexual abuse victims received forensic medical examinations. Characteristics considered were gender, age, and race of victim, whether penetration or physical injury occurred, whether the child disclosed and how supportive the non-offending caregiver was. A table showing these characteristics of the four CAC and the comparison sites was provided, as well as tables and figures illustrating the other findings. Suspected sexual abuse victims at CAC’s were two times more likely to have forensic medical examinations than those seen at comparison communities. Girls, children with reported penetration, victims who were physically injured while being abused, white victims, and younger children were more likely to have forensic medical examinations. A discussion of the results was provided with many references made to previous studies regarding the importance of forensic medical evaluations. The authors concluded that CAC’s are helping to increase the rate of medical involvement in sexual abuse cases.


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The authors reviewed the development of the medical knowledge and clinical expertise in child sexual abuse by examining the relevant literature of the previous 25 years. The study indicated that the majority of children who give a history of sexual abuse have no evidence of anal or genital injury. The literature revealed that only four percent of girls alleging penetration had abnormal genital examinations. Other studies have corroborated this by finding that only six percent of pregnant adolescents had definite findings of penetrating injury upon examination. The conclusion drawn from the research is that it is very important that both medical and non-medical professionals understand that a child’s credible history of abuse should not be discounted due to a normal physical examination. Further studies have shown that physicians, even board certified pediatrician are not necessarily experts in child abuse. Studies have shown that many pediatricians lack sufficient knowledge of basic prepubertal anatomy. The researchers
concluded based upon the research, that specialized training or extensive clinical experience along with ongoing continuing medical education in the field of child sexual abuse should be a “prime factor in judicial determination of expert qualifications”. The study also concluded that except under circumstances where children refuse imaging, every examination should be recorded either by photograph, video, or digital imaging. This must be done in order to preserve the evidence from the examination, allow for peer review of examinations, and allow the opposing counsel to secure their own expert review. From the review of the literature the authors further concluded that all examiners should have a method for oversight and peer review, due to the weight that abnormal examination can carry as evidence and the risk of cases being lost or won upon the basis of medical findings. The researchers concluded by stressing that continual and ongoing research concerning medical examinations is needed.


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The authors evaluated 190 cases of children less than 13 years of age urgently referred to a community child advocacy center. The study compared them to those non-urgently referred with regard to their physical examination findings, sexually transmitted infections and other variables. This study collected information about all patients seen at a community CAC for the medical evaluation of child sexual abuse or assault. The researchers’ premise was that although the history obtained from the child is essential, the diagnosis of CSA is augmented by physical findings and other forensic evidence in a small but important number of cases and is affected by the child’s age, gender and stage of sexual development. The researchers conceded that although the American Academy of Pediatrics had recommended immediate medical examinations for children after recent sexual contact, the immediate need for evaluation may sometimes preclude the use of child-friendly settings. Forensic specimens were analyzed through standard techniques by a group of five forensic scientists at the regional state police forensic laboratory. The proportions of children with disclosures, positive physical examination findings, STI, and positive forensic evidence were compared in the urgent and non-urgent groups.
The proportion of children with positive results varied widely during the 72 hours since last reported sexual contact. Analysis was conducted to better understand which factors best predicted positive examinations and forensic evidence. The study found that children seen urgently were younger and had less frequent CPS involvement. They also had more disclosures, more positive physical examinations and more contact with older perpetrators than those seen non-urgently. Questions for further study involve which case characteristics can be used to schedule a medical assessment after sexual abuse. The authors found that the current study agreed with previous studies that boys had fewer findings and fewer disclosures than girls, and that female victims had fewer injuries than male victims.


Gail Hornor, RNC, MS, CPNP is a pediatric nurse practitioner at Nationwide Children’s Hospital, Center for Child and Family Advocacy, Columbus, Ohio. She is chairwoman of the Child Maltreatment & Neglect Special Interest Group of the National Association of Pediatric Nurse Practitioners and has presented at the International Association of Forensic Nurses. She writes often in the pediatric health care literature about sexual abuse examinations. This article provided an overview of physical assessment for children who present with various physical injuries. The goal of the article was to provide medical providers, including nurse practitioners, with a framework for recognizing physical abuse injuries. Horner reviewed the literature emphasizing the importance of obtaining complete history and a complete timeline of the injury, noting any delay in seeking medical attention. Following a thorough, examination documentation should be done in objective and specific terminology. Horner reviewed best practices when examining and documenting bruises, bite marks, burns, coetaneous mimickers, skeletal injuries, abdominal injuries, and head injuries. The literature revealed implications for practice including the need for early recognition and reporting of further abuse.


Astrid Heger, MD, Lynne Ticson, M. D., and Oralia Velasquez, LCSW, are all affiliated with the Los Angeles County Public Health Department’s Child Abuse Prevention Programs (CAPP). Dr. Heger is Professor of Clinical Pediatrics at the USC Keck School of Medicine and the founder and Executive Director of the Violence Intervention Program (VIP) at Los Angeles County-USC Medical Center in East Los Angeles. This was the first Family Advocacy Center in the US, and offers medical, mental health, forensic, legal and supportive services to victims of child and elder
The purpose of this study was to compare rates of positive medical findings in a prospective study of 2,384 children who were referred for evaluation of possible sexual abuse in the Child Advocacy Center at Los Angeles County and the University of Southern California between 1985 and 1990. These children were referred after they disclosed sexual abuse, because of behavioral changes or exposure to an abusive environment, and because of possible medical conditions. A total of 96.3% of all children referred for evaluation had a normal medical evaluation; 95.6% of children reporting abuse were normal, and 99.8% who were referred for behavioral changes or exposure to abuse were also normal. Of the 182 children referred for evaluation of medical conditions, 8% were diagnosed with sexually transmitted diseases, acute or healed genital injuries, and were 17% of the total cases found to have medical findings diagnostic of abuse. The authors concluded that history of the child remains the single most important diagnostic feature in concluding that a child has been sexually abused, since only 4% of all children referred for medical evaluation of sexual abuse have abnormal examinations at the time of evaluation.

The authors began the article with a brief, well-referenced, overview of the research in the medical literature regarding the diagnosis of child sexual abuse. They acknowledged that studies found in the literature have led to recommendations for diagnostic criteria or standards as well as the development of classification schemes by APSAC and the American Academy of Pediatrics Committee on Child Abuse and Neglect. They noted that the first decade of research on CSA covered a wide range of clinical findings but lacked a consistency in terminology, methods, and results. However, since 1989, most of the published research has relied on photodocumentation, and this has enhanced the potential for consistency and peer review. Table 1 in the article showed a comparison, from 1979 to 2000, of research comparing abnormal genital findings in children referred for possible sexual abuse. Table 2 illustrated the evolution of classification scales from Muram’s in 1989, to Adams in 2001.

The methodology was thoroughly explained and a table was provided of medical findings and patterns of referral which categorizes the children by whether or not they disclosed. Another table looked at abnormal medical findings in disclosures of severe and non-severe forms of abuse by gender. The authors pointed out the limitations of the study, most notably they were unable to
include the 358 children who were evaluated in the Pediatric Emergency Room by trained staff but without photo-documentation. The authors compared their findings with previous studies, and pointed out that they were still surprised that such a small percentage of children had genital findings diagnostic of prior trauma from sexual abuse. They noted that only one published study had a higher frequency of normal examinations, 97.5% (Berenson, 2000). However, in the Berenson study, the median length of time since the last episode of abuse was 42 days, in this study most children were evaluated with seven days of the last event. In the conclusion, the authors emphasized the importance of the medical examination in the healing of the child and the reassurance of the child and family. They urged the medical professional to prevent the focus from shifting from the child to the presence or absence of medical findings diagnostic of penetrating trauma. They lamented the fact that medical evidence is often the most significant factor in the progress of a case through the legal system, since most exams are normal.
Mental Health


Colleen Cary is a doctoral student in the University of Chicago, School of Social Service Administration (SSA). She is interested in how children and adolescents experience trauma, particularly those youth who have been placed in the foster care system as a result of parental maltreatment. J. Curtis McMillen, PhD, is a Professor in the University of Chicago, School of Social Service Administration, where he teaches direct practice courses in the master of social work program. He focuses his work around improving mental health services for children and youth in foster care.

The purpose of this study was to systematically review the evidence supporting the efficacy of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in reducing symptoms of post-traumatic stress, depression, and behavior problems. Previous to this work there were no such published systematic reviews of the research on TF-CBT efficacy. Background information about TF-CBT is provided, including details about the branded version (Cohen, 2006) and other versions using the same components. Cary and McMillen explained that the value of the systematic review is the inclusion of all the eligible trials conducted to date and the assessment of the quality of the research studies. Other advantages include the weighing of the results of some studies over others, providing a more complete picture, and revealing inconsistencies across studies. The process of determining studies to be included in the review was as follows: database search resulting in 1621 items, review of all abstracts resulting in 58 items retained, 58 articles read and 23 retained, inclusion criteria applied and 10 studies retained for analysis. Inclusion criteria were: used a randomized trial design with a non-TF-CBT comparison condition, included study participants who were under the age of 18, included study participants that had survived at least one traumatic event, assessed symptoms of posttraumatic stress disorder, and was published between 1990 and 2011. Quality of studies was determined by assessing (1) study design, selection bias, unaccounted for confounders, data collection, handling of missing data, intervention integrity, and analysis. Study quality was high for all 10 studies. In seven of the 10 studies there was a significant difference between the TF-CBT condition and the comparison conditions in reducing symptoms of PTSD at immediate post. Three studies showed no significant difference. Four studies showed medium to large effect size for reduction in depression symptoms and three studies showed medium effects for reduction of behavior problems. The pooled estimates across the studies strongly suggested that TF-CBT was more effective than attention control, standard community care and waitlist control conditions at reducing symptoms of PTSD, both immediately and 12 months after the termination of treatment. The pooled estimates across the studies also strongly suggested that TF-CBT was
more effective than other conditions at reducing symptoms of depression and behavior problems at immediate post, although children receiving other treatments often made the same gains at t 12 month follow up. Limitations of this research include 1) sample sizes in some studies were small, 2) no studies were designed to examine mediating and moderating effects, and 3) the review was unable to account for treatment length and session length among the 10 studies. The authors suggest that future research should include an analysis of the isolated effects of each component. This review did identify TF-CBT as an effective treatment for PTSD and one that may speed recovery from depression and behavioral problems. The authors obtained no apparent personal gain from the results of this research.


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This study adds to a limited amount of research on mental health screening, referral and follow-up in CACs. This study reports on the implementation of a new mental health screening for children seen in Child Advocacy Centers with results from the first year of implementation reported. Introductory material included is the history of Child Advocacy Centers and mental health services in the CAC model. A substantial review of the literature and attending gaps in the literature are discussed. The authors refer to three previous studies that have examined the mental health referral process in the CAC model. Previous studies have examined the rate of therapy initiation following a mental health referral. The authors stated that most of the research has focused upon identifying whether centers provided mental health services. They additionally assert that the extent of the need for mental health services, the rate of referrals, aspects of therapy success, and family characteristics related to not seeking services or remaining in services following a referral should be examined. This study attempts to fill this void by reporting on a new protocol of mental health screening for children seen in Arkansas CACs. The
Arkansas Building Effective Services for Trauma (AR BEST) was developed through the following process. A review by team members and collaborators of current practices of 13 Arkansas CACs related to screening of mental health issues, referral and follow up on services. This review found that screening and referral practices were inconsistent and undocumented. The next step involved identification of key areas of information that would be needed to benefit the CACs and children. These included demographic characteristics, appropriate emotional/behavioral screening for mental health issues, follow-up information regarding status of mental health services. Several questions were developed for use by CAC staff. CAC advocates were asked to complete a short electronic client registration form with demographic data and information about the trauma and alleged perpetrator for each child evaluated at the CAC. Follow-up forms to be completed at one week, one month, and three months after child’s initial visit to the CAC were also to be completed. These forms were designed to gather information about services received, barriers to service, and needs of the family. Follow-up information was gathered from caregivers by phone or in-person. A brief screening tool for emotional/behavioral problems consisting of eight questions (4 internalizing and 4 externalizing) was developed for use by CAC staff. To evaluate success of this new protocol the researchers examined the number of records entered into the data collection system by CAC staff. Second, they surveyed CAC staff one year later to obtain feedback on the new process. The review of records submitted in the new system determined that of the 2,165 children seen in the CACs in Fiscal Year 2010, 1,685 (77.8%) were entered into the AR BEST data collection system. Advocates were successful in completing at least one follow-up screening with close to half of registered clients. The one year follow up survey was sent to 22 advocates with 17 responding. Before the system was implemented, 57.1% of advocates had reservations about the data collection process, while at one year, 71.5% reported having fewer concerns. Consistent with previous literature, many children were not experiencing significant externalizing or internalizing symptoms, while a small number had higher scores. Also similar to previous literature, predictors of more severe internalizing problems were age, parent or step-parent offender, and removal from the home. At one week follow-up, about half of those interviewed had entered counseling or had a scheduled appointment. Percentage was slightly higher at one month follow-up. The reason given most often for not seeking treatment was that caregivers did not perceive that the child was in need of treatment. Removal from the home or having a parent offender increased the likelihood of services by the one month follow-up. Limitations to the study included 1) data collection was completed by CAC staff instead of by trained data collectors, 2) a small number of mental health screening items were utilized, and 3) no comparison group was assessed. The authors state that the results suggest that implementation of a consistent approach to mental health screening in a CAC may be possible, and may be beneficial in helping staff more readily understand the needs of their clients. They suggest that future research in CAC settings should examine organizations factors, such as staff training and facility characteristics that may affect mental health screening and referral process.

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This study provides additional support to the existing strong empirical evidence of the durability of TF-CBT for maintaining positive treatment effects over time. This study reports on the findings from assessments conducted at 6-month and 12-month follow-up after TF-CBT treatment for victims of child sexual abuse. Results are discussed in the context of previous literature on TF-CBT efficacy. The authors provide a short overview of TF-CBT as well as rationale for conducting this research based upon results from previous research. In a previous study by these researchers, four conditions were used to examine efficacy of TF-CBT: 16 week treatment with Trauma Narrative (TN), 16 week treatment without TN, eight week treatment with TN, and eight week treatment without TN. Sixteen week treatment was found to be more effective than eight week treatment for reducing symptoms of PTSD. The No TN condition was found to be more effective at improving parenting practices and more effective in reducing externalizing behavior problems. The current study postulated that all of the improvements attained at posttreatment would be maintained at 6-month and 12-month follow up. The study sample involved 158 children ages 4-11 (mean age 7.6) and 144 parents. 62% were female and 38% were male. Five parent report measures and five child report measures were used to assess outcomes. Children were randomly assigned to the four conditions, and siblings were assigned to the same condition. Four therapists provided all treatment in 90 minute sessions. Follow-up assessments were conducted with two weeks of the 6-month and 12-month time periods following treatment completion. Data analysis was conducted upon all outcome measures and displayed in tables. Consistent with previous research, results for hypothesis one showed that 6-month and 12-month follow-ups of TF-CBT treatment gains were sustained in both the eight-session and 16 session conditions. Second, although all four groups continued to improve during treatment, the differences between gains among them at post-treatment were not sustained at 6-
month and 12-month follow-up. A third finding was that two dependent variables, parental emotional distress which was quite lower at 12-month follow-up than at post-treatment, and children’s self-report of anxiety which was also significantly lower at 12-month follow-up than at post-treatment, continued to decline during post-treatment period. The researchers point to three limitations to the study. First, there was small number of children in each study conditions. Second, some of the child self-report instruments were not administered to the children under age seven, thus full assessment of anxiety and depression was not possible for younger children. Third, most of the children were living in stable home settings, differentiating them from children without a consistent supportive adult. The authors assert that given these limitations, the lack of outcome differences between the No TN and TN conditions should not deter clinicians from including TN in treatment. The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.


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The researchers’ purpose for this study was two-fold. The first was to evaluate the linkage to and the successful completion of trauma treatment for victims of child sexual abuse. The second purpose was to describe differences between children who do access treatment versus those who do not, and to identify predictors of treatment completion for children and families. The study began with a review of previous research which found that although well-established treatments such as TF-CBT are widely available, studies have shown that between 65% and 69% of victims were successfully linked to treatment. Further studies have found that of those who do begin treatment, completion rates for adult and child patients was only 54%. Parental involvement had been found to have a significant impact upon beginning and completing treatment. The method for conducting this study was a retrospective chart review of a sample of children (N=490) evaluated at an Ohio hospital-based CAC and who were referred for trauma-focused mental health counseling. The main dependent variables were patient linked with counseling services and treatment goals achieved. Results showed that 52% of the children who were referred for treatment were linked to services, while 39% of those who began treatment successfully
completed therapy. Results also showed that patients were more like to complete treatment if caregivers also participated or, if they were referred to other mental health services. Enrollment in Medicaid or only one child victim in the family did not seem to affect completion rates. Contrary to previous studies, this study did not show SES as a significant factor in treatment participation. Furthermore, contrary to previous findings, this study did not find that ethnicity, severity and duration of abuse, or placement in foster care had a significant impact of rate of participation in treatment. The authors posit that this difference from previous research may be attributed to the model of service delivery for the medical and mental health components of evaluation and treatment. Previous studies did not evaluate mental health outcomes from a collocated medical/mental health treatment facility. The authors assert that referral to an in-house treatment program may prompt compliance with treatment recommendations, especially in a population at higher risk for dropout and noncompliance. Study findings that were consistent with previous research included 1) caregiver participation in treatment increased likelihood of treatment completion, and 2) engagement and support of caregivers increased likelihood of good mental health outcomes among patients. The researchers noted limitations to the study including the fact that patient records monitored for only six months after referral to treatment, and data were not collected on the 532 patients who began therapy prior to the medical evaluation for csa. The authors declared no conflict of interest with respect to this research.


Steven Berkowitz, MD, is a Child and Adolescent Psychiatrist and an Associate Professor of Clinical Psychiatry at the University of Pennsylvania, Department of Psychiatry. His main research focus has been on the development of interventions for children living in psychosocial adversity especially in the area childhood trauma with a focus on Crisis and Early Intervention. Carla Smith Stover, PhD, is an Assistant Professor and clinical psychologist at the Yale University Child Study Center. Dr. Stover provides clinical services and conducts program/treatment evaluation studies for families impacted by violence. Steven R. Marans, PhD, is Professor in the Child Study Center; Director, National Center for Children Exposed to Violence/Childhood Violent Trauma Center at the Yale Child Study. His research interests include child, adolescent, and adult psychoanalysis and psychotherapy; trauma consultation and treatment.
This article contributes the findings of a four-session caregiver-child early intervention and secondary prevention model, the Child and Family Traumatic Stress Intervention (CFTSI), for children ages 7–17. This report reviews the key components of CFTSI and reviews the limited literature evaluating the treatment. This study specifically evaluates whether the CFTSI, was more effective in preventing the development of Chronic PTSD as compared to an Individual Child, 4-session intervention that provided supportive counseling and psychoeducation. A randomized pilot study was conducted with 112 youths ages 7-17 who had been exposed to a potentially traumatic event and who had at least one symptom of PTSD on the Posttraumatic Checklist within 30 days of the study. The Trauma History Questionnaire (THQ) was administered at baseline and follow-up to establish the number previous of PTEs. Other measures included the Parent Behavior Inventory, the Perceived Social Support-Family Scale, and others. Two related outcomes were examined: differences in TSCC symptom severity on the PTS, Anxiety and Dissociation indices, and PTSD diagnosis and severity of symptoms at the 3-month follow-up. Results of analyses of data at baseline, post treatment and at three month follow-up indicated that the CFTSI has promise as an early intervention designed to prevent the development of chronic PTSD and associated symptoms. Children who received the CFTSI were 65% less likely to meet criteria for PTSD at the 3-month follow up than children that received the comparison condition. CFTSI participants also showed a significant decrease in the Avoidance and Re-experiencing criteria. The authors reported that the study was limited by the fact that attrition form the initial phone screen to study consent was 64 families failing to attend their first appointment. The reasons for this dropout were not obtained. Another limitation was that the study did not evaluate which elements of the CFTSI were essential therapeutic mechanisms. The authors suggested that future research should disaggregate the various elements of the CFTSI for evaluation. There are no known benefits to the researchers based on study outcomes.


David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. Anne-Marie E. Iselin is a Researcher in the Center for Child and Family at Duke University. Kevin J. Gully, PhD, (deceased) was a psychologist who worked with the Safe and Healthy Families Program at Primary Children’s Medical Center in Salt Lake City, Utah.
This study evaluated the use and impact of AF-CBT, in relation to four other EBTs. An initial efficacy trial examining AF-CBT’s two main approaches, individual CBT and family therapy and some empirical studies showing the contribution of caregiver cognition and affect to child-directed aggression. In the present study, four key issues related to treatment dissemination were examined: 1) is there any evidence showing the sustainable use of AF-CBT and the other EBTs several, 2) what is the level of overlap between AF-CBT and the other four EBTs, 3) when the unique content of the other four EBTs is controlled for, is there evidence for the relative effectiveness of AF-CBT content (general or abuse-specific) on clinical outcomes, and 4) to what extent does the use of AF-CBT content vary by key patient background and clinical characteristics? The evaluation was conducted of 52 families receiving treatment for physical abuse from seven therapists in a child protection program from early 2005 through mid-2007. One objective of this paper was to simply document the use of AF-CBT practices by agency clinicians who had been trained in the model between three and five years earlier. Clinicians reported that they had “definitely used” 57% of all of the AF-CBT content items with this clinical sample and a high level of use per treatment practice item. The average use ratings per item for the other four EBTs was about the same. The results also provide information about the individual AF-CBT practices that were used the most or the least with physically abusive families. The two AF-CBT content scores (General, Abuse-specific) were moderately related and differentially associated with the four other EBTs. On standardized child clinical dysfunction measures, greater use of AF-CBT General content was related to a near-significant decrease in child ratings of the severity of the child’s anger problems. Furthermore, greater use of AF-CBT Abuse-specific content was related to significant decreases in parent-reports of the child’s externalizing behavior problems, child-rated anxiety and anger problems, and parent reports of child’s social competence. The most significant improvement associated with AF-CBT Abuse-specific content was ratings indicating that the child had become less scared/sad and happier, and more safe from harm, therapist and parent ratings of the child being better able to have friends without harming them. Additional findings and implications are reported in the paper. Some limitations are identified. First, the study was not a clinical trial or a controlled evaluation of the use of a single EBT. There was no behavioral data on treatment fidelity. Lastly, the small number of cases used in the study should be taken into consideration and impetus for further investigation.


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This research examines the efficacy of Cognitive Behavioral Therapy (CBT) for treatment of pediatric PTSD by preparation of an annotated bibliography and meta-analysis of eight studies. The paper begins with an introduction and review of PTSD including discussion of the limited amount of research on PTSD as applied to children compared to adults. Previous research has investigated TF-CBT finding efficacy in both individual and group therapy for children. This research sought to examine previous research to review the overall efficacy of CBT in the treatment of pediatric PTSD. The authors conducted a systematic search for publications from years 1966 through 2010. Twenty-one randomized controlled trials using CBT in the treatment of children were identified. Eight of the 21 studies were selected because they were randomized, compared to an active control group, utilized the CBCL for evaluation, and reported pre-and post-intervention scores. The researchers measured for effect size and heterogeneity because several of the studies had small sample sizes. Publication bias was also assessed. For all measures assessed (Total Problems, Internalizing, Externalizing, and Total Competence), substantial homogeneity was found among the eight studies. Assessment also determined that publication bias was unlikely to have affected findings. Annotated bibliography results were displayed in table form. Results supported the efficacy in general of CBT for pediatric PTSD. The meta-analysis of the eight trials showed favorable outcomes in the CBT treatment groups versus the control groups. Results for Total Problems and Internalizing indices supported the effectiveness of CBT in reducing symptoms and promoting significant positive change. This analysis was limited by the relatively low number of studies included and therefore, generalizability was also limited. The researchers also note inconsistencies in methodologies across the studies, further limiting results of the meta-analysis. The researchers suggested that future research should seek to examine the components of CBT to determine which symptoms of PTSD are most responsive to the treatment.


Poonam Tavkar, PhD, graduated from the Clinical Psychology Training Program at the University of Nebraska-Lincoln in 2010. She is currently employed as a post-doctoral fellow at the University of Tennessee Health Science Center. David J. Hansen, PhD, Chair of the Department of Psychology at The University of Nebraska at Lincoln. His primary research area
is child maltreatment (sexual abuse, physical abuse, neglect, and witnessing domestic violence), including factors related to identification and reporting, assessment and intervention with victims and families, and the correlates and consequences of maltreatment.

This paper adds to the literature a review of mental health interventions provided at Child Advocacy Centers along with recommendations for future research and clinical practice. A review of the literature documents the need for mental health services for victims and caregivers. The authors point to literature that discusses CACs as increasingly used as initial access sites for mental health services either through on-site care or referral. In light of these increased needs, this paper presents a review of various types of mental health interventions and modalities available; and second, a review of rationale and recommendations for dissemination of these interventions on site at CACs. The review and supporting literature begins with types of crisis interventions for victims, caregivers, and non-abused siblings. Second, review and supporting literature is provided for time-limited interventions for victims, caregivers, and non-abused siblings. A large portion is devoted to studies of efficacy of TF-CBT. Group interventions for victims, caregivers, and non-abused siblings are also reviewed. The authors assert while many of the interventions are effective, there is often a need for long-term treatment. Literature cited supports the case that although group treatment has been shown to provide many benefits, it may be insufficient in meeting each child’s individual needs. The researchers note literature supporting long-term effects such as anxiety, depression, and other more severe symptoms commonly associated with child sexual abuse for both victims and caregivers. They suggest the need for long-term treatments. Following review of available interventions, the authors summarize Project SAFE (Sexual Abuse Family Education), a cognitive-behavioral treatment program established by David Hansen and team members in 1996 at the University of Nebraska at Lincoln. In 2000, Project SAFE was established at the CAC of Lincoln/Lancaster County. The project offers four interventions that are selected to meet victim and family needs. The Project SAFE intervention group treatment is a 12-week CBT for victims ages 7-18 and their caregivers. It utilizes a parallel design for youth and parent groups to meet separately. The second intervention in the program is group treatment designed for non-abused siblings. Developed in 2004, the SAFE Group Treatment for non-abused siblings (ages 7-18) is a 6-week, parallel group treatment that meets for 90 minutes each week. The authors note that there is a dearth of literature on treatment for siblings and therefore, a need for study of treatment efficacy. Project SAFE Crisis Intervention was developed in 2002 to provide a single crisis session to help with coping and immediate issues that arise following a disclosure. These sessions vary from one to three hours. The fourth intervention in Project SAFE is Brief Family Intervention, developed to provide short-term, one hour sessions over three to four meetings. This treatment is individualized for families who are already taking advantage of group treatment, yet need more specific, individual treatment. Tavkar and Hansen list benefits and treatment gains of the SAFE Program as 1) greater ability to begin care as soon as possible based on individual needs, 2) free multiple-session therapy, 3) education tailored to help prevent revictimization, 4) flexible
scheduling for appointments, 5) addressing needs of non-abused siblings, and 6) child care for younger children. Project SAFE is continually monitored and assessed. The authors believe that considering the varied needs of persons needing mental health services on-site at CACs, Project SAFE may be a model program implementable throughout CACs. The final section of the paper provides recommendations. First, the authors suggest that CACs should continue to be used for initial access point for provision of services. Second, they suggest that the collaboration between mental health professionals at CACs and other agencies should be strengthened. Third, they assert that more research is needed to identify impact of CSA on non-offending caregivers and non-abused siblings. Finally, they suggest that more research is needed to better understand what outcomes may result from more effective treatment.


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The purpose of this study was to explore challenges faced by hospital and community based medically oriented child abuse teams when (1) arranging for mental health services for all children evaluated for suspected maltreatment and (2) serving children with special health care needs (CSHCN). The authors began the article with the recognition of the limited availability, access, funding and reimbursement of mental health services for maltreated children. They also point out studies which have shown that CSHCN are more likely to be maltreated than children without special needs and acknowledge that more research and training is needed to address this problem.
The authors conducted a self-report survey in 1999 with 45 questions. The results from 28 of these questions were described in a previous article (2004), which focused on staffing and financial characteristics. This article focused on the responses to the other 17 questions and Table 1 lists these questions. A narrative description of the question design is also provided. This survey was mailed to 528 medically oriented child protection teams, whose listings who were identified by the American Academy of Pediatrics’ Executive Committee on Child Abuse and Neglect, the National Association of Children’s Hospitals and Related Institutions, the National Children’s Alliance, and the National Center on Child Abuse and Neglect. Responses were received from 320 organizations, which is a 67.8% rate. However, criterion for inclusion was that the teams have at least one physician or nurse practitioner, so this narrowed the sample to 153 teams. These teams adequately parallel the population rates and disability rates of children five years of age and older by geographic region, as shown in Table 2. There were 91 hospital based teams (HBT) and 62 community based teams (CBT). Half of the CBT’s were based in children’s advocacy centers.

Table 3 illustrates the team’s self-rating of competence in working with specific needs populations across 14 special needs, including congenital, developmental, and behavioral disorders, as well as those caused by traumatic injury. There were five key findings related to how medically oriented teams managed CSHCN: (1) both HBT’s and CBT’s reported working with a large number of CSHCN; (2) over two-thirds of teams did not have a specialized program or staff to serve CSHCN; (3) over 80% of the teams said more time was needed to evaluate CSHCN; (4) over two-thirds of teams identified the increased difficulty in mental health planning and referral for CSHCN; and (5) while most medically oriented teams reported evaluating deaf children and children of deaf parents, a significantly smaller number reported that they used a professional sign language interpreter or sign fluent staff. 19.5% of respondents reported using family members or school personnel to interpret child protection evaluations involving deaf children or deaf parents, and the authors note that the practice of using family members for interpretation is specifically prohibited by the Americans with Disabilities Act and many state laws. They make recommendations considering evaluation of deaf children and children with deaf parents and note other federal laws which are relevant to this issue.

The authors list the three major limitations of this study: (1) its currency, (2) inability to identify all medically oriented child maltreatment teams in the US, and (3) that the respondents may have overstated their capabilities and competencies. The conclude that medically oriented child maltreatment teams and mental health service providers for maltreated children would improve gaps in services by: (1) recruiting and training bilingual professionals, (2) ensuring that children or family members who are deaf receive professional ASL services, and (3) ensuring that training is provided related to the needs of CSHCN.

Judith A. Cohen, MD, a Child and Adolescent Psychiatrist, is Medical Director of the Center for Traumatic Stress in Children & Adolescents at Allegheny General Hospital in Pittsburgh, PA, and Professor of Psychiatry at Drexel University College of Medicine. Since 1983 she has been funded by more than a dozen federally-supported grants to conduct research related to the assessment and treatment of traumatized children. With her colleagues, Anthony Mannarino, PhD and Esther Deblinger, PhD, she has developed and tested Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based treatment for sexually abused and multiply traumatized children and their non-offending parents. Dr. Cohen has served on the Board of Directors of the American Professional Society on the Abuse of Children (APSAC), and received its Outstanding Professional Award in 2000. She is currently a member of the Board of Directors of the International Society for Traumatic Stress Studies, and is Associate Editor of its *Journal of Traumatic Stress*. She also served as the first author of the ISTSS published guidelines for treating childhood PTSD.

While the primary intended audience for these Practice Parameters was child and adolescent psychiatrists, the information contained in these practice parameters is also very useful for other mental health professionals treating children (17 years of age and younger) who are being assessed and/or receiving treatment for Posttraumatic Stress Disorder (PTSD). It was an update of the last such Practice Parameter which was published in 1998. Since the diagnosis of PTSD requires the passage of at least one month after exposure to an index trauma, this parameter did not address the immediate psychological needs of trauma-exposed children and adolescents.

A thorough literature search of MEDLINE, PsycINFO, and the PILOTS databases was conducted in 2007. The search covered 1996-2006. The specific methodology of this literature search was given, as well as other resources that were considered such as programs listed on the National Child Traumatic Stress Network (NCTSN) Web site, those nominated by expert reviewers, and recently accepted publications in peer-reviewed journals. A thorough description of the clinical presentation of PTSD in children was provided, including the requirement of a known traumatic event, either by child report or compelling evidence; caution in diagnosis of PTSD; referral for a forensic evaluation without evidence of a traumatic event when PTSD symptoms are present; treatment issues immediately after the traumatic event; and comorbid conditions. The three distinct PTSD symptom clusters are described and the authors discuss the debate about the validity of the DSM-IV-TR diagnostic criteria for children. The many adversarial outcomes of childhood PTSD, including cognitive impairment, high-risk sexual risk taking, depression, substance abuse, anxiety disorders, and poor relationship skills. Studies which have looked at the overall lifetime prevalence of PTSD were discussed, including those
which show a gradual improvement over time; however, studies have also shown that victims may continue to meet the criteria for chronic PTSD for long periods of time. The authors emphasize the need for research on whether younger children are more vulnerable to PTSD and whether or not earlier treatment would result in better outcomes. Risk factors for childhood PTSD included: female gender, previous trauma exposure, multiple traumas, greater exposure to the index trauma, presence of a preexisting psychiatric disorder, parental psychopathology, and lack of social support. Protective factors included parental support, lower levels of parental PTSD, resolution of other parental trauma-related symptoms, and genetic factors. The evidence base for best treatment practices were categorized by Minimal, Clinical guideline, Option and Not endorsed. The specifics of each of these categories are provided, including how the strength of the empirical evidence was rated. Then 11 recommendations are provided for screening; evaluation; treatment; and prevention and early screening. Each recommendation was also supported by a detailed evidence-based narrative. Table 1 is an abbreviated UCLA PTSD Reaction Index. The authors provided a detailed description of the trauma-focused psychotherapies that have proven most efficacious with childhood PTSD, and state that there is growing support for trauma-focused therapies that (1) directly address children’s traumatic experiences, (2) include parents in treatment in some manner as agents of change, and (3) focus not only on symptom improvement but also on enhancing functioning, resiliency, and /or developmental trajectory.


David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. His current research is devoted to dissemination and implementation efforts designed to adapt and then transport effective interventions for these clinical problems to various community settings or systems serving children, youth, and families, including pediatric primary care, juvenile justice, child welfare, public health/safety, and mental health. Michael S. Hurlburt, PhD, is an Assistant Professor, University of Southern California School of Social Work and an assistant research scientist at the Child and Adolescent Services Research Center, Rady Children’s Hospital, San Diego. His current work concentrates on using technologically-supported behavioral measurements to improve prediction and prevention of unplanned foster placement disruptions. He has published widely in the areas of child welfare.
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A nationally recognized mental health services researcher, she has co-authored over 250
publications and was the lead author for the review of effective treatment for mental disorders in
children and adolescents for the 1999 U.S. Surgeon General's Report on Mental Health. She also
has had a key role in the SAMHSA Implementing Evidence-Based Practices Project. Dr. Burns
is currently investigating the effectiveness of an enhanced model of long-term treatment foster
care, best practices for child trauma, the effectiveness of group homes, and mental health
services for children in the child welfare system.

The objective in this study, which was funded by the National Institute of Mental Health and the
Administration on Children, Youth, and Families, U. S. Department of Health and Human
Services, was to document the prevalence of heightened Posttraumatic Stress Symptoms (PTS)
in a nationally representative sample (NSCAW) of children in the child welfare system (CWS).
1,848 children and adolescents ages 8-14 placed in out-of-home care (OHC) and those who
stayed in their original homes (IHC) were studied. Of these, 88.4% were living at home. The
authors hypothesized that level of violence exposure in the home would be a more powerful
predictor of elevated PTS than the specific type of maltreatment for which study referral was
made and that these predictors would increase the rate of reported PTS.

In the introduction, the authors provided a review of several small studies which reported the
rates of PTS among children or youth exposed to violence or abuse are much higher than those
found among the general population of children or youth. They also pointed to studies that have identified risk factors for heightened PTS symptoms or actual PTSD in children or youth, and emphasize the lack of research as to whether or not neglect causes PTS. Research on other possible contributing factors to PTS, such as child’s developmental stage, exposure to violence, and placement setting was provided.

The methodology was explained well, including the NSCAW sample design. For this study, the sample was divided into two age groups, children 8-10 years of age, and youth aged 11-14. Gender, race/ethnicity, placement status, family risk factors, types of maltreatment, perpetrator status, and violence exposure were the primary variables considered. The children completed the PTS scale of the Trauma Symptom Checklist for Children (TSCC) to determine the severity of their PTS symptoms. Child Depression was assessed using the Children’s Depression Inventory (CDI). Table 1 illustrated the mean TSCC PTS Scores and Rates of heightened PTS (T score above 64) by age group within placement setting. Table 2 illustrated the relationship between putative risk factors and heightened PTS status in children and adolescents separately, and Table 3 showed the relationship between all proposed predictors and elevated PTS symptoms in the overall sample. Figure 1 showed the prevalence of heightened PTS symptoms as a function of alleged perpetrator relationship to child as well as type of abuse. All of the Tables and Figures are very detailed as is the accompanying narrative. The discussion of the findings was quite comprehensive and references are made to previous studies which reported similar findings. The overall reported prevalence of heightened PTS symptoms was 11.7%. This rate was lower than expected, however, and the authors give many plausible explanations for this. Younger age, alleged abuse by a non-biological parent perpetrator, violence victimization in the home, and child depression were contributing factors to heightened PTS symptoms. They also pointed out the limitations of this study, particularly that the CWS investigations were not necessarily substantiated.


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clinical psychologist with extensive clinical and research experience working with school-age children placed in foster care. She currently serves as the Doctoral Faculty Representative for the Department of Pediatrics, University of Colorado Denver School of Medicine. She served on the U. S. Department of Justice’s Executive Panel on Mentoring, examining the science associated with mentoring programs. She has been honored for her work on child abuse and neglect from the International Society for the Prevention of Child Abuse and Neglect.

The authors began this article by providing the statistics on child maltreatment of children investigated by child protective services during 2006. They listed the prevalence by type of abuse, as well as age, gender and ethnicity. They pointed out that these children are at a risk for experiencing many mental health problems, regardless of whether or not they are placed in out-of-home care. However, many children were not receiving the mental health services that they need, although children in out-of-home care are receiving these services at higher rates than children who are not in out-of-home care. In the past, the lack of EBT available for maltreated children also compounded this problem. During the last decade there has been rigorous testing of EBP interventions for the mental health problems associated with child maltreatment, and the authors provide a succinct description of EBP and highlight some of the most promising EBP interventions for the treatment of child maltreatment.

Two of the primary projects that have addressed the need for identifying EBPs for treating abused children and their families have been the 2003 project funded by the U. S. Office for Victims of Crime (OVC), which developed guideline for treatment of child physical and sexual abuse; and the Kauffman Best Practices Project, which followed up on the OVC guideline project. The authors explained the criteria utilized by experts from across the nation in these projects: strength of empiric support, soundness of theoretical foundation, potential for harm, clinical utility and acceptance, and transportability to clinical settings. For the OVC project, only TF-CBT received the highest rating. In the Kauffman project, the three best practices identified were TF-CBT, Parent-Child Interaction Therapy, and Abuse-Focused-Cognitive Behavioral Therapy. The authors pointed out the importance of the National Child Traumatic Stress Network (NCTSN) as an excellent resource for identifying evidence-based practices and qualified practitioners when treating maltreated children.

Ten of the most promising EBPs in the treatment of child maltreatment are briefly described with references to articles in the literature about each of these practices. These are broken down into three types: (1) Parenting Interventions: Parent-Child Interaction Therapy and Abuse-Focused Cognitive Behavioral Therapy; (2) Interventions for Child Trauma: Trauma-focused cognitive-behavioral therapy, Child—Parent Psychotherapy; and (3) Interventions for Children in Out-of-Home Care: Multidimensional Treatment Foster Care, Early Intervention Foster Care, Attachment and Biobehavioral Catch-Up, Incredible Years Adaptation, Wraparound Services, and Fostering Healthy Futures. Future directions for research in EBP for child maltreatment are
addressed and the authors call for specific goals for ongoing efficacy research including:
addressing common methodological challenges, evaluating culturally competent intervention
effectiveness, and developing strategies which enhance already promising and efficacious
interventions. They also call for more research on adapting and evaluating current EBP for use
with additional types of trauma, different developmental levels, and co-morbid conditions. The
dire need for research on treatment efficacy for neglected children was mentioned as was the
SafeCare Program, an intervention that directly addresses problems associated with child neglect
as well as other types of child maltreatment and enhances positive parenting behaviors. SafeCare
has shown positive results in nonrandomized research trials. In closing, the authors noted that the
collaborative challenges of EBP adoption at community, organizational, and clinician levels
must be a priority for researchers, community mental health agencies and those involved in child
welfare.

and mental health service providers, children’s service use, and outcomes. *Child Abuse &
Neglect, 33*(6), 372-381.

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colleagues on two projects, America’s Promise Alliance and the Child and Family Support
Teams Initiative. Dr. Bai is interested in using advanced methodology to answer difficult
research questions. Rebecca Wells, PhD, holds a Doctorate in Health Services Organization and
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North Carolina at Chapel Hill. Her research focuses on how health and human service
organizations improve health services access for marginalized populations. Marianne M.
Hillemeier, PhD, earned her Doctorate in Population Studies/Demography and holds Masters
degrees in Nursing and Public Health and is a frequent author in peer-reviewed literature. She is
an Associate Professor, The Pennsylvania State University, Department of Health Policy and
Administration and Demography. She holds joint appointments in Department of Public Health
Sciences, Department of Obstetrics and Gynecology, and School of Nursing.

The authors used multilevel modeling of data from a 36-month period in the National Survey of
Child and Adolescent Well-Being (NSCAW), to attempt to answer the following questions about
interorganizational relationships (IORs): (1) do IORs between child welfare agencies and mental
health service providers increase the use of mental health services for the children they serve?
and (2) do IORs improve children’s mental health status?

Interorganizational relationships not only occur at the case level, but also through additional
information sharing, cross-training of staff, collective development of service delivery policies,
and even joint budgeting. The authors noted that insufficient provision of mental health services to emotionally disturbed children in the child welfare system has been well documented, and the authors hypothesize that inadequate IORs may partly account for the substantial gap between needs and use of mental health services by these children. In their literature review they pointed to two previous studies that suggest that IORs can improve mental health service use, including decreased differences in service use between white and African-American children. However, there was less evidence that IORs improve children’s psychosocial functioning, and the authors provided their opinions on why this has been the case.

Figure 1 in this article applied the health services utilization model to mental health utilization and psychological outcomes for children in child welfare. Agency level factors were intensity of IORs and medical care resources. Child level factors included numerous predisposing characteristics, enabling resources, and need. The characteristics of children who were part of the sample are provided in Table 1, a clinical Child Behavior Checklist score of 64 or greater at baseline was the clinical cut-off point. All children where aged two or older. This provided a sample of 1,613 children from 75 different child welfare agencies. In Table 3 the use of mental health services is broken down into child-level and child and agency-level variables and Table 4 uses the same breakdown, but is illustrating mental health status improvement.

In the discussion of the results, the authors stated that agency-level factors accounted for significant variance in the probability of service use and improvement in the children’s psychosocial functioning. Greater intensity of IORs was associated with higher likelihood of both service use and mental health improvement, controlling for a variety of predisposing, enabling, and need factors. They authors pointed out that the association found in this study between the intensity of IORs and children’s clinical status contrasts with results in previous large scale studies of care (Bickman, 1996). They posited that this may be because of the difference in the populations studied, and that certain types of interagency ties matter more than others, particularly between CPS and mental health service providers.


Michael Andrew deArellano, PhD, holds a Doctorate in Clinical Psychology and is an Associate Professor at the National Crime Victims Research and Treatment Center, Director of the NCVC Community Outreach Program – Esperanza (COPE), Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston. He specializes in serving children and adults who have been victimized by crime and other types of traumatic events. His research
focuses on evaluating and adapting evidence-based treatments for ethnic minority populations. Dr. de Arellano has developed several clinical programs that provide evidence-based practices to trauma exposed children and families from traditionally underserved populations (e.g., ethnic minority, rural/remote, inner city, economically disadvantaged). He also runs a specialized program for Hispanic women and men that have experienced domestic violence, sexual assault, or stalking. Dr. de Arellano has received national recognition for his work with traditionally underserved populations, and he continues to develop clinical programs and research to address disparities in mental health. Susan J. Ko, PhD, also holds a Doctorate in Clinical Psychology and is Director of Service Systems Program at the National Center for Child Traumatic Stress. She is also a staff Clinical Psychologist at Sacramento State University, maintains a private clinical practice, and is a consultant on trauma in juvenile justice settings and diversity and cultural competence. She specializes in cross cultural counseling, Asian mental health, women issues and training and development problems. Her research interests include therapeutic working alliance and outcome research as it relates to brief therapy. Cally Sprague, MA, is pursuing a Doctorate in Clinical Psychology at the University of California, Santa Barbara, where she is part of the Kia-Ketting Research Lab. She was the Service Systems Program Coordinator at (NCTSN) and also worked on numerous initiatives geared towards enhancing culturally competent practices, including the evaluation of evidence-based interventions for diverse cultural groups. Her research interests include developmental trauma and identifying specific risk and protective factors for children and adolescents exposed to trauma.

This project resulted from a collaboration between the National Crime Victims Research and Treatment Center in the Department of Psychiatry at the Medical University of South Carolina and the National Center for Child Traumatic Stress (NCTSN) and was developed to assist mental health practitioners, policy makers, researchers, educators and clinicians. The foundation for this work was the Child physical and sexual abuse: Guidelines for treatment (Revised Report; April 26, 2004), published by the National Crime Victims Research and Treatment Center. The primary goals of the 2008 project were:

(1) To collect information on interventions that are currently being used for a broad array of diverse cultural groups of youth affected by trauma;

(2) To provide descriptions of existing clinical and/or research evidence for each of these interventions;

(3) To encourage practitioners and intervention developers to summarize practice-based and anecdotal evidence in written form so that treatments can be more widely disseminated and more thoroughly evaluated;
(4) To create a formal comprehensive report which documents our systematic process and describes the interventions that were identified and submitted by treatment developers. The report can then be used by practitioners when selecting treatments for the diverse communities they serve;

(5) To develop a web-based, searchable database describing the existing clinical and research evidence for the use of trauma-informed interventions with various cultural groups of youth exposed to trauma. The database will help to facilitate the identification and use of treatments for diverse communities affected by trauma.

Culture was broadly defined to include ethnicity, sexual orientation, socioeconomic status, spirituality, disability, and geography. Culture-specific fact sheets on 22 different trauma-informed interventions which have been utilized with children and families who have exposed to a variety of different traumas were provided. These fact sheets included the components of interventions, engagement strategies, clinical and research evidence, types of trauma and populations with which the intervention has been used.

The methodology for this project, which took three years of collaboration, was explained well. A standardized template was completed by each treatment’s developer. They provided a description of the treatment and listed information about target population and essential treatment components. They also provided information regarding clinical, anecdotal, and research evidence, implementation requirements and readiness, training materials and clinics, requirements for training, and outcome measures. Each treatment description provided several pages of culture-specific information. This included a description of engagement, language challenges, culture-specific symptom expression, assessment, cultural adaptations, and intervention delivery method. Three Appendices were included which illustrate the templates completed by the treatments’ developers: General Information Intervention Template, Culture-Specific Information Intervention Template, and Treatment Protocol Classification System. However, descriptions of how to deliver treatment were not provided. This resource should not be considered a treatment manual; rather, it is a valuable tool for determining treatment options, particularly with children and families from diverse cultures.

In conclusion, the authors state that culturally competent trauma-informed therapies should include some, or all, of the following principles listed below, and offer suggestions for enacting these policies.

(1) Engagement with the child, the family, and the community.
(2) Sensitivity to the family’s cultural background when building a strong therapeutic relationship.
(3) Consideration of the impact of culture on symptom expression.
(4) Careful use of interpreters, when necessary.
(5) Understanding that differences in emotional expression exist among cultures.
(6) Assessment of the impact of cultural views on cognitive processing or reframing.
(7) Construction of a coherent trauma narrative using culturally congruent methods.
(8) Highlighting ways in which culture may be a source of resiliency and strength.


Gully, Kevin J. PhD, recently deceased, was the manager of Safe and Healthy Families, Primary Children’s Medical Center, in Salt Lake City, Utah. He held dual Professorships in Clinical and Educational Psychology at the University of Utah and was a Diplomate in Forensic Psychology with the American Board of Professional Psychology (ABPP). Dr. Gully developed two important psychological evaluation tests, the “Social Behavior Inventory” and the “Expectations Test”. Brittany L. Price, PhD, completed her pre-doctoral internship with Safe and Healthy Families, Primary Children’s Medical Center, in Salt Lake City. She is a psychology resident at The Children’s Center in Salt Lake City, a nonprofit community mental health center that provides treatment to preschool-aged children and their families. Marilyn K. Johnson, RN, is the Clinic Coordinator for Safe and Healthy Families, Primary Children’s Medical Center, in Salt Lake City.

The authors began this article with a description of the need for evidence-based mental health treatment (EBT) for victims of child abuse. They posited that forensic medical examinations offer a unique point of contact during which there may be an opportunity to empower parents so they can access EBT for their children. The authors designed this study to measure whether a protocol employed by nurses during forensic medical examinations would empower parents to increase access to EBT for their children. This protocol was based on social learning theory about parent-empowering approaches, as well as literature emphasizing the importance of a collaborative relationship between parents and health-service professionals providing services. Two studies were completed. The first was a quasi-experimental design and the second was a randomized controlled trial. Methodology, procedures, outcome measures and results were explained in detail. Tables which illustrate the effect/components of the protocol measured through the parental questionnaire and results of the questionnaire are provided. The authors discussed the limitations in this study and call for future research in specific areas regarding promotion and access of EBT for children who are victims of abuse. They concluded that both studies demonstrate that a simple protocol employed by nurses during the forensic medical examination can increase reported access to EBT for children and parent-reported satisfaction.
with their child’s care. Also, the authors believed that this protocol was sustainable because nurses who implemented it viewed the protocol favorably and were not unduly burdened by it.


Judith Cohen, MD, is Medical Director of the Center for Traumatic Stress in Children & Adolescents at Allegheny General Hospital in Pittsburgh, Pennsylvania, and Professor of Psychiatry at Drexel University College of Medicine. Since 1983, Dr. Cohen has been funded by more than a dozen federally-supported grants to conduct research related to the assessment and treatment of traumatized children. With her colleagues, Anthony Mannarino, PhD, and Esther Deblinger, PhD, she has developed and tested Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based treatment for sexually abused and multiply traumatized children and their non-offending parents. Dr. Cohen has served on the Board of Directors of the American Professional Society on the Abuse of Children, and received its Outstanding Professional Award in 2000. She is currently a member of the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS), and is Associate Editor of its *Journal of Traumatic Stress*. She also served as the first author of the ISTSS published guidelines for treating childhood PTSD. Dr. Cohen is the principal author of the Practice Parameters for the Assessment and Treatment of Childhood PTSD published by the American Academy of Child & Adolescent Psychiatry (AACAP). In 2004, ACCAP awarded her its 2004 Rieger Award for Scientific Achievement.

Anthony P. Mannarino, MD, is currently Chairman, Department of Psychiatry, and Director of the Center for Traumatic Stress in Children and Adolescents at Allegheny General Hospital, Pittsburgh, Pennsylvania. He is also Professor of Psychiatry at the Drexel University College of Medicine. Dr. Mannarino has been a leader in the field of child traumatic stress for the past 25 years. He has been awarded numerous federal grants from the National Center on Child Abuse and Neglect and NIMH to investigate the clinical course of traumatic stress symptoms in children and to develop effective treatment approaches for traumatized children and their families. Dr. Mannarino has received many honors for his work, including the Betty Elmer Outstanding Professional Award, the Most Outstanding Article Award for papers published in the journal, *Child Maltreatment*, given by the American Professional Society on the Abuse of Children (APSAC), and the Model Program Award from the Substance Abuse and Mental Health Services Administration for “Cognitive Behavioral Therapy for Child Traumatic Stress”.

Dr. Knudsen is a mental health services researcher with the Office of Program Evaluation and Research, Ohio Department of Mental Health.

In the introduction of this article the authors provided a concise review of studies which have shown that TF-CBT is a superior treatment option when treating children who have been sexually abused. In this study, their objective was to show that TF-CBT is not only an efficacious
treatment for traumatized children, but how efficiently it works and how long the treatment effects after maintained after the treatment is completed. Subjects in this study were 82 children and adolescents 8-15 years of age who were referred to an urban outpatient child psychiatric program specializing in the treatment of traumatic stress in children. These children were referred from CPS, pediatric clinics, police, forensic investigative agencies, victim advocacy programs, community health agencies, rape crisis centers, the courts, and from patient- or family-initiated referrals. These children were from suburban and rural areas as well as the city where the outpatient clinic was based, and perpetrators were both intra and non-familial. The study evaluated the duration of treatment effects of two alternative 12-week treatments for these children over the course of the year following the end of treatment. TF-CBT was the index treatment and NST was the comparison treatment. The methodology was thoroughly explained and Table 1 illustrates the pretreatment to 1-year follow-up group by time interactions on outcome measures, of which there were 14, including CSBI CDI, and CBCL. The authors concluded that TF-CBT was superior to NST in producing durable improvement in depressive, anxiety, and sexual concern symptoms over the course of a year following treatment. They noted the limitations of the study, particularly that the measure used for PTSD was less than optimal, and the drop-out rate in the comparison group was high.


Barbara J. Burns, PhD, is the Director of the Services Effectiveness Research Program and Professor of Medical Psychology, Duke University School of Medicine. A nationally recognized mental health services researcher, she has co-authored over 250 publications and was the lead author for the review of effective treatment for mental disorders in children and adolescents for the 1999 U.S. Surgeon General's Report on Mental Health. She also has had a key role in the SAMHSA Implementing Evidence-Based Practices Project. Dr. Burns is currently investigating the effectiveness of an enhanced model of long-term treatment foster care, best practices for child trauma, the effectiveness of group homes, and mental health services for children in the child welfare system. Susan D. Phillips, PhD, is an Assistant Professor, Jane Adams College of Social Work, University of Illinois, Chicago. Her work has focused on the well-being of children whose parents are incarcerated. Ryan Wagner, PhD, is an Associate Research Professor of Medical Psychology in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center. Currently, he has refocused his interests in psychiatric epidemiology and mental health services research. Richard P. Barth, PhD, is the Dean of the School of Social Work at the University of Maryland. An internationally renowned scholar and innovator in the
area of children’s services research and programs, Barth has authored more than 150 peer research papers, written 11 books, and presented expert testimony before the U.S. House of Representatives on adoption, child welfare, and substance abuse. David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. His current research is devoted to dissemination and implementation efforts designed to adapt and then transport effective interventions for these clinical problems to various community settings or systems serving children, youth, and families, including pediatric primary care, juvenile justice, child welfare, public health/safety, and mental health. Yvonne Campbell, MSW, is a past Director of Child Protective Services, San Diego County, California. John Landsverk, PhD, is a Professor Emeritus, San Diego State University School of Social Work and a Senior Scholar at George Warren Brown School of Social Work, Washington University in St. Louis. Dr. Landsverk also leads the National Institutes of Mental Health (NIMH) funded Child and Adolescent Interdisciplinary Research Network (CAIRN), a network of 25 researchers and service system managers from the disciplines of clinical and developmental psychology, anthropology, sociology, social work, health care, economics, and pediatrics. The principal focus of this network is to improve mental health services for children involved with child welfare systems, with particular emphasis on the use of evidence-based interventions that address externalizing problems. Since 1999, Dr. Landsverk has been the principal investigator of the NIMH funded study, Caring for Children in Child Welfare, that has examined the use of mental health and developmental services for children involved in the national child welfare study, National Survey of Child and Adolescent Well-Being (NSCAW).

The objective of this NIMH funded study was to identify factors related to the need for and use of mental health services among youths early in an episode with the child welfare system. This article specifically addressed (1) the clinical need and related characteristics, (2) the correlates of mental health service utilization, and (3) the rates and types of mental health service use. Data utilized was from NSCAW. Two cohorts of children, their caregivers and child welfare workers, were randomly selected between October 1999 and December 2000 to take part in this survey. The stratified two-stage sample survey design is explained, including analysis weights. The five measures used were described: (1) need for mental health services, (2) mental health service use, (3) types of alleged maltreatment, (4) types of placement, and (5) child welfare worker risk assessment. The methods of data analysis used were described and missing data on risk assessment and type of alleged maltreatment is noted. To measure the need for mental health services, the Child Behavior Checklist (CBCL), Youth Self-Report and the Teacher’s Report Form were used. Data on the use of mental health services was based on an adapted version of the Child and Adolescent Services Assessment.
The authors began the article with a review of the existing literature on mental health need and mental health service use by maltreated youths. They pointed to previous studies that suggest that as many as 80% of youths involved with child welfare agencies need mental health intervention, which contrasts significantly with youth from the general population, at only 20%. They also pointed to studies that show that youths placed in non-relative foster care are more likely to use publicly funded mental health services than children who stay with their families. Studies which show that youth with the most severe problems appear to be the most likely to receive treatment are mentioned. Also, use of mental health services appears to be influenced by child welfare placement type, race/ethnicity, and type of maltreatment. Sexually abused youths were more likely to receive services, irrespective of their level of mental health need, when compared to children who have been physically abused or neglected.

Table 1 showed the sample characteristics, clinical range designation, and mental health service use of youths aged 2-14 years who were subjects of investigated reports of maltreatment. These sample child and family characteristics were extensive and categorized by age, race/ethnicity, gender, current placement, maltreatment type and parental risk factors. Table 2 categorizes the factors associated with mental health service use by youths who were subjects of investigated reports of maltreatment into three age groups. The authors noted that sexually abused preschool children were 3.7 times more likely to receive mental health services than preschool children who had suffered neglect. Figures were provided which illustrate the use of mental health services by clinical range CBCL score as well as type of mental health services based on whether or not their CBCL score placed them in clinical range.

The authors’ discussion pointed out the gaps between need for and use of mental health services for maltreated youth, and they address both the causes for these gaps as well as potential solutions. They emphasized that maltreated youth have many factors working against them including family risk factors and frequent placement changes, and when these are combined with the severe emotional and behavioral problems often present, the critical need for mental health services cannot be overlooked.
Case Review


Shelly L. Jackson is Assistant Professor, in the Institute of Law, Psychiatry and Public Policy in the Department of Psychiatry and Neurobehavioral Sciences, University of Virginia where she teaches among other subjects, *Family Violence Across the Lifespan*. Among Dr. Jackson’s many professional publications and activities, she guided the development and implementation of a comprehensive evaluation of the Foothills Child Advocacy Center, was a member of the Federal Implementation Committee for a Multi-Site Demonstration of Collaborations to Address Domestic Violence and Child Maltreatment and the Federal Interagency Working Group on Child Abuse and Neglect.

The purpose of this study was to examine MDT knowledge and philosophy as well as perceptions of case review meetings. Jackson sought to fill a gap in the literature concerning evaluation of MDTs and specifically the role of the CAC director. The findings point to several areas in need of further research. A survey was administered to MDT members, including CAC staff from the 16 CACs in the state of Virginia. Respondents represented 13 disciplines, with the majority (63%) being frontline workers. Developing, associate, and accredited CACs were represented. Survey questions addressed 1) MDTs perception of how well case review was functioning, 2) MDT knowledge of team philosophy and procedures, and 3) attendance, length of, and frequency of case review meetings. Open ended questions asked about what was working well and what needed improvement. Several issues emerged from analysis of the survey data. First, differences were found among the professional groups. CAC staff, directors for the most part, reported attending all case review meetings. This group also perceived that case review meetings were not well attended, while other group reported this to a lesser degree. Jackson suggests that more training for CAC directors is needed concerning managing MDTs and case review. A second issue that emerged was the differences in perceptions between investigators and service providers. Investigators felt that case review meetings lasted too long and that they could obtain more information observing interviews, while service providers felt meetings were not too long and were a better venue for obtaining case information. Another emerging issue was the difference in perception between supervisors and frontline workers for several variables including frontline workers feelings of having less status in decision making, and service provision as the core function of the CAC. Jackson suggests ways to level the perceptions of status among MDT members including holding meetings in a neutral location and restricting group size. A further issue emerged with regard to differences between views of developing, associate, and accredited CAC staff members. Developing CAC MDT members identified struggling with financial and staffing issues as a pressing issue, while accredited CACs identified specific aspects of case review as in need of improvement and those from associate CACs...
identified lack of attendance and participation in case review meetings as an issue needing improvement. Jackson stresses that these differences require different targeted resources to meet the varying needs. This research provides a contribution to the literature on MDTs by identifying differences among the various groups involved in MDTs as well as suggestions for tackling the issues. Jackson notes that the study was limited by comparison across CACs and voluntary participation. She suggests that future research should use within MDT comparison data and should strive to eliminate bias. Jackson further suggests that the field would benefit by examination of research on MDTs from other areas such as medicine.


Mark D. Everson, PhD, directs the Program on Childhood Trauma and Maltreatment (PCTM) in the University of North Carolina at Chapel Hill Department of Psychiatry, an outpatient clinical program specializing in the assessment and treatment of abused, neglected, and psychologically traumatized children and adolescents. Jose Miguel Sandoval is a statistician working on the America's Promise Alliance evaluation. Sandoval formerly worked in the Injury Prevention Research Center at the University of North Carolina at Chapel Hill.

Everson and Sandoval sought to address the concern that evaluators examining the same evidence in assessments of child sexual abuse, often arrive at quite different conclusions. Their examination of the literature, primarily from the 1990s, found that subjectivity was a major component in the evaluation process. They further found that little was known about the specific subjective factors affecting professional judgments. Everson and Sandoval then identified three forensic attitudes that may contribute to disagreements in professional judgments. From Runyan (1998), they identified the concepts of sensitivity and specificity, both referring to indices of diagnostic accuracy. The third forensic attitude identified was skepticism toward child disclosures or the beliefs about the likely truthfulness of allegations. Previous research found CPS workers to be significantly less skeptical than law enforcement and the least skeptical among all groups assessed. This study was designed to determine whether the three forensic attitudes (specificity, sensitivity, and skepticism) influence professional judgment, thereby contributing to evaluator disagreements in cases of child sexual abuse. Development of an instrument for assessing the three attitudes and determining how forensic attitudes differ by professional position, years of experience and gender were also study objectives. Study participants were 1,106 professionals recruited from continuing education trainings and national professional conferences from 2005 to 2008. The researchers developed a 28-item Child Forensic Attitude Scale (CFAS): a self-administered and self-scored survey. Three decision exercises were also designed to assess the validity of the CFAS as a measure of forensic
attitudes. The exercises included a case vignette exercise, mock evaluation exercise, and record review exercise. The first major finding of the study was that the three attitudes could be quantified using a brief questionnaire. Statistical analyses confirmed that the four subscales in the CFAS were statistically distinct. The second major finding was that significant effects were found for all demographic variables. Victim advocates ranked highest among professional groups on sensitivity and specificity subscales. Women emphasized sensitivity while men emphasized specificity. The authors assert that this may explain results from previous studies in which women were more likely to view allegations as credible. The third major finding was that the influence of forensic attitudes was spread across all professional groups. Furthermore, attitudes were found to predict case ratings in all three decision exercises. The authors assert that this provides more evidence of the validity of the CFAS and for the hypothesis that individual differences in forensic attitudes can help explain evaluator disagreements. They further posit that high levels of these attitudes may bias a professional’s view of a case. A significant difference from three previous studies concerned attitudes of CPS workers. CPS workers scored significantly higher on specificity than all other groups and significantly higher on skepticism than all but one group. The authors found this troubling because this pattern of scores is associated with a higher probability of disbelieving sexual abuse allegations. Due to the sharp contrast in findings for attitudes of CPS workers from this study to previous studies, the authors called for further research. Implications for practice included 1) the assessment of forensic attitudes can be used to build individualized trainings that address specific biases, 2) results suggest that strong case facts may weaken the influence of subjective factors, and 3) a team approach to assessment that emphasizes diversity in professional disciplines, gender, and experience levels may be helpful in balancing individual biases. The study was limited by the fact that the sample was recruited from workshops and conferences instead of by random selection. Other limitations included use of a new and untested scale as well as the fact that attitudes were assessed within classroom and conference settings rather than in the field. The researchers obtained no known benefits from results of this study.


Jane Li is a research scientist at CSIRO ICT Centre’s Information Engineering Laboratory based at Sydney. Her research interests are in the areas of Computer Supported Cooperated Work (CSCW), Human-Computer Interaction (HCI) and e-Health. Her research focuses on understanding work practices, human-computer interactions and usability issues that occur in emerging interaction technologies and how to use these field and lab understandings to design advanced collaboration technologies that fit well with particular work settings. Toni Robertson is
a Professor of Interaction Design at the University of Technology in Sydney, and a specialist in Human-Computer Interaction. Her work focuses on building an understanding of human practices, as situated, social activities, into technology design practices.

This research examined processes involved with multidisciplinary cancer teams in three hospitals in Australia using technology to conduct meetings. The examination focused upon organizational context, existing technology facilities, and use of available digital medical information systems. Emphasis was placed upon the roles played by differences in both physical and information-sharing settings. Data were collected via interviews of team members and observation of team meetings conducted via video conferencing and typically reviewing five to ten cases. Presentation of pathology slides and radiology images were usually shared for case discussion. Sketches were also made of the physical meeting spaces. Data collected led the researchers to conclude that the spatial arrangement of meeting participants in a room influenced interaction patterns. Participation was enhanced when participants were more visible to the remote team and had better view of the screen for viewing the remote team. Additionally, information sharing via technology needed to be set up in order to facilitate the space-function of each meeting room. Although room setups were constrained by organizational contexts, the researchers suggested that consideration should be given in each unique situation to the optimal setup for participation and sharing. This research contributes to understanding of how design of a collaborative workspace with appropriate configuration of physical space can support greater information sharing and participation. Room size, team size, seating arrangements, and other physical space issues were shown to clearly influence conversation and information sharing.


Teresa M. Smith, LSW, PhD, is Outreach and Training Coordinator for the Northeast Region Children’s Advocacy Center and an Accreditation Site Reviewer for the National Children’s Alliance. Dr. Smith was co-founder of the Children’s Resource Center in Harrisburg, Pennsylvania.

The purpose of this research was to explore the roles and relationships of team leaders and team members on child abuse case review teams in Children’s Advocacy Centers. The study informs about the benefits of team member and leader acceptance of diverse perspectives and open communication in how to best manage collaborative teams. The study also contributes to information for CACs regarding key components to be considered for ideal case review team interactions and relationships. Key components included: alignment of foundational documents,
leadership quality, meeting location, meeting attendance and participation, and leadership boundaries. Smith reviewed the literature and theory supporting multidisciplinary team case review and the literature on problems associated with cooperation among case review team members. The primary research question for this study was: How can the CAC team members and the team leader best interact to manage the case review team process to achieve the team’s goals? The data for this research was collected from in-depth examination of the case review teams at five Children’s Advocacy Centers in Pennsylvania. The case study included: 1) analyses of program documents including written mission statements, interagency agreements, and team protocols, 2) observation of one case review team meeting of each CAC participating in the study, 3) a team member self-report survey, 4) individual interviews with designated team facilitators, and 5) group interviews with case review team members. Sixty-seven percent of case review team members completed the survey. Six major themes were identified from the research: 1. Alignment of written documents with the operations of the CAC is important. 2. Trust was experienced at different levels between team members and team leaders. 3. Quality of facilitation and communication skills varied among team leaders. 4. Attendance at and participation in team meetings is highly valued. 5. CAC Director and team leader boundaries can become blurred. 6. Meeting locations may affect participation. From these themes Smith identified three major concepts essential for optimal team member and team leader interactions: 1) sense of trust in team members and the process, 2) respect for members and leaders as demonstrated by acceptance of each other’s differences in beliefs, perceptions, and experiences, and 3) commitment to working as a multidisciplinary team and holding others accountable for their level of engagement in the case review process. Smith found these concepts were supported by previous research and by the theoretical framework. From this study Smith identified recommendations for practice including recognition of the importance of clear and aligned written documents that detail the intent and operations of an organization. A second recommendation was the development and/or coordination of team training on a regular basis. For future research, Smith recommended observations of and interviews with persons in administrative roles of relevant disciplines to determine if supervisors and administrators influence over direct service workers may impact attendance and participation on the case review team. Another area of recommended future research was examination of perceived power and authority of the team leader to affect team effectiveness. Study limitations identified by Smith include the possibility of Social Desirability effect whereby team members may have responded positively on the issues discussed as a result of wanting themselves or their Center to be seen in a positive light. Other limitations included the fact that the centers studied were not randomly selected and the fact that observations and interviews were limited to one session per team and individual. Although the author documents her previous experience with CACs, there are no known inherent conflicts of interest of benefits to research outcomes of this study.

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The authors conducted this study with the objective of creating expert consensus on tasks that Child Protection Teams (CPTs) should perform and factors that contribute to effectiveness. The method used consisted of three rounds of self-administered surveys used to establish expert consensus among 29 professionals from 16 states who either consulted with or were members of a CPT. Round one used open-ended questions to generate a wide range of topics related to tasks that CPTs should perform. In the second round the participants used a Likert scale to rank their level of agreement with statements generated in round one. In the third round, participants were given the opportunity to compare their responses with the group average and to adjust their responses. In round four, participants were asked to rank the five most important tasks that CPTs should perform. After round three, a high number of statements related to CPT tasks and characteristics related to team effectiveness had reached consensus. The CPT tasks which ranked the highest included (1) providing Child Abuse and neglect (CAN) medical consultations, (2) facilitating accurate communication of CAN-related findings to appropriate agencies, (3) participating in multidisciplinary reviews of cases of possible abuse or neglect, (4) conducting forensic interviews of children, and (5) testifying in court. The experts believed that CPT performance should be evaluated on the basis of whether the involvement of the CPT resulted in more timely investigations of cases, the provision of more services to families and better CAN education of medical professionals. The variables that ranked as most important by the highest number of participants were active interdisciplinary collaboration (95%), a sense of team collegiality (75%), and mutual trust and respect (75%). The researchers concluded that CPTs should focus internal efforts upon improving member collegiality and encouraging active interdisciplinary collaboration.

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The authors conducted this study with the goal of promoting greater learning through audit. By analyzing the recommendations from serious case reviews, the study examined the suggested method proposed by Handley and Green of auditing which requires an inter-agency approach, thus providing a holistic picture of progress. The method for conducting the study was examination of 24 anonymous serious cases from the previous ten years. A total of 182 health recommendations were constructed from the cases. The health recommendations were then categorized under three headings: resources, professional actions, and professional knowledge/skills. Each recommendation was then analyzed to see if it was (1) specific or setting out exactly what should be done, (2) measurable, (3) achievable by the person the recommendation is addressed, (4) realistic, and (5) timely. The analysis found that of the 182 recommendations, 20 or 11% met all five criteria, 129 or 71% met three criteria, 107 met the “specific” criteria, 101 were rated realistic, 92 were rated as measurable, and just 21 were rated as achievable. These results were similar to previous studies, which determined that there has been a lack of clarity in the formation of recommendations while focus has been upon services and compliance with procedures. The 2002 study by Sinclair and Bullock revealed several concerns including inadequate sharing of information, poor assessments, ineffective decision making, lack of inter-agency working and poor recording. The primary conclusion from the review of the literature and this current study was that adequate assessment is vital and that appropriate training is essential to the understanding that information must be shared in the best interest of the child. The study did not examine the impact of the serious case reviews, however the researchers found that better “communication resulted in improved understanding of specific issue by practitioners and more trusting working relationships.”

The authors of this article are researchers in the Department of Child and Adolescent Psychiatry/Psychoterapy at University Hospital Ulm, Germany. Lutz Goldbeck, PhD, is a child and adolescent psychologist whose areas of research include psychosocial aspects of chronic pediatric conditions, coping, quality of life; psychiatric co-morbidity; development and evaluation of psychosocial interventions; evaluation of mental health services; and interventions for pediatric post-traumatic stress disorder. He is a noted teacher, researcher and Associate Editor of the journal *Child and Adolescent Psychiatry and Mental Health*. Anita Laib-Koehnemund is a research scientist and Jorg Michael Fegert, MD, is a recognized expert in Germany on the gaps in the child protection system.

This study evaluated the effects of expert-assisted child abuse and neglect case management in the German child welfare and healthcare system as perceived by the case workers themselves. From the review of the literature the authors cited Carter, Bannon, Limbert, Doherty, and Barlow (2006) who concluded that evidence suggests that procedural changes, such as checklists and structured protocols improve documentation and awareness by healthcare professionals’ case management. They found a lack of evidence for the effectiveness of various risk assessment and case management procedures. Additionally, they cite Kirchhofer (1996) who described the need for more training and case-specific supervision for professionals dealing with alleged cases of sexual child abuse. The researchers posited that “The case workers’ satisfaction with the perceived degree of child protection after intervention, their self-perceived certainty with case evaluation, risk assessment and intervention planning, their evaluation of the communication with other institutions that are involved in the case, and the involvement of the children and parents can be seen as relevant indicators of good practice.” They hypothesized that compared to intra-institutional case management, expert-assisted case management would improve 5 areas: (1) case workers’ satisfaction with the degree to which they felt the child would be protected, (2) case workers’ certainty of decision-making on validation, risk assessment, and intervention planning, (3) the involvement of different institutions responsible for the security of the child, (4) the quality of inter-disciplinary communication, and (5) the involvement of the children and their caregivers in the process of diagnosis and intervention planning.

Social workers, physicians, psychologists, psychotherapists, and counselors from 12 different institutions in the German state of Baden-Wuerttemberg participated in this study. Eighty newly recognized or suspected cases of child abuse were used in the study. The cases were randomly assigned to the intervention group or to the control group. Follow up assessment was completed after six months in both groups. Intervention was done by experts with practical expertise in child protection from different professions and affiliations such as office and clinic-based physicians, psychologist, and social workers. Information on case-specific goal attainment was
taken from the protocols of the case reviews. At the six month follow-up assessment there were no significant differences between groups in risk assessment or proportion of closed cases. The interaction effect of time and group indicated a tendency toward better intervention planning in the intervention group compared to the control group. The results showed no support for the researchers’ hypothesis that case workers perceived intervention as effective. The comparison of the involvement of children revealed some adverse effects of the intervention. The authors believed that performing case review without the child and/or the caregivers may have the side effect of excluding the child from decision making during the case management. The results were summarized by saying that expert-assisted case management was not generally effective according to the case workers’ reports.


Each of the authors, Lee Chi Wai, Anselm, FHKAM (Paediatrics), Li Chak Ho, FHKAM (Paediatrics) and So Kwan Tong, FRCP, FHKAM (Paediatrics), is affiliated with the department of Paediatrics & Adolescent Medicine at Tuen Mun Hospital, Hong Kong.

The researchers focused primarily upon the medical practitioner as part of the case review team. This study includes review of the literature along with practical suggestions. The review included explanation of the fact that in times past the cost of case review, given the number of professionals involved and the time spent on meetings was considered substantial. However, case review has evolved into an important venue where professionals from various fields can contribute their expertise. From the review, the study found that success of case review depends on the knowledge and experience of participating members and the way in which the review is steered “when complicated issues or discrepant views emerge.” Based upon review and experience the several suggestions for the medical practitioner are provided. First, the authors determined that preparation and familiarity are key. Documentation including written, photo, and any diagrams/drawings should be complete. Agenda: For successful case review the participants should be prepared to circulate reports prior to the meeting to save time in reading during the meeting. Participants should be respectful, objective, resourceful, and helpful to other professionals. A follow-up plan with objective assessment should be laid out including a decision whether the case will be reviewed again in possibly three or six months later. Although the focus of this study was upon medical practitioners, the suggestions apply to most professionals. The authors asserted that case review should not be regarded as the only means of inter-agency communication and decision-making.

The authors are all lecturers at the University of East Anglia. Marion Brandon, PhD, is a Senior Lecturer in Social Work and Director of Post-qualifying Programmes, (Children and Families). She is a founder member of the International Association for Outcome-based Evaluation and Research on Family and Children’s Services. Jane Dodsworth, PhD, is a Lecturer in Social Work at the UEA. She worked previously as the Inter-Agency Development Officer for Norfolk ACPC and is a former social worker with experience in the residential field and in children and family teams. Her current research interests are in child sexual exploitation and in the analysis of Serious Case Reviews. Daphne Rumball, PhD, is a senior lecturer in social work, and is also affiliated with Norfolk & Waveney Mental Health Partnership NHS Trust.

The authors performed an analysis of 20 serious case reviews studying them using a layered reading methodology to ascertain emerging themes. The authors come from the standpoint that expertise is not exclusive to professionals, meaning that children and their families are experts in their own lives. They posited that communicating effectively and developing common understanding is very difficult to achieve between professionals and even harder between policymakers, professionals, and the children they are serving. This study of 20 case reviews was accomplished by reading and rereading all of the reports associated with the reviews. The same finding tended to recur among all cases: “inadequacies of assessment, agencies’ inability to communicate with each other effectively, poor supervision arrangements, and lack of attention to the voice of the child.” They also found that knowledge and experience from interconnecting groups was rarely brought together in a systematic way to construct strong analytical assessments. They found that a common barrier to rigorous assessment was professional insularity and reluctance to trust other professional groups. Additionally, in half of the cases studied there was inadequate or absent supervision as well as lack of formal support.

The conclusions of this study were in agreement with previous studies such as Stevenson (1989), Reder and Duncan (2003), and Munro (2002) which found that a more rigorous approach and clearer use of expertise as well as capacity to be more open-minded and less insular would foster better outcomes for clients. The role of the lead professional in case review was examined. The results suggested that the lead professional should have a key role in piecing information together, seeing gaps and coordinating expert knowledge. The lead professional should develop creative ways in which to seek specialist knowledge and incorporate it into assessment and planning. The study found similar to Reder and Duncan (2003), that an awareness of blocks caused by group dynamics is crucial to clear assessments and to the factors that “promote professional tension and cloud decision-making and actions.” Limits to the study include the size of the sample.

Leonard John Baglow, BSW, G.D.U.R.P, Child Abuse Counsellor, presented a multidimensional treatment model for agencies and individuals to use to clarify roles and help professionals overcome liaison difficulties. At the time of this study little had been written about the ways different agencies can achieve better working relationships. Baglow pointed to five points where problems can occur: at the initial point of cross-referral, at the joint case conference, at the allocation of treatment responsibilities, during the process of the treatment modes, and at the point of joint periodic assessment.

Specifically during joint case conference or case review, potential problems in communication increase as the number of agencies increases. During review of the literature Baglow found that Hallet and Stevenson (1980) list five dynamics affecting the process: participants usually do not start as a group, confident in each other’s roles and skills; participants are aware of their own responsibility, participants have several other cases they are working on; the participants do not have a common background in terms of education, experience, training, and agency structure; and the case review process is a more formal and public interaction than in many other professional meetings. Other than difficult personal dynamics, case review participants are often expected to address several complex issues of which no single agency has all the answers. Goal clarification is essential in order to prioritize the needs and to evaluate the resources available to meet those needs. Baglow found also that it is essential that any deviation from an agreed upon plan is discussed with the other participants. Proposed changes must be explained clearly along with how the change fits into the wider plan. Baglow also found that the most difficult question in case review is most often whether or not to close a case. He offered suggestions for avoiding problems rising from competing views. Participants should discuss (1) has the risk of further abuse been reduced? (2) have the treatment goals been achieved? and (3) does the family agree that it no longer needs the assistance of the agencies involved? Baglow pointed out that this study of abilities of agencies to cooperate as well as the dynamics of agencies working together on child abuse cases was in its infancy.
Case Tracking


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The purpose of this commentary was to examine range, status, and goals of surveillance systems of ten countries. The paper contributes a sense of the wide range of developmental stage, capacity, and comprehensiveness of coverage of data collections systems. The authors stated that roles for most systems include raising societal awareness, enhancing use of resources, and monitoring overall progress toward policy goals. The authors defined a national specific child maltreatment data collection system as one that is based on information recorded as part of an intervention for maltreatment. Six of the ten examples included in this paper are based on data obtained by social service agencies. The remaining four are one each from the following sectors: justice, health, health social services, and undetermined. A brief description of data collection, obstacles, and dissemination for the ten countries is provided with the understanding that this is a self-selected scan rather than a representation of global status of the systems. The six countries included in the social service sector were Australia, Belgium, Canada, England, New Zealand, and the United States. Lebanon represents the justice sector. The Philippines represents the health service sector. Saudi Arabia represents the health and social services sector combination. Germany does not collect national level data on child maltreatment. The author reports that assessment of exposure to abuse and neglect were not included in a national child health survey. Germany does not have mandatory reporting laws and there is not an established collaboration between child welfare system and the healthcare system. Data protection laws are quite strict and many professionals, according to the author, fear that data collection may stigmatize families rather than assist children in danger. In conclusion, the authors assert that countries that do not...
have well-resourced and systematically organized social service sectors may face substantial challenges in developing corresponding administrative systems. They further suggest that in countries with fragile social service sectors, it may be more feasible for health or judicial sectors to be the starting point for developing data collection systems. Recommendations for the future include general improvements such as implementation of standard assessment instruments, case definition, and documentation in order to improve validity and usefulness of data on a national level.


Frances Gragg, MA, has more than 25 years of experience in data analysis, research design, survey management, and research and evaluation methods. Gragg has conducted research in child abuse and neglect, commercially sexually exploited children, human trafficking, juvenile/criminal justice, and special education. Roberta Cronin, MA, is a private Research and Program Development Consultant with more than 20 years of experience in the field of juvenile justice. Dana Schultz, M.P.P., is a senior policy analyst at the RAND Corporation, where her research focuses on child welfare and children's exposure to violence.

The Safe Kids/Safe Streets (SK/SS) Program, sponsored by the U.S. Department of Justice, was designed to reduce child maltreatment in five demonstration sites. This report looks at the processing and outcomes of child abuse and neglect cases in three of the SK/SS communities—Burlington, Vermont; Huntsville, Alabama; and Kansas City, Missouri. The objective was to identify outcome for child and families in each of the three sites. Information on outcomes using a case tracking methodology was conducted. Case tracking was used to collect data on agency involvement for cases involving multiple agencies, service referrals and delivery, case processing, and outcomes. The paper provides information on methodology, sampling, measures, and outcomes for each of the three sites. The tracking method allowed for changes in case processing, changes in services, and changes in outcomes for children and families to be identified for each site. The researchers reported that the tracking method allowed each community to systematically examine case handling and outcomes across agencies and determine how procedures and outcomes at each stage match community or agency objectives and standards. This allowed for the Multidisciplinary Teams to better understand the impact of their individual services and identify potential areas for case improvement. Second, they stated that the method assists communities with assessing whether reforms in policies, practices and procedures, service enhancements, and other changes have intended effects as the MDT is constantly working to improve these outcomes. Findings from the case tracking study at site one included: 37 percent of the reports went through the Child Protection Center (CPC) for forensic interviews or medical assessments, the
Children’s Division and/or the Family Court limited the perpetrator’s access to victims in nearly one-half of the sampled reports, and the Children’s Division closed nearly three-quarters of the reports studied within 2 years. At site two findings included: 48 percent of cases were closed and in 45 percent of those cases, families had either been reunited or the child(ren) had remained home during the process, 35 percent of the victims in open cases remained in the home or had been returned to parents, and in closed cases, at least 59 percent of the victims with permanency plans had reached their permanency goal. The case tracking study at site three examined safety and permanency and found no clear patterns of safety. Also, there was little change in permanency rates over the time of the study. The researchers stated the primary reason for this is that far fewer children were removed from home. Observed changes in services included a statistically significant change in substance abuse assessment, more families were identified as needing in-home visiting by a service provider, and decreased time from assessment of need to service delivery. The researchers offered four recommendations based upon study outcomes including lessons learned. First, they recommended that local and national partnerships for case tracking studies should be forged early in the process so that all parties can contribute to study design. Second, outcome evaluation efforts need to be developed and funded earlier. Third, communities should determine whether some case tracking data could be collected on an ongoing basis. The final recommendation was the development of a realistic timeline for change that should help schedule the research and reduce frustrations of those working on the reform.


Andrea J. Sedlak, PhD, is a social psychologist whose areas of research focus on troubled, vulnerable, and victimized groups of children and youth. She is a Vice-President at Westat in Rockville, Maryland. Dana Schultz holds her MPP from Harvard and is a policy analyst at the RAND Corporation. She has led or co-led several projects involving process and outcome evaluation design, implementation, and analysis. Her research focuses on child welfare and children's exposure to violence. She is the co-principal investigator for the National Evaluation of Safe Start Promising Approaches, which examines the effectiveness of school- and community-based mental health interventions aimed at reducing the harmful effects of children's exposure to violence. As principal investigator, she helped develop and implement a toolkit for an evidence-based school intervention for traumatized youth in foster care and conducted secondary data analysis on the relationship between protective factors and outcomes for children investigated for maltreatment using the National Survey of Adolescent and Child Well-Being data. Susan J. Wells, PhD is a professor with dual appointments in the Schools of Social Work & Psychology at the University of British Columbia, Ikanagan Campus. Peter Lyons, PhD is associate professor of Social Work and provost for institutional effectiveness at Georgia State
University. Howard J. Doueck is Professor and Associate Dean of Academic Affairs, School of Social Work, SUNY at Buffalo. Francis Gragg is Senior Project Director at Westat.

This study examined the trajectory of cases through four systems: child protection, law enforcement, the dependency courts, and the criminal courts. This study sought to understand more thoroughly the daily interaction of these systems and to identify how cases proceed through, or are diverted from, the court system. A review of the literature revealed that little was known about the decision making process of the four systems and the interconnectedness between them in situations of child maltreatment as well as the complexities of their roles. The literature also revealed that although a greater percentage of cases undergo dependency proceedings as opposed to criminal prosecution, the overall percentage of CPS cases in this category is also relatively small. The researchers pointed out that no study to date had so thoroughly attended to the multiple sources of case referral and tracking cases through the system including both juvenile and criminal court. Cases from both law enforcement and CPS were tracked from time of the original complaint through the final disposition. A mid-size county was selected for which all aspects of the systems’ data collection appeared to be functional and in which all informants claimed that computerized systems existed to aid sample selection and data collection. 225 reported cases that met the criteria were identified for in-depth tracking. Results include that a total of 36% of cases in the original sample were filed in criminal court by the Prosecutor’s office; almost 1/3 were filed as felonies and 4% as misdemeanors. Insufficient evidence was the most common reason the prosecutor decided to drop a case. Thirty-one percent of the CPS cases continued to the prosecutor’s office and had completed criminal court proceedings. In over 1/4 of CPS sample cases, there was a guilty plea. Of the perpetrator cases that were filed as felonies, 34% reached criminal court and were completed. More than one quarter (28%) of the arrested perpetrators in the sample pled guilty in criminal court, 2% pled no contest to the charges. Other cases were dismissed, went to trial or were found not guilty. Nearly all of the perpetrator cases filed as misdemeanors (49 cases) were completed in criminal court. Of the cases that were filed as felonies, 34% reached criminal court and were completed. More than one quarter (28%) of the arrested perpetrators in the sample pled guilty in criminal court, 2% pled no contest to the charges. Other cases were dismissed, went to trial or were found not guilty. The researchers viewed the major findings of the study as the degree to which: (1) case processing mirrored prior studies in wide ranging jurisdictions, (2) physical abuse cases were prosecuted, (3) cases appropriate for CPS and known to law enforcement were not referred to CPS, (4) factors outside the case processing protocols affected actual referrals, and (5) case tracking across organizations was hindered by internal organizational systems. One difference between this and earlier studies was that the rate of prosecution represents almost 10 times the rate of filings found in studies ten years earlier. The authors further stated that systems which use cross-organizational case identification will need to develop more systematic methods for case identification. Without this ability, positive collaborative relationships will be meaningless.
The researchers noted that a limitation of the study was the use of a single site and the lack of a comparison site.


Adam Tomison, PhD is Director of the Australian Institute of Criminology; Associate Professor and Head of Child Protection Program, Menzies School of Health Research; and Adjunct Professor at Australian Catholic University.

Tomison began with the premise that there was a growing body of evidence to suggest that different types of abuse may occur simultaneously in the same family. This study had three goals (1) to examine the link between child abuse and domestic violence, (2) to discuss the inter-relationship between the two forms of violence, and (3) to identify issues in professional assessment and management of suspected child abuse cases. The data collection for the study was designed to evaluate the decision making of the various professionals involved in management of cases. Participants in the study were 110 professionals from major health, counseling and investigative agencies within a region. The study tracked suspected cases of physical, sexual, and emotional abuse and neglect identified by the professionals. The total number of cases in the study was 295 with about 70% assigned by the professionals as either sexual, physical, or emotional abuse or neglect. The other 30% were labeled as combination cases. Twenty-two percent of the cases were reported to occur in homes where domestic violence also occurred. The study found a number of significant differences found between child abuse cases which were combined with domestic violence cases and those child abuse cases not combined with domestic violence. It appeared that the presence of domestic violence indicated multiple family stressors or that domestic violence increased the likelihood of child abuse developing. Another finding from the tracking study was that domestic violence was often treated in a “manner similar to drug and alcohol problems, with other workers being expected to alleviate these stressors as part of an overall case management plan”. The study also found indications that caregivers known to be violent were often associated with child abuse cases likely to be rated as severe and in which the child was rated as at risk for further abuse. This study found similar to Hiller, Goddard, and Diemer (1989) that a violent, coercive environment was almost as like for sexual abuse cases as it was for physical abuse cases, especially in more severe cases. Several of the placement decisions for the children in the cases indicated a lack of understanding of the further risks to the children. The researcher concluded from the study that there was need for further education of professionals dealing with child abuse cases as to the risk to children in homes where domestic violence was occurring. Tomison also posited that some of the lack of attention by the professionals to identify domestic violence was similar to the acts of omission commonly associated with a neglecting parent. The researcher stated the main point
emerging from the study was that a significant proportion of the cases will coincide with domestic violence and that this will have implications for practice and inter-professional communication and collaboration.


Will Johnson, DSW, is a Supervising Management Analyst, Alameda County Social Services Agency, Oakland, California. His research includes risk assessment and efficiency in Child Protection Services in affecting behavioral change. Thomas P. McDonald is Professor/Assoc Dean, School of Social Welfare at the University of Kansas. His research interests are child welfare and children’s mental health; research methods and statistical analysis; service delivery; use of information systems in policy and practice decisions.

The purpose of this study was to extend the understanding of what happens to reported sexual abuse cases in several ways. 157 sexual abuse reports received and investigated by the emergency response unit of an urban California county during a three-month period in 1985 were examined for this study. Close to 100 measures were used in relation to the recurrence of child maltreatment. The study found that 16% of the victims were reported for maltreatment a second time during the follow-up period. In 62% of the second reports the investigation no abuse/neglect. Therefore, the recidivism rate for the same was near ten percent. The authors point out that the findings of this study differ significantly from that of Faller (1991) which found a recidivism rate of 22%. They reported several factors affecting differences in the two studies. For example, the difference in sample selection procedures may have played a role. This study attempted to extend beyond merely reporting case tracking to searching for predictors of recurrence. One important finding was that neglect plays an important role in predicting recurrence. Another finding was that the caretaker’s ability to engage positively with the agency was the only significant caretaker measure. The researchers pointed out that as a single study with a limited sample, the findings cannot be generalized to all situations and that case tracking should be studied longitudinally to provide a more complete picture.
Organizational Capacity


Marcus Lam, PhD, is Assistant Professor at the Columbia University School of Social Work. His research interests are in nonprofit finance, comparative organizational behavior, and effectiveness of nonprofit, for-profit, and public providers in the delivery of social, health, and human services. Sacha Klein, PhD, is Assistant Professor in the Michigan State University School of Social Work. Her research interests are in the areas of child abuse prevention, infants and toddlers in the child welfare system, and public policy analysis and advocacy. Bridget Freisthler, PhD, is Associate Professor in the Department of Social Welfare at UCLA Meyer and Renee Luskin School of Public Affairs. Her research focuses the spatial ecology of problems, particularly child maltreatment, and the development of environmental interventions to prevent problems. Robert E. Weiss, PhD, is Professor of Biostatistics at the UCLA School of Public Health. His research interests are in the areas of hierarchical models, longitudinal data analysis and Bayesian modeling.

This research examined the influence of child care center ownership structure: nonprofit, for-profit sole proprietors, for-profit companies, and governmental centers, on organizational stability. The study also included age and size of centers as a variable for stability. This study may have implications for stability of nonprofit children’s advocacy centers. This study addressed the question: Are nonprofit childcare centers less likely to close compared to for-profit and governmental childcare centers? Following a review of the history of the childcare industry, the authors discussed theory including Trust Theory which forms partial basis for the study. The theory predicts that nonprofits are likely to have a competitive advantage over their governmental and for-profit counterparts. According to this theory, nonprofits are less likely to exploit consumers and donors because they are legally constrained from distributing profits to managers or directors for personal gain, and therefore, they are seen as more trustworthy. Data for the study was obtained from California State Department of Social Services records for the year 2007. The dependent variable of center closure was measured in terms of expired licenses. The primary predictor variable was ownership structure. The analysis found that nonprofit childcare centers older than four years were less likely to close. Further it was found that larger centers were less likely to close. Based upon Trust Theory it was hypothesized that nonprofits would have lower closure rates. However, results showed that nonprofits had the second largest proportion of closures, second only to for-profit sole proprietorships. This was not consistent with a 2005 Canadian study that found for-profit centers were more likely to experience closures than nonprofits. The authors discuss implications for policy and funding that may be applicable to Children’s Advocacy Centers. Limitations include lack of generalizability, lack of data on
reasons for center closures, and no consideration of diversity of nonprofit centers. The researchers received no apparent personal or professional gain from study outcomes.


Emily Barman, PhD, is Associate Professor in the Department of Sociology at Boston University. Her research focuses on the social organization of altruism and philanthropy. Heather MacIndoe, PhD, is Assistant Professor in the Department of Public Policy and Public Affairs, McCormack Graduate School at University of Massachusetts Boston. Her research applies theoretical frameworks from organizational and urban sociology to address questions concerning the organizational behavior of nonprofit organizations, patterns of public and private funding to nonprofit organizations, and the role of nonprofits in public policy.

This research, according to the authors, is the first to empirically test the salience of organizational capacity in respect to whether practices are adopted across an organizational field. To examine adoption of an organizational practice, the researchers focused on the use of outcome measurement (OM) by nonprofit organizations. An overview of OM, the process of quantifying the impact of programs or services upon clients, is provided. The dependent variable was OM. The independent variables were organizational characteristics, institutional explanations, and organizational capacity. Quantitative data were collected via a survey of executive directors of 600 Boston area service-providing nonprofit organizations. Organizational age was found to be a significant predictor of an organization’s use of OM. Each year of experience made an organization less likely to use OM. A second finding was that being a nonprofit was not a significant predictor of use of OM. Also found was that organizations that implement OM are often subject to greater institutional expectations toward OM, while the likelihood of adoption of OM increased when nonprofits also have adequate organizational capacity to do so. Further, it was found that receipt of funding from United Way or government agencies did not impact rate of adoption of OM. Both administrative capacity and the presence of technical expertise in an organization were significant predictors of adoption of OM. Additionally, organizations with an accountant were significantly more likely to use OM than were those without an accountant. In conclusion, the authors argue that their findings add to scholarship that seeks to account for uneven diffusion of practices across and organizational field. They further posit that attention to organizational capacity does not mean a return to the old view of organizations as unconstrained in their pursuit of interests. The results suggest ways that the concept of organizational capacity may impact the adoption of practices. First, the amount of organizational effort required to implement a practice may determine the relevance of
organizational capacity. Second, the relevance of organizational capacity might differ based on a field’s expectations of how both internal and external factors will result in implementation of a new practice. The researchers note study limitations as generalizability of results from a sample taken in the Boston area, as well as the collection of quantitative data only. They suggest that future research should include in-depth, qualitative data.


Mitchell Brown, PhD, is Associate Professor in the Department of Political Science at Auburn University. Her broader research agenda focuses on the empowerment efforts of marginalized communities, particularly those enacted through organizations.

This article begins with a discussion of the different ways in which organizational capacity, service delivery capability, and sustainability may be enhanced. An overview of the Justice Rural Pilot Program (RPP) and its evaluation, how capacity was measured, and results from validating the self-administered assessment instruments. The RPP was designed to fill a gap in services to victims of domestic violence in rural areas by providing limited OVC funding to community or faith-based organizations. The evaluation of the RPP included a process evaluation, examination of the value added by the faith component, and a capacity study. The self-assessment of capacity was a survey with six major components including 58 elements. The paper presents information on capacity changes and sustainability within the program sites. Almost all participating organizations indicated that the influx of OVW funding increased the organizations’ engagement with state and local funders, and almost half reported increased utilization of volunteers. The most significant changes that funded organizations experienced was increase in both staff size and technological capacity. Furthermore, the capacity of the organizations to sustain change increased during the grant period and did not diminish after the funding period. Brown found from the evaluation that the RPP was an example of the positive effects of policy innovation and diffusion. Further, it was substantiated that agencies must commit to longer-term funding to assure their programs show improvements in outputs and outcomes, as well as long-term sustainability.

Jennifer E. Mosley, PhD, is an assistant professor at the University of Chicago’s School of Social Service Administration. Matthew P. Maronick is a Ph.D. student at the University of Chicago’s School of Social Service Administration. Hagai Katz is director of the Israeli Center for Third-Sector Research, Ben Gurion University of the Negev, Beer-Sheva, Israel.

This research examined how structural, managerial, and financial characteristics affect the adaptive tactics used by human service nonprofits during times of financial stress. The literature review revealed that organizations should use adaptive tactics to respond to changing environments. This study builds on previous work in this area by looking at human service nonprofits and focusing on select variables more closely. The authors identified a gap in the research about how an organization’s managerial, structural, or financial characteristics may affect what tactics it adopts. Therefore, this study assessed how size, age, strategic planning, use of performance measurement tools, professionalization of leadership, and financial challenges, both objective and perceived, affect adaptive tactics that are adopted by nonprofit organizations. The use of five adaptive tactics (dependent variables) that may be used by human service nonprofits when faced with economic uncertainty: (1) adding new programs, (2) discontinuing existing programs or reducing staff, (3) starting joint programs, (4) increasing earned income, and (5) starting or expanding advocacy involvement were investigated. The eight independent variables were structural, managerial, and financial. Longitudinal data were collected from a large sample of human service nonprofits in Los Angeles County, California. Executive directors of 667 agencies were surveyed by telephone and then asked to complete a short follow-up questionnaire 18 months later, following an economic downturn. For the tactic of adding new programs it was found that organizations that foresaw financial challenges were 74 percent more likely to start a new program than organizations that did not foresee such a challenge. For the tactic of discontinuing existing programs or reducing staff was significantly predicted by larger size. This tactic was also used significantly during both perceived and real funding difficulties. Organizations that had experienced financial stress during the prior eighteen months had a 90 percent higher likelihood of discontinuing programs or reducing staff. Two variables that predicted expanding or starting a joint program with another organization were having a strategic plan and not reporting funding as a future challenge. Organizations with a recent strategic plan were 81 percent more likely to expand or start a joint program, while belief that funding would be a future challenge reduced the odds of engaging in this tactic by 45 percent. The tactic of pursuing additional earned income was significantly more likely in larger organizations and in those with strategic plans. Larger size was the only one of the eight independent variables that was found to significantly predict increased advocacy involvement. The researchers assert that this is strong evidence that advocacy is tied to capacity. They conclude that larger size was a
significant predictor of nearly all the adaptive tactics. Size was more significant than other managerial and financial characteristics. On the other hand, use of performance managerial tools was unrelated to every tactic. Having a strategic plan appeared to provide organizations with the ability to carry out some complex new activities, such as joint programs or expanding earned income. Several additional results are discussed in detail. The authors suggest that this study has important implications for practice as well as research.


Karl Besel, PhD, is Associate Professor at The University of Indiana at Kokomo. His research has focused upon nonprofit management and sustainability within the health and human services fields. Charlotte Lewellen Williams, PhD, Charlotte L. Williams is the associate professor and director of the Center on Community Philanthropy at the University of Arkansas Clinton School of Public Service. Joanna Klak is a researcher at the University of Arkansas Clinton School of Public Service.

This research sought to address the issue of substantial cutbacks in both federal and state funds in the current recession and declines in philanthropic giving and best practice strategies on sustaining nonprofit organizations. The authors built a theoretical framework for examining financial sustainability by combining the major points of institutional and population ecology theories. Further, the research sought to build upon previous studies in exploring the influences of networking with community leaders upon financial viability. This study focuses on twenty-six health, human services, and community and economic development organizations in the Mississippi River Delta area. Comparable areas in the Midwest and South were also chosen. All of the communities selected receive federal and state funds. Data was collected from three sources: surveys administered with agency directors, agency financial reports, including annual fiscal reports between 2003 and 2008, and interviews with key informants. Analysis of survey results along with interviews with key informants revealed that in general, the agencies exhibited more similarities than differences with regard to funding diversity, and reliance on government funding and contracts. Nonprofits serving areas receiving federal funds for urban or rural redevelopment were found to be generating revenue streams from a variety of nongovernment sources including fee-for-service programs, annual fund drives, and individual donations. Fifty-eight percent of agencies viewed government funding or contracts as their most dependable source of revenue. Most key informants viewed the current economic downturn and declines in philanthropic giving as the end of large gifts to local nonprofits. Most key informants had reservations about their organization’s reliance on government funding. These reservations were concerned with considerable restrictions on how public funds can be utilized, and the relatively large amount of time and resources spent in complying with state and federal requirements.
Some of agency directors interviewed stated that a “formalized relationship with a government institution” was more important than the securing of government funds for their sustainability. Some differences were reported between urban and rural organizations. Participants were asked about board involvement in fundraising and other sustainability issues. Few agency directors reported utilizing board members to initiate or perpetuate government funding/contracts, most nonprofit leaders that depended upon private sector funding reported specific strategies for board recruitment and retention. Many directors that required board member fundraising spoke about this volunteer responsibility as “increasing levels of shared governance.” Unlike some previous studies, results of this study showed that board members can contribute to the financial sustainability of a nonprofit for certain philanthropic endeavors such as soliciting donations from local residents. The authors report the small sample size as a limitation to this study. This study found similar to previous studies that most of the organizations examined were able to maintain and grow a diversified funding base, while still depending for the most part on government funding or contracts for long-term financial sustainability. There are no known benefits to the researchers based on study outcomes.


H. Woods Bowman, PhD, is Professor in the School of Public Service at DePaul University. His areas of expertise and interest are economics, ethics, and finance.

This study contributes a sustainability principle that gives managers short-term budget surplus targets needed to reach the objective of maintaining long-term financial capacity and sustainability through a rate of change that is sufficient to maintain assets at their replacement cost. The author proposes a model for the long term objective of maintaining services while meeting the short term objective of resilience in uncertain economic times. Following a review of the literature covering financial modeling, Bowman presents the model that gives nonprofits a framework for quantifying financial condition, setting financial goals and monitoring progress. The model addresses several issues related to both short-term and long-term capacity and sustainability issues. Formulas are included to demonstrate each point presented. Bowman suggests several issues for future research including reasons for greater variability in long-term capacity than in short-term capacity, effect of change in board chair or executive on capacity and sustainability.

Andrew Agatston is an attorney in Marietta, Georgia who has represented crime victims in civil litigation. Mr. Agatston has served on the board of directors of the Children’s Advocacy Centers of Georgia. Mr. Agatston has written two books providing legal guidance to children’s advocacy centers. Jason P. Kutulakis is an attorney in private practice in Carlisle, Pennsylvania. Mr. Kutulakis currently serves as president of the Pennsylvania Children and Youth Solicitors Association. Thomas Leclair is the Senior Resource Attorney for the Children’s Law Office at the University of South Carolina. Stephanie Smith is a former prosecutor from Indiana who currently serves as Southern Regional Director, National Child Protection Training Center. Victor Vieth is the Director of the National Child Protection Training Center at Winona State University.

This paper provides general guidelines for forensic interviewers and Children’s Advocacy Centers for assessing their liability. Tips are offered for preventing or minimizing the chance of a lawsuit. The authors focus upon two scenarios whereby a lawsuit could occur. First, an offending parent may sue when a child’s disclosure results in filing of criminal charges or a civil protection action. The second possibility is the case when a child does not disclose during an interview and no action takes place. The authors offer four steps that should be taken to limit potential liability. First, as is supported and validated by research, is the videotaping and other documentation of the forensic interview. Case law is provided in support of the need for videotaping. The second step suggested it that a CAC must provide proper supervision of its forensic interviews and interview process. The author suggest that a record of properly trained and peer reviewed, as well as adherence to Standards of Best Practice can provide a powerful defense for the CAC. The third area is determination of state, national and professional standards under which they work. They further suggest that interviewers should be aware of court decisions that may impact their work. The fourth recommendation is that a CAC should have access to counsel for advice on liability issues. They suggest that the best case is for a CAC to have a longstanding relationship with legal counsel whose knowledge of the work of the CAC will better prepare him to assist were a lawsuit to occur. Five suggestions are offered in the event of a lawsuit, including abstaining from contacting the party filing the lawsuit, determining the legal basis of the lawsuit, determining the actual alleged misconduct, determining if the forensic interviewer or CAC has immunity, and educating the CAC attorney with research, case law, evidence, and contact information for national organizations that may be able to assist. Details for each of these suggestions are provided.

Betty Yung, PhD, is a professor in the School of Professional Psychology, Wright State University in Dayton, Ohio. She is the Director of the Research and Evaluation Enhancement Program (REEP), an initiative directed to improving the evaluation capacity of organizations in Ohio that provide health services to minority communities. The remaining authors have all served on the REEP Evaluation Work Group panel since its inception in 2005. Peter Leahy, PhD, is a Professor and Interim Director at the Institute for Health and Social Policy, The University of Akron. Lucinda M. Deason-Howell, PhD, is an Associate Professor in the Department of Public Administration and Urban Studies at The University of Akron. Robert L. Fischer is a Research Associate Professor and Co-Director of the Center on Urban Poverty and Community Development in the Mandel School of Applied Social Sciences at Case Western University in Cleveland, Ohio. Fatima Perkins, MNO, is the Director of Adult Services at the Cuyahoga County Public Library in Parma, Ohio, and was formerly with United Way of Cleveland, Ohio. Carla Clasen, MPH, RN, is Co-Director of the Center for Health Communities and their Program Director of Research and Evaluation, at Wright State University Boonshoft School of Medicine. Manoj Sharma, MBBS, CHES, PhD, is a Professor in the College of Education, Criminal Justice, and Human Services at the University of Cincinnati. Dr. Sharma is a physician by initial training and also holds a Doctorate in Preventive Medicine/Public Health. He has worked in community health for more than 25 years at the local, state, national, and international level. Dr. Sharma's research interests are in designing and evaluating theory-based health education and health promotion programs, alternative and complementary systems of health, and community-based participatory research.

Most studies conducted on the capacity-building needs of nonprofits have been focused on larger nonprofits rather than those with more limited budgets. This study was designed to identify the capacity-building technical assistance needs of organizations providing health promotion services to ethnic minority consumers in Ohio. The study is relevant because many clients served by CAC’s come from diverse ethnic backgrounds, and thus, capacity-building must include provisions of planning for their unique needs. A literature review was done which makes many references to “Building Nonprofit Capacity: A framework for addressing the problem” (De Vita, Fleming, & Twombly, 2001). The authors concluded that the nonprofit capacity-building literature provided conceptual definitions and operationalized dimensions of capacity building and identified strategies and models for building capacity. However, they found that few, if any studies used a mixed methods approach to directly assess the capacity-building needs of nonprofit organizations serving ethnic minority populations. This study consisted of two parts, a telephone survey and follow-up focus groups. The results were described in great detail and illustrated with several Tables. A very diverse group of organizations participated in the study,
such as neighborhood health clinics, substance abuse treatment centers, and rural community development corporations that provide health promotion or health education services for ethnic communities. Services provided by some of the participants included violence prevention and support groups.

The authors found that it was beneficial to have both the telephone survey and focus groups. The telephone survey indicated greater capacity-building needs while the focus groups provided a more in-depth understanding of the capacity-building needs and provided recommendations on the best delivery system for providing technical assistance services as well as specific suggestions on content needed in web-based venues. The focus group participants represented smaller organizations with fewer staff, and many staff members had both managerial as well as direct service delivery responsibilities. Organizations that primarily served a minority population were more interested in receiving technical assistance than organizations that served minorities as a secondary focus. Tables illustrated interest in technical assistance and ability to pay categorized by population served, primary service focus, geographic service area and annual budget. Technical assistance needs were broken down into 23 needs and the results from the surveys were labeled as urgent, helpful or no need. The most frequently identified primary need was researching grant funding sources, followed by writing grant proposals and creating fund-raising plans. Focus group themes were identified in the areas of sustainability and delivery of mission. Diversifying the funding base, staffing, governance, succession planning, and competition among community organizations for board members were a few of the sustainability issues identified. Another point that is not often mentioned in the literature, but a reality in the nonprofit human services sector, is the desire to have consumer representation on boards, even they know that these individuals might not have the knowledge and training needed to help with organizational survival. Challenges in mission delivery included marketing their agencies and services to policy makers, especially those nonprofits based in rural areas; and difficulty in identifying evidence-based best practice models. The authors called for more focused needs assessments; reduced cost or free capacity-building opportunities; resources listing capacity-building consultants and web-based resources for ethnic organizations; and assistance with revenue-enhancing activities. They noted that even though this study looked specifically at minority nonprofit health organizations, the assessment tools could be utilized by other domains in the nonprofit services arena to prioritize capacity-building content and delivery mechanisms most needed by organizations in their sector.


Shannon K. Vaughan is an Assistant Professor in the Department of Government and Justice Studies at Appalachian State University. Her research focuses on not-for-profit organizations,
public policy, and ethics. Shelly Arsenault, PhD, is an Associate Professor in the Department of Political Science at California State University, Fullerton. Her research interests are in the areas of Social Policy including poverty and welfare, health, non-profit organizations, organizational theory/behavior, and federalism.

The authors began with an overview of why not-for-profits are often an alternative to direct government action to promote the public interest. The purpose of this study was to analyze the role of two nonprofit organizations, National Children’s Alliance (NCA) and National Alliance on Mental Illness (NAMI), in affecting policy change, excluding lobbying activities. These two grassroots organizations were chosen because each was formed to radically change public and professional perceptions of their respective issues and reform the way services are offered to those in need.

In their literature review, the authors discussed many of the terms commonly found in policy literature, such as image and framing, venue, problem, policy entrepreneur (change agents). They explained how the interaction of these elements leads to policy changes. They pointed to the dramatic increase in nonprofit service delivery and policy advocacy and put forth these two questions: How do these organizations bring about changes in policy images of public problems; and to what extent does the nonprofit provision of services designed to address a new definition of a policy problem affect public awareness and acceptance of the new policy image?

Historical overviews of NCA and NAMI were given, and important legislation regarding child abuse and mental health issues was discussed, as well as how media attention, celebrity disclosures, and high-profile court cases helped reshape the child abuse policy abuse image into a criminal justice issue. The founding of the first child advocacy center (CAC) in Huntsville, Alabama, and the social entrepreneurship of U. S. Representative Bud Cramer was highlighted. His advocacy efforts as a member of Congress reflected a change in public perception of the problem of child abuse away from merely a criminal justice issue to an emphasis on the well-being of the child. NAMI was formed by family members of the mentally ill, who sought to destigmatize those with “brain disorders” through education of federal legislation, current research and treatment options; mutual help/advocacy groups to improve the lives of the mentally ill and their families; and creation of a national organization of help/advocacy groups. Celebrity disclosures and the movie A Beautiful Mind also led to changes in public images of mental illness.

The authors used LexisNexis to perform content analysis of nationwide press coverage of NCA and NIMA. All major U. S. newspapers and at least one newspaper per state were included. These 234 newspapers were examined from 1980-2004. CACs were mentioned in approximately 4,000 articles. A time series plot of the annual ratio of CAC articles per newspapers searched in relation to nonprofit activity and subsequent policy change was presented. Twenty states,
between 1986 and 2003, adopted a total of 71 pieces of legislation that pertain directly and exclusively to CACs. The seven types of legislation that were adopted addressed multidisciplinary teams, confidentiality, minimum standards, state organization, funding, liability, and board compensation. An increase in NCA activity coincides with an increase in print media coverage, as well as a growing legislative record in favor of the CAC approach. The authors linked the growth in the number of CACs as instrumental in successfully promoting a new perception of child abuse and in changing public policy. Likewise, the authors linked the rapid growth of NAMI as an agent of change for parity legislation, research funding, and destigmatization of mental illness. In closing, the authors pointed to the impact that nonprofits can have on policy image change and change of venue, but called for further research on the impact of specific advocacy efforts by nonprofits.


Francie Ostrower, PhD, is Professor in the LBJ School of Public Affairs and the Department of Theatre and Dance, and Senior Fellow in the RGK Center for Philanthropy and Community Service. Prior to joining the University of Texas in 2008, she was Senior Research Associate at the Urban Institute Center on Nonprofits and Philanthropy. Prior to that, she was a sociology faculty member at Harvard University. Dr. Ostrower received her doctorate in Sociology from Yale University, where she also served as Associate Director of the Program on Nonprofit Organizations.

In 2005, the Urban Institute conducted the first-ever national survey of nonprofit governance and the results are reported in this article. This sample was drawn from a database of public charities that file IRS form 990, meaning that they had at least $25,000 in annual receipts. The sample was stratified by organizational size and the survey was sent to the Executive Director of the nonprofit. Responses could also be e-mailed, and the response rate was 41%. A pie-graph shows the response rate of the Executive Directors based on their annual expenditures, which ranged from below $100,000 (37.5%) to over $40,000,000 (1.99%).

This survey was conducted for a number of reasons and these are reflected in the questions posed: How does public policy affect nonprofit governance? What factors associated with promoting or impeding boards’ performance of basic stewardship responsibilities related to overseeing and supporting the organization’s mission? Are nonprofits becoming less ethnically homogenous? The author explained how Sarbanes-Oxley, even though it has not been extended
to nonprofits, has affected them and lists six practices which are becoming more common in the public sector: external audit; an independent audit committee; rotating audit firms and/or lead partners every five years; a written conflict of interest policy; a formal process for employees to report complaints with retaliation (whistleblower policy); and a document destruction and retention policy. This study found that organizations which have corporate members on their boards are more likely to engage in all of these practices except document retention. A table illustrated factors associated with variations in adoption of Sarbanes-Oxley type practices provided which looks at these six practices across the categories of board size; whether or not the CEO is a voting board member; diversity of board; organizational size; age; field; and funding sources.

The author discussed the conflicts that can arise when board members engage in financial transactions with the nonprofit they are serving on. She pointed out the need for policies that ensure that these transactions are in the nonprofit’s best interest. A graph illustrating the percentage of organizations obtaining goods or services below and at market rates from board members broken down by size or organization was provided. Smaller nonprofits were considerably more likely than larger ones to obtain goods and services from board members at below market cost. 58% of nonprofits with under $100,000 in expenses obtained goods or services at below market cost from a board member, but among nonprofits with over $40,000,000 in expenses this number drops to 24%. The survey found that a substantial number of nonprofits, including those engaged in financial transactions with board members, do not follow good governance guidelines.

Board compensation for nonprofits is frowned upon, and this survey found no indication that compensating trustees promotes higher levels of board engagement. In fact, compensation was negatively associated with levels of board activity in fundraising, community relations, and educating the public about the organization and its mission. Boards that compensated were less likely to have members with professional backgrounds or expertise in management, law, or accounting and were no more likely to achieve greater racial or ethnic diversity. Board performance was rated active, somewhat active, and not active across the following responsibilities: policy setting; financial oversight; planning; monitor programs; sounding board; CEO evaluation; community relations; public education; fund raising; board monitoring; and influence public policy. Then the survey delved even more deeply and considered these responsibilities across many factors such as board size, organizational size, diversity funding, etc. So many factors were considered that the table illustrating the results takes one and a half pages. A minority of boards was very active when it came to most of the activities that were surveyed, but the author pointed out significant findings, one in particular being that having the CEO/executive director serve as a voting board member was negatively related to board activity at every level. Also, different types of board members bring different strengths to the table, and this should be considered so that boards are able to address their many areas of responsibilities,
from fund-raising, community relations, financial oversight, etc. This survey also considered the variables of gender, ethnicity, age, and whether or not board members are related.

In closing, the author emphasized that the findings from this study reveal that it is difficult to generalize about studies from one type of nonprofit to another; these differences must be considered when policy initiatives and good governance guidelines for nonprofits are proposed. However, these findings do offer implications for policy and practice and address commonly held views about nonprofit board governance. The findings also indicated that that the public policy environment on nonprofit governance goes beyond formal legislation and regulations aimed at nonprofits, as is the case with Sarbanes-Oxley. This is an important consideration as board members often serve on both corporate and nonprofit boards, and bring experience, practice and norms from the corporate to the nonprofit world. This is not always advantageous for a nonprofit, particularly with regards to having the CEO/Executive Director serve as a voting board member. The author also pointed to the importance of engagement of board members not only in fundraising, but in obtaining public legitimacy and support for the nonprofit where they serve. She called for research in several areas, particularly addressing the barriers to obtaining board members and emphasizes where nonprofit boards are lacking, especially in board composition, with regards to ethnicity, race and age of members, and called for research in several areas, particularly addressing the barriers to obtaining board members.


Both authors are affiliated with The Center for Social Work Practice and Policy Research at Wayne State University in Detroit, Michigan. Joanne Sobeck, PhD, is the Director of the Center and she holds a Doctorate in Political Science with undergraduate and master’s degrees are in Social Work. Her research include capacity building with community-based organizations, applications of evidence based programs in community settings, and processes related to policy, program development, implementation and evaluation. She is also active in the Native American community and serves on the board for American Indian Health and Family Services of Southeastern Michigan. Elizabeth Agius, BS, is Manager of Community Research Partnerships at the Center and has been the principal investigator on many of the research projects there. She is also a Board Member at the Michigan Association for Evaluation. Her undergraduate degree was in Political Science and her graduate studies were in Public Policy, American Government and International Relations.

The authors conducted this study to address the gap between evaluation research, and the practice of capacity building with nonprofits. The authors approached the study from the premise
that although organizational capacity building is promoted as a way to enhance the effectiveness and sustainability of nonprofits, the evaluation of these efforts has lagged behind. Their review of the literature revealed that previous studies had identified potential outcomes ranging from improving management competencies and diversifying funding to serving more clients and improving sustainability. The current research was conducted by a five year longitudinal study of a program designed to strengthen the management of small, grassroots organizations and focusing upon leadership development, organizational systems development and strategy formulation and management. The data was collected over five years including budget, program size, and number of staff and board members of the 23 participating agencies with 501(c)3 status. Pre and posttest face-to-face interviews of executive directors were conducted covering the topics of program services, evaluation, finances/fund development, collaboration, and future goals. Results of the longitudinal study included (1) the agencies experienced increased visibility of their organizations, (2) by improved documentation of processes such as financial and program plans, and (3) increased collaboration. The study found also that there was continuing need to obtain input from all stakeholders beginning with design of a logic model for interpreting and understanding program results. The researchers concluded that organizational capacity building was very important for nonprofits and especially grassroots organizations by providing structure for creating opportunities for bonding within their communities. The authors pointed out that the model of capacity building used in this study needs to be tested with other nonprofits, both larger and with different substantive focus.


Dana Brakman Reiser, JD, is a Professor of Law at Brooklyn Law School, and a graduate of Harvard Law School. She is an expert in the law of non-profit organizations, and her recent scholarship focuses on the legal and social ramifications of the increasing trend toward hybridization of nonprofit and for-profit endeavors. She also has written extensively on non-profit governance and the role of non-fiduciary constituencies in non-profit organizations. She is a member of the Executive Committee of the AALS Nonprofit and Philanthropy Law Section, the Association for Research on Nonprofit Associations and Voluntary Action (ARNOVA), and the Government Relations Committee of the Nonprofit Coordinating Committee of New York.

Professor Reiser conducted a review of the literature covering important components of nonprofit directorship. The author’s standpoint was that nonprofits should be led by independent directors. This research reviewed the literature examining the important questions regarding the adaptation of independent director reforms. The study concluded that nonprofits should be audited by independent auditors such as that required by the California Nonprofit Integrity Act.
The study found that to preserve integrity audits should not be staff members and must not have “a material financial interest in any entity doing business with the organization”. It was determined further that the independent auditor is required in order to be able to perform the audit with an oversight role free of personal conflict.


Russell G. Schuh, EdD, holds a Doctorate in Planning and Program Evaluation and is a visiting research professor in the School of Medicine at the University of Pittsburgh. Dr. Schuh has in-depth experience in both program management and evaluation research at the national, state and local levels. He has worked on a number of University collaborations with community-based nonprofit service organizations and the Allegheny County Health Department and reviews proposals for the National Science Foundation. Laura C. Leviton, PhD, received her Doctorate in Social Psychology and is a distinguished applied social researcher, evaluator, and academician. She is a Special Adviser for Evaluation at the Robert Wood Johnson Foundation and is a past president of the American Evaluation Association. Dr. Leviton was previously a professor of public health at the University of Alabama at Birmingham and on the faculty of the University of Pittsburgh School of Public Health. During this time, she collaborated on the earliest randomized experiment on effective ways to prevent human immunodeficiency virus (HIV) infection in gay and bisexual men. For her work in HIV prevention and worksite health promotion, she received the 1993 award for Distinguished Contributions to Psychology in the Public Interest from the American Psychological Association.

The authors presented a framework for considering how non-profit agencies’ development and capacity affect program implementation. The operational definition of organizational capacity used was: “the ability to successfully implement and complete a new project or to expand an existing one successfully.” The review of the literature suggested two levels of organizational capacity which tend to improve the levels of success: individual expertise and organizational resources and procedures that allow agencies to use individual expertise productively. The authors determined that expertise goes beyond experience and training to a level of ability to solve problems in different ways. Studies also found that governing boards strongly affect other aspects of interest to program planning and evaluation, boards of new and less developed agencies tend to be small and to operate informally, and as agencies mature, boards tend to grow in size and become more formal in their structures and work. The researchers identified financial resources as a feature allowing an organization’s sustainability and mission development. Components of financial resources include financial maturity, the routinely and formally conducted activities to obtain funds, and financial vulnerability, the ability to stay in operation despite a variety of financial stresses or agency transition. The researchers also observed that core services tend to develop first, followed by some aspects of financial
management. An unexpected finding was that development of administrative infrastructure often lags behind while board development and functioning generally lags even more.


Each of the authors of this article is affiliated with the Public Intersection Project, which helps businesses, nonprofit organizations improve communication, relationships, and collaboration; and develops materials for use in addressing local problems. It is based in the School of Government at the University of North Carolina at Chapel Hill. Lydian Altman-Sauer, MPA, is the Director, Strategic Public Leadership Initiative, at UNC. She has spent over twenty years working with public sector organizations. She was Director of the Scotland County Domestic Violence and Rape Crisis Center, and has been an active community volunteer with organizations such as Smart Start and United Way. She facilitates retreats, conducts strategic planning efforts and performs organizational development work for public sector organizations. Margaret Henderson, MPA, has twenty years of experience in human services including work in state and local governments as well as nonprofits. From 1992-1999, she served as Executive Director of the Orange County Rape Crisis Center in Chapel Hill, NC. Gordon Whitaker, PhD., is a Professor of Public Administration and Government at UNC, Chapel Hill, where he teaches organization theory and in public management and leadership. Whitaker has served on the Executive Council of the National Association of Schools of Public Affairs and Administration (NASPAA) and as chair of NASPAA's Commission on Peer Review and Accreditation. In 2005 he received the Ned Brooks Award for Public Service, presented by the Carolina Center for Public Service.

While this article was directed toward those who work in local governments, it is very relevant for those who work for nonprofits, since they need to be aware of the considerations that governments make when deciding which nonprofits they will fund, and then in turn they can be prepared to sell their mission and value to the community to governmental funding sources. The authors pointed out many reasons why local governments should support nonprofits and gave a summary of the special challenges faced by nonprofits. They developed a model which addresses the multidimensional and interconnected nature of nonprofit capacity which includes these seven elements: Aspirations; Strategies; Organizational Skills; Human Resources; Systems and Infrastructure; Organizational Structure; and Culture. A chart was included which succinctly described how local governments can support the capacity-building efforts of non-profit organizations which across these seven elements, as well as the important aspects of Funding and Value. Nonprofits must also realize that sustainability is not only based on financial considerations, and local governments can help with feedback, training, in-kind support, systems and infrastructure support.

J. Michael Martinez, MPA, JD, PhD, is Professor of Political Science at Kennesaw State University and works as a government affairs representative and corporate counsel with Dart Container Corporation. Since 1998, he has taught political science as a part-time instructor at Kennesaw State University; political science, administrative ethics, environmental law, and constitutional law at several Atlanta-area universities; and is also a part-time instructor at the Department of Public Administration and Policy School of Public and International Affairs, The University of Georgia. He is co-author of the book, *Administrative Ethics in the Twenty-first Century.*

The author examined three major components of liability: whether the organization is liable to third parties for acts performed by volunteers, whether the organization is liable to volunteers injured while on duty, and whether a volunteer is liable for acts performed while working in a volunteer organization. Then Dr. Martinez examined effective risk management practices which may reduce liability. He began with an overview of the history of law covering liability for nonprofits leading to the charitable immunity doctrine. Numerous studies have revealed that piecemeal exceptions to the doctrine created a confusing area of the law where courts tried to balance the needs of the charity to exist unencumbered by potentially crippling lawsuits against the needs of plaintiffs to recover for damages. Obvious inequities led to gradual enacting of measures to reduce or eliminate charitable immunity. Dr. Martinez approached the study with the view that organizations that rely on a volunteer labor force have a stronger incentive to minimize liability through effective risk management practices and procedures perhaps than do for-profit entities.

The review of the literature revealed that increasing uncertainty of outcomes in the tort system has caused greater concern about risk for nonprofits and insurer. The author found that the data on organizations being sued in increasing numbers is mixed, however he found that nonprofits do not seem to be sued in any greater numbers than for profit organizations and neither is the frequency of new filings increasing. The problem then is two-fold: nonprofits are undercapitalized and therefore even a minor lawsuit may have a very detrimental effect on a nonprofit’s financial circumstances. Second, donations can be affected because donors do not want their funds used to pay lawsuits or legal fees. Because courts do not differentiate between nonprofit and for-profit organizations with regard to liability, the literature reveals that eliminating workplace risk is the most effective manner of ensuring volunteer safety. Findings suggested that organizations should consider requiring that volunteers waive their right to sue for personal injury and property damage although this may influence some not to volunteer. The liability of volunteers varies by state. A review of the state statutes showed that many address the issue by granting immunity to volunteers as long as the volunteers act in good faith. Still other
states have exceptions to the standard of care immunity. Dr. Martinez concluded with a discussion of risk management practices and procedures.


At the time this article was published, all three authors were at the Urban Institute’s Center on Nonprofits and Philanthropy (CNP). The CNP conducts and disseminates research on the role and impact of nonprofit organizations and philanthropy. Carol J. De Vita, PhD, is a Senior Research Associate at CNP and holds a Doctorate in Social Welfare Policy. Cory Fleming, MS, was the center administrator at CNP and is now Senior Project Manager at International City/County Management Association. Eric C. Twombly, PhD, holds a Doctorate in Public Policy and is Director of Organizational Studies at KDHRC, a research institution that constructs and evaluates public programs. Dr. Twombly is a leading expert on the organizational behavior of community-based nonprofit providers and has been the chief evaluator on several public health projects funded by the National Institutes of Health. He is also an assistant professor in the Andrew Young School of Policy Studies at Georgia State University.

The authors completed a study of the literature leading to development of a conceptual model for thinking about effective ways for capacity building in nonprofits. The study began with the premises that to identify community needs and set priorities the need is to determine community preferences and balance competing interests. Additionally, while nonprofit organizations are often the common vehicle for mobilizing and empowering local residents and for representing their collective interests through the advocacy process, they must have continual renewal to maintain their value and effectiveness. The researchers found through analysis of the literature, that internal capacity building can be enhanced using strategic management theory suggesting that nonprofits can revamp their operational activities. They also found that strategies such as increased staff training, greater use of volunteers and more public outreach programs can reduce the costs of delivering services or build a stronger community constituency. The literature also revealed that external capacity-building strategies attempting to alter the relationship between individual nonprofits and the funding and political systems in which they operate can be accomplished by adopting new resource strategies to address uncertainty and to heighten the possibility of organizational survival, stabilize relations with other groups in the community, and reduce over dependence on specific sources of funding. The research also found that nonprofit organizations generate income in different and more numerous ways than for-profit organizations and therefore demand more complex tracking and reporting systems. Nonprofits must show greater transparency and accountability in their financial operations, prompting the need to improve accounting and reporting systems. Based upon the need for effective
interventions targeted where flows of energy are most concentrated and have the most influence
the authors identified five steps which enable foundations to strategically determine these
strategies: (1) determine the basic needs and assets of the community, (2) measure the
community-based resources that are potentially available to address local concerns, (3) identify
the infrastructure that can be used to build nonprofit capacity, (4) select appropriate capacity-
building strategies, and (5) monitor and assess progress on a periodic basis.

Moore, M. H. (2000). Managing for value: Organizational strategy in for-profit, nonprofit, and
governmental organizations. *Nonprofit and Voluntary Sector Quarterly, 29*(1), 183-204.

Mark H. Moore, PhD, is the Hauser Professor of Nonprofit Organizations and Faculty Chair of
the Hauser Center for Nonprofit Organizations. He was the Founding Chairman of the Kennedy
School's Committee on Executive Programs, and served in that role for over a decade. Moore's
work focuses on the ways in which leaders of public organizations can engage communities in
supporting and legitimatizing their work and in the role that value commitments play in enabling
leadership in public sector enterprises.

In this article the author described the differences between strategic models in for-profit,
nonprofit and governmental organizations. The normative goals, principal sources of revenue,
measures of performance and key calculations vary greatly in the for-profit and public sectors.
This is because both nonprofit and governmental organizations define the value they produce in
terms of the mission of the organization rather in their financial performance, and they secure
their revenues from people who are paying for external benefits to people other than themselves
rather than customers who buy things for their own benefit. He suggested that nonprofit
managers must focus on three key issues when developing a sustainable strategic plan and puts
forth a “strategic triangle”: (1) public value to be created, (2) sources of legitimacy and support,
and (3) operational capacity to deliver the value. An organization whose strategic plan does not
cover all these bases is doomed to fail. The organization must have a clearly defined mission,
and its value is tied to how successfully it achieves this purpose. It must understand the
importance of developing a plan to garner support from the authorizing environment of donors,
citizens, the media, interest groups and government sources. This “authorizing environment”
differs importantly from the clients they serve. Nonprofits create value for society in ways other
than achieving their mission and serving their clients. They are valuable channels for donors’
charitable aspirations and help to create social capital. Finally, the management of the
organization must possess the knowledge, support and capabilities to form a strategic plan which
describes the activities that must be pursued for the organization to successfully meet the needs
of its clients and the volunteers who give money, time and materials towards the support and
legitimacy of the organization and its organizational capacities.

Each of these authors is affiliated with the National Institute of Mental Health’s funded Child Mental Health Research Center (CMHRC) at the University of Tennessee. The Center's goal is to implement high-quality research on social and mental health services for children with an emphasis on research designed to improve child welfare, juvenile justice, and mental health services to children and families at risk. Charles A. Glisson, PhD, is the founder and Director of the Center and is a University Distinguished Research Professor. He has been principal investigator on multiple major research projects concerned with children's services and is a noted author and editor in the social work, mental health, and organizational research literature. Dr. Anthony Hemmelgarn, PhD, received his Doctorate in Industrial and Organizational Psychology and is a Research Professor at the CMHRSRC. He has worked for more than 15 years in both state and private agencies conducting research, training, assessment technologies and organizational-development efforts designed to create high-performing organizations. He has been a significant contributor to the development of the Research Center’s empirically-based organizational intervention, labeled ARC, and has served as an ARC change consultant in preliminary studies. He has worked with numerous organizations around the country to assess organizational social contexts, provided training in a variety of human service agencies, and facilitates ongoing organizational change efforts for CMHRSRC’s organizational intervention projects.

The authors conducted a study examining the effects of organizational characteristics, including organizational climate and interorganizational coordination, on the quality and outcomes of children’s service systems. The study assessed the effects of organizational variables on service quality and outcomes in a sample of 32 public children’s services offices located in the 12 pilot counties and 12 matched control counties. The authors generalized the results to more general human service organizations concerned with organizational effectiveness. The author’s premise was that this study would provide support for the work that questions the benefits of services coordination and suggests alternative organizational strategies for improving services to populations at risk. The research found that although service coordination had the largest effect on service quality, increased service coordination was related to reduced service quality, quality had no effect on service outcomes, and positive organizational climates were associated with both higher service quality and better service outcomes. The authors posited that the study’s most important finding was that improvements in psychosocial functioning are significantly greater for children served by offices with more positive climates. The authors believed that these results could be generalized to other types of social service organizations. A third finding was that organizational climate was found to positively affect both service quality and outcomes. Children who were served by agencies with more positive climates were more likely to receive more comprehensive services, there was more continuity in the services they received, and their
Caseworkers were more responsive and available. The researchers agreed with previous studies (Mayer & Schoorman, 1992; Ostroff & Schmitt, 1993) that while extensive research on improving climate has been conducted in business and industrial organizations, the successful techniques have not been transported into public agencies that serve children.
Child Focused Setting


Lisa M. Jones, PhD, is a research associate professor of psychology at the Crimes against Children Research Center at the University of New Hampshire. She has been conducting research on issues of child victimization intervention and prevention for more than 10 years, including research on CACs, child maltreatment trends, children’s experiences with sexual abuse investigations, and Internet crimes against children. Kathryn E. Atoro, MBA, is Project Coordinator of the Internet Crimes against Children (ICAC) Task Force in the Criminal Justice Division at Fox Valley Technical College. Wendy A. Walsh, PhD, is a research associate professor of sociology at the Crimes against Children Research Center at the University of New Hampshire. She conducts applied research on the system response to child maltreatment, including Children’s Advocacy Centers, access to services for victims, and criminal justice outcomes. Theodore P. Cross, PhD, is a research full professor at the Children and Family Research Center in the School of Social Work at the University of Illinois at Urbana-Champaign. He directed the Multisite Evaluation of Children’s Advocacy Centers and has published numerous studies for more than 21 years on the investigation and response to child abuse. Amy L. Shadoin, PhD, was formerly research officer of the National Children's Advocacy Center. She now works as an evaluator with community-based organizations that address a broad spectrum of family violence issues. Suzanne Magnuson, MS, served as research associate at the National Children’s Advocacy Center (NCAC), Huntsville, AL. She helped to direct the NCAC’s participation in the Multi-Site Children’s Advocacy Center Evaluation Project and collaborated on research on forensic evaluation procedures and the economic impact of child maltreatment. This research contributes an update to the literature on youth and caregiver experiences with sexual abuse investigations. Previous research was completed more than ten years prior to this study. Changes and expansion of CACs have occurred, making it necessary to update data on this issue. Previous research (Jones, 2007) comparing client satisfaction in CAC and non-CAC communities found an overall satisfaction rate higher in CAC communities. Data for this study was collected as part of the multisite evaluation of CACs (Cross et al., 2008). A subset of cases was chosen from the sample of 1,452 cases. From this subset, 358 interviews of caregivers and youths were conducted. Analysis was conducted on 220 cases of child sexual abuse. Ninety-two percent of caregiver respondents were female, while 79% of victims were female. Only children eight years and older were interviewed. Quantitative data were collected from caregivers using a 14-item Investigation Satisfaction Scale (ISS) developed for this study. Six questions were developed to assess youth satisfaction. Qualitative measures of investigative experiences were asked during interviews. Caregivers were asked two open-ended questions concerning what aspects of the investigation were better or were worse than expected. Two similar questions reworded for youths were asked of the victims. Caregiver responses to satisfaction on the ISS
were high overall. In contrast, responses to open-ended questions identified experiences that were consistently viewed as disappointing. The most common (55%) response by caregivers concerning what was worse than expected involved disappointment with the thoroughness of evidence collection, perceived failures by investigators to pursue justice fully, and problematic investigation procedures. The second most common response (32%) concerned disappointment in the level of communication about case status. The most common responses concerning what was better than expected were in regard to the emotional support provided by investigators (34%) and investigators’ skills in interviewing (27%). Very few caregivers commented on the physical environment provided for their child’s interview. Youths also reported a high rate of satisfaction on the closed ended questions. Most reported liking the place where they were interviewed (a little, 54%; a lot, 35%). For the open-ended questions, 20% had suggestions for improving the handling of their case. Twenty percent praised investigator helpfulness with the case and outcome while another 20% commented positively on investigators’ emotional supportiveness. Few of the youths commented on the physical environment, but those who did comment said they liked the toys provided at the interview site. There were no identified differences in responses by subgroups (race, case type). Similar to Jones (2007), there was some indication that law enforcement involvement and outcomes increased the sense that investigators were committed to their case. The researchers identified some implications of these results. First, similar to previous research this study showed that quantitative satisfaction scales most often result in high ratings while open-ended questions are more likely to identify areas of dissatisfaction. Further, the authors suggest that researchers work to identify procedures that improve likelihood that offenders will be identified and prosecuted. Communication about how cases were proceeding was identified as needing improvement. Therefore, the authors suggest that regular timed verbal or written updates by investigators could be instituted. Further suggestions for work with youths are identified based upon results of this study. Limitations to the study include the inability to collect data on caregiver expectations prior to the investigations. A second limitation was that the majority of data collection was based on interviews conducted in CACs. There was no comparison data for non-CAC cases. There was no apparent personal gain by authors from study results.


Bodil Rasmusson, PhD, is Professor in the School of Social Work at Lund University in Sweden. Her area of research focuses on children’s rights within the field of child welfare and foster care with special emphasis on children's rights to participation.
This article contributes a qualitative examination of experiences of child victims and caregivers at Children’s Advocacy Centers (Barnahus) in Sweden. There is a dearth of research using children as informants about their own experiences. This article presents the results of an evaluation of barnahus in Sweden with the purpose of reaching a better understanding of the meaning of “child-centered” approach. A review of the development of CACs in Sweden is provided along with a review of the literature on evaluation of the model and on the child centered approach. The evaluation project conducted in Sweden consisted of five components, including the experiences of children and parents component presented in this article. From lists of clients provided by six CACs, the researchers sent invitation letters to parents to participate in interviews. From these contacts 22 parents and 12 victims ages 8-16 were interviewed. Ten of the parents were alleged offenders, while 12 were non-offenders. Some of the children had visited the barnahus several times while others had been there only for a forensic interview and possibly a medical examination. The interviews were conducted in conversation style around five central themes: the location and premises of the CAC, reception, previous contacts with the professionals, information, and experience of the process and possibilities to receive assistance and support. Perceptions of the physical environment from a couple of the older children were that it was too childish. However, the overall design was generally appreciated and it came out in the interviews that the children had noticed and appreciated the colors, toys and furnishings. Two of the older girls commented that the CAC was much better and safer than the police station in which they had been previously interviewed. The treatment by staff and law enforcement was described positively by all children interviewed. The barnahus staff was described as “very kind” and “nice”. Perceptions of the parents were very similar to that of the children with regard to physical environment and reception. The parents who had previous experiences in police stations viewed the barnahus experience as “much better”. Many of the parents expressed dissatisfaction with information they had received. The article provides examples of comments made by children and parents reflecting conclusions drawn. The author states that every child’s experience is unique and there is no typical “barnahus child” or family. However, Rasmusson asserts that the societal child perspective is reflected in the stories about how they were treated and what they experienced in the CAC. She suggests that the results offer an understanding of clients’ perspectives as well as a basis for further research using children and parents as informants that can provide more generalizable results.


Theodore P. Cross, PhD, was the director of the Multi-Site Evaluation of Children’s Advocacy Centers in the Crimes Against Children Research Center (CRCC) at the University of New
Hampshire. He is now a Visiting Research Specialist in Quantitative Analysis at The Children and Family Research Center, University of Illinois, Urbana-Champaign. Lisa Jones, PhD, is Research Assistant Professor of Psychology at the CRCC and helped direct the five-year, quasi-experimental Multi-site CAC Evaluation Project, funded by OJJDP. She is recognized in the child abuse field for her experience conducting research on sexual crimes against children with a focus on analyzing and evaluating national, state, and community-level responses to victims. Currently, Dr. Jones is the recipient of a grant from the National Institute of Justice to conduct a process evaluation of four of the most prominent Internet safety prevention programs. Wendy A. Walsh, PhD, is a Research Assistant Professor of Sociology at the CCRC and a research associate at the Carsey Institute at the University of New Hampshire. Her research includes studies on enhancing the community and criminal justice response to child abuse assessed; caregiver and child satisfaction after an investigation of child abuse; resilience among maltreated children with the National Survey of Child and Adolescent Well-Being (NSCAW) data, and a longitudinal probability study on outcomes for children involved in child protective investigations. Monique Simone, MSW, is a Research Associate at the CRCC. David J. Kolko, PhD, is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His work primarily deals with the study and treatment of disruptive behavior disorders and children’s antisocial behavior, including sexually abusive (offending) behavior in youth, child maltreatment, and adolescent depression/suicide. His current research is devoted to dissemination and implementation efforts designed to adapt and then transport effective interventions for these clinical problems to various community settings or systems serving children, youth, and families, including pediatric primary care, juvenile justice, child welfare, public health/safety, and mental health.

This study was one part of the Multi-Site Evaluation of Children’s Advocacy Centers, done at the CRCC. Four established Children’s Advocacy Centers from across the country were compared with non-CAC same state comparison communities to evaluate whether they have increased coordination on investigations and forensic interviewing; more child-friendly settings; and reduced number of forensic interviews. This particular study evaluated the information gained obtained from descriptive, site-level data and case file data. The methodology utilized and limitations are thoroughly addressed, six tables which represent the data are easy to understand based on the verbal descriptions and explanations of statistical analysis utilized. This study found that the non-CAC communities were much more likely to hold interviews in less child-friendly settings, such as police stations, CPS agencies, victims’ homes, juvenile detentions center, group homes and shelters. The authors noted why many of the afore-mentioned locations are not neutral, present many distractions, and instill fear in the victim and/or non-offending caregivers. They described many of the child-friendly aspects of CACs: waiting rooms decorated to be appealing to children with appropriate toys; private interview rooms; absence of the alleged offender; and monitoring and support of the children by staff or volunteers. They also found that interviews were more likely to be electronically recorded in a CAC location. They concluded
that CACs offer a more thorough and child-oriented response to sexual abuse reports, and families appeared to have a more positive experience on average when compared to non-CAC comparison sites.


Mary Chesney, PhD, RN, CNP, is a Clinical Assistant Professor at the School of Nursing at the University of Minnesota. Linda Lindeke, PhD, RN, CNP, is an Associate Professor and Director of Graduate Studies at the School of Nursing at the University of Minnesota. Lauren Johnson, MS, RN, APN-BC, is Nursing Practice Project Lead, Fairview University Medical Center, Minneapolis, Minnesota; Angela Jukkala, PhD, RN, is an Assistant Professor of Nursing at University of Alabama in Birmingham; and Sandra Lynch, MS, RN, is a Pediatric Cardiac Clinical Nurse Specialist at University of Minnesota Children’s Hospital.

This study was conducted at two ambulatory pediatric subspecialty clinics in the Midwest. Satisfaction surveys were given to parents, children and teens. The authors noted that children and teens are rarely asked their opinion about satisfaction with care; most studies have only focused on parental perceptions. The survey items were shown in a table which illustrates the child/teen ratings compared to parent ratings. There were statistically significant differences between child/teen scores and parental scores for eight out of twelve questions. Another table displayed the three additional open-ended questions with the main themes voiced by each group, these questions allowed the participants to voice their opinions on the best and worst part of the clinic experience and also to provide suggestions for improvement. Children and teens thought the best part of the clinic experience was a caring staff, helpful communication and clinic play experiences. The worst aspect was painful procedures, long waits, distance from home, and boredom. The participants’ discussions to the open-ended questions support the rationale behind the Child-Focused Setting Standard for NCA, provision of a comfortable and private setting which is also physically and psychologically safe for victims and their non-offending family members.

When this article was written each of the authors of this article was affiliated with Temple University. Bernie Sue Newman, PhD, is Chair of the Social Work Department and an Associate Professor; Paul Dannenfelser is a Field Education Specialist; and Derek Pendleton was a student pursuing his Master’s degree.

The authors surveyed 290 Child Protective Services (CPS) and Law Enforcement (LE) investigators who use a Children’s Advocacy Center (CAC) in their investigations of criminal cases of child abuse to determine the reasons chosen for using a CAC. Included was historical information about the development of CACs, followed by an explanation of the research design. The study described the five major reasons front-line LE and CPS investigators use CACs when investigating cases of child abuse: (1) child-friendly environment; (2) referrals, support, assistance with counseling, medical exam; (3) expertise of interviewers at the CAC; (4) formal protocol when a sexual abuse case is investigated; and (5) access to video and audio equipment and two-way mirror. The authors emphasized that while the idea of a child-friendly environment seems deceptively simple, it is critically important, not only in increasing the comfort level for the victim, but also in promoting self-disclosure and improving the accuracy of the information provided, thereby facilitating the pathway to prosecution.


Shelly L. Jackson, PhD, is an Assistant Professor in the Department of Psychiatry and Neurobehavioral Sciences and Director of Grants and Program Development at the Institute of Law, Psychiatry and Public Policy at the University of Virginia. She holds a doctorate in developmental psychology and completed a National Institute of Mental Health Postdoctoral Fellowship in Law and Psychology. She developed *A Resource for Evaluating Child Advocacy Centers* while a Fellow at the National Institute of Justice. Her work over the past 13 years has focused on family violence.

The author’s purpose was to access how different Children’s Advocacy Centers implemented eight of the NCA standards, including Child Friendly Facility and Child Investigative Interview. Participants in the study included 117 CAC, directors, 71 of whom complied with NCA standards. The participants came from most of the 50 states, and were affiliated with CAC’s of various sizes and which served diverse ethnic groups. A semi-structured telephone interview of the participants was conducted. However, while all of the CAC member directors and 89% of
the non-CAC directors felt their facility was child-friendly, over half (52%) of the directors from each group felt their waiting rooms and/or play areas were geared towards younger children. The remaining directors felt their waiting rooms and/or play areas were appropriate for all ages of children and adolescents. 83% of CAC members and 87% of nonmember centers had one interviewer who interviewed the victims at their center, while other members of the multidisciplinary team actively observed the interview and had the opportunity to communicate with the interviewer. The author noted that the two primary limitations of this study were that specific criteria for accessing adherence to the NCA standards were not utilized and no visits were made to the participating centers. The responses obtained to the survey were purely based on the perspectives of the directors interviewed. Variability of the centers to conform to the needs of the community was noted, and the call for more extensive evaluation of the CAC model was made.


Judy Cashmore holds a PhD in Developmental Psychology and is an Associate Professor at the University of Sydney Law School in Australia. She has considerable research experience in relation to children's involvement in legal proceedings and other processes in which decisions are made about children's care, protection, and guardianship, with a particular focus on children's perceptions of the process and the implications for social policy.

The author began the chapter with a brief overview of the changes in investigative and court procedures that have occurred to better accommodate the needs of child witnesses while still protecting the rights of the accused over the last two decades. These fall under three categories: modifications to the court environment to alleviate the main stressors for children in court, empowering children by preparing them for the court experience, and increasing the skills of the professionals involved in the investigative and court process. The focus of the chapter was on the use of video-technology which allows children’s evidence to be recorded beforehand or to be transmitted real-time from another place (CCT or live-link). Children often report that their greatest concern in testifying is facing the accused. The author reviewed research studies which examined whether video technology reduces the stress on the child and improves and preserves the quality and completeness of the child’s evidence. Experimental and court simulation studies as well as court observation and evaluation studies were described. The effects of video-technology on jurors’ perceptions, reliability of the evidence, and the legal process were discussed. The author proposed that one of the main benefits of video-technology with regards to the children involved is that it allows for therapeutic intervention to begin sooner, without
concern for contamination of evidence. She noted that video-technology is not the panacea some had hoped for and calls on additional education for lawyers and judges so that may be sensitive to the linguistic and power differences regarding child witnesses.


When this article was written, each of the authors was affiliated with Christchurch School of Medicine, New Zealand. Eileen Merriman was a medical student and Rosemary Ikram was a clinical lecturer. Paul Corwin was also senior lecturer, Department of Public Health and General Practice.

No research existed in the literature which examined the cleanliness of toys in Children’s Advocacy Centers. However, this study compared the bacteriology of toys and the potential for cross-infection in General Practitioners’ waiting rooms, a day-care centre, and a public library. Hard toys were found to be less contaminated, easier to clean, and did not recontaminate as rapidly as soft toys. Hard toys could be effectively decontaminated by cleaning and them soaking them in a hypochlorite (2.5 g/l) solution for one hour. Bacterial counts remained high even after machine washing and drying of soft toys. Since the threat for potential pathogens found on soft toys is difficult to eliminate, the authors recommend that soft toys are unsuitable for doctors’ waiting rooms.


Eidell Wasserman, PhD, is a clinical psychologist who works in the areas of child abuse and domestic violence with victim assistance programs in Indian Country and has received awards from the Department of Justice for her service to victims of crime in Indian Country. In 1988, she developed an on-reservation treatment program for sexual abuse victims on the Hopi reservation in Arizona.

The author points out the difficulty of maintaining confidentiality in small reservation communities when “everyone know everyone else” and when numerous agencies are part of the case. She listed the ten interests of children and families in privacy and the seven essential
elements of staff training on confidentiality from the Soler, Shotton, and Bell book *Glass Walls*, which was published in 1993. The author also pointed out the importance of written policies as to what type of information can be shared between agencies and when it can be shared and gives examples of situations where confidentiality comes into play. She also stressed the need for knowledge of CAC’s with regards to federal, state, and local laws which deal with confidentiality. Although this article was written about confidentiality issues in Indian Country, it was very relevant for all CAC’s, particularly those in small towns or rural areas, since confidentiality and respect for client privacy is of paramount concern in a CAC.
MEDICAL RESPONSE DE 2015
Medical Response to Child Abuse

Karen Farst, MD, MPH
University of Arkansas for Medical Sciences
Arkansas Children’s Hospital

Outline

• Introduction
• Medical Response
  – Definition, importance, case examples
• National standards
• State Responses
• Opportunities and Challenges
<table>
<thead>
<tr>
<th></th>
<th># CAP's (Helfer)</th>
<th># Child Abuse Programs (AAP)</th>
<th># Counties</th>
<th>Child population</th>
<th>% pop in poverty</th>
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</tr>
<tr>
<td>Delaware</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>205,000</td>
<td>16 %</td>
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http://datacenter.kidscount.org/

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**Child Maltreatment: 2013**
National Child Abuse and Neglect Data System: “NCANDS”

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<tr>
<th></th>
<th># Children receiving investigation or alternate response</th>
<th># Victims (“true” cases)</th>
<th>Victim Rate per 1,000 children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>61,000</td>
<td>10,370</td>
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</tr>
<tr>
<td>Delaware</td>
<td>13,300</td>
<td>1,915</td>
<td>9.4</td>
</tr>
</tbody>
</table>

http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf#page=31
Children’s Advocacy Centers Service Area
14 Centers
10 have daytime medical coverage on site
8 have ability to do on-site medical 24/7
Providers are RN-SANE with local medical director

Child Abuse/Child Maltreatment

- Sexual Abuse
  - Contact, Exposure, Pornography, Trafficking
- Physical Abuse
  - Skin injuries: Burns, Bruises, Cuts, Welts
  - Fractures
  - Abusive Head Trauma: Shaking, Contact, Other
- Neglect
  - Medical, Supervision, Drug Exposure...
- Emotional/Psychological Abuse
- Munchausen by Proxy
  - Pediatric Condition Falsification
  - Medical Child Abuse
Definitions

- Child welfare (CW) = DSCYF, DHS, CPS, DSS.....
- PA = Prosecuting Attorney
- AG = Attorney General
- CAC = Children’s Advocacy Center
- Medical providers
  - Physician = MD or DO
  - APN = Advanced Practice Nurse or Nurse Practitioner
  - RN = Registered Nurse (not advanced practice)
  - SANE = Sexual Assault Nurse Examiner (could be RN or APN)
    - SANE-P = pediatric (up to age 18)
    - SANE-A = adolescent or adult

Medical Response

- History
  - Present, Past, Family, Social, Body Systems
- Physical Examination
- Lab Tests
- Radiology
  - X-rays, CT scans, MRI
- History
- Findings
  - Match = No Report
  - No Match = Report
Multi-disciplinary Response

- Medical History and Findings
- Prior Criminal and Child Welfare History
- Forensic Interview
- Investigative Interview
- Scene Investigation


What sells better?

National Standards

- Mandated Reporting in all 50 states
- 50 different ways to respond
  - AR, TX, LA
- Standards most defined for sexual abuse
  - National Children’s Alliance, Dept of Justice
- Medical guidelines
- Guidelines for non-medical personnel
  - US Dept of Justice
National standards and guidelines

National Children’s Alliance

• Over 750 member centers in the U.S.
• Over 315,000 children served in 2014
• Tracking Outcome Measures
Medical Response in CAC’s

2013 Key Survey Findings

National Multi-Site Survey of Children’s Advocacy Centers

Figure 6. Location of Acute and Non-Acute Medical Evaluations

<table>
<thead>
<tr>
<th>Location of Acute Medical Evaluations</th>
<th>Location of Non-Acute Medical Evaluations</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-site at the CAC</td>
<td>6%</td>
</tr>
<tr>
<td>Hospital</td>
<td>8%</td>
</tr>
<tr>
<td>Out-patient Clinic</td>
<td>59%</td>
</tr>
<tr>
<td>Other</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>54%</td>
</tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6. Medical Staff Providing Acute Medical Evaluations

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Physician (MD)</td>
<td>162</td>
<td>81%</td>
<td>224</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>59</td>
<td>29%</td>
<td>102</td>
</tr>
<tr>
<td>Nurse - SANE-P Certified</td>
<td>-</td>
<td>-</td>
<td>116</td>
</tr>
<tr>
<td>Nurse - SANE-A Certified</td>
<td>-</td>
<td>-</td>
<td>93</td>
</tr>
<tr>
<td>Nurse - SANE-P Trained not Certified</td>
<td>-</td>
<td>-</td>
<td>19</td>
</tr>
<tr>
<td>Forensic Nurse Examiner (FNE)</td>
<td>-</td>
<td>-</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 7. Medical Staff Providing Non-Acute Medical Evaluations

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Physician (MD)</td>
<td>162</td>
<td>81%</td>
<td>224</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>59</td>
<td>29%</td>
<td>102</td>
</tr>
<tr>
<td>Nurse - SANE-P Certified</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Nurse - SANE-A Certified</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Forensic Nurse Examiner (FNE)</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
Medical Standards

- Sexual Abuse
  - NCA
  - American Academy of Pediatrics (AAP)
  - Adams’ Guidelines
- Human Trafficking/Sexual Exploitation
  - AAP, APSAC, US DHHS
- Physical Abuse
  - AAP
  - Condition specific protocols in literature

American Academy of Pediatrics Clinical Guidelines

Evaluating Children With Fractures for Child Physical Abuse
Eunice G. Fishbory, Jennifer M. Perez-Rosello, Michael A. Levine, William L. Hennrikus, and the AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON CHILD ABUSE AND NEGLECT, SECTION ON RADIOLOGY, SECTION ON ENDOCRINOLOGY, SECTION ON ORTHOPAEDICS and the SOCIETY FOR PEDIATRIC RADIOLOGY
Pediatrics 2014;133:e477; originally published online January 27, 2014;
DOI: 10.1542/peds.2013-3793

The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected
Evidence-based medical guidelines

Development of Hospital-Based Guidelines for Skeletal Survey in Young Children With Bruises

Pediatrics 2015;135;e312

Journal of Ped and Ado Gynecology 2015;

Guidelines for non-medical personnel

Recognizing When a Child’s Injury or Illness Is Caused by Abuse
Challenges to physical abuse response

- Medical response to physical abuse is more dependent on advanced training and access to advanced technology.
  - Differential diagnosis
  - Lab testing
  - Radiology studies
- Many state funding systems are set up to support sexual assault and not physical abuse

<table>
<thead>
<tr>
<th>State</th>
<th># CAP's (Helfer)</th>
<th># Child Abuse Programs (AAP)</th>
<th># Counties</th>
<th>Child population</th>
<th>% pop in poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>2</td>
<td>1</td>
<td>75</td>
<td>712,000</td>
<td>27%</td>
</tr>
<tr>
<td>Delaware</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>205,000</td>
<td>16%</td>
</tr>
<tr>
<td>Indiana</td>
<td>3</td>
<td>2</td>
<td>92</td>
<td>1.6 M</td>
<td>20%</td>
</tr>
<tr>
<td>New York</td>
<td>23</td>
<td>12</td>
<td>62</td>
<td>4.3 M</td>
<td>24%</td>
</tr>
<tr>
<td>North Car</td>
<td>17</td>
<td>9</td>
<td>100</td>
<td>2.3 M</td>
<td>23%</td>
</tr>
<tr>
<td>Oregon</td>
<td>5</td>
<td>20</td>
<td>36</td>
<td>865,000</td>
<td>19%</td>
</tr>
<tr>
<td>Texas</td>
<td>25</td>
<td>10</td>
<td>254</td>
<td>6.9 M</td>
<td>24%</td>
</tr>
<tr>
<td>Utah</td>
<td>7</td>
<td>1</td>
<td>29</td>
<td>873,000</td>
<td>12%</td>
</tr>
</tbody>
</table>

http://datacenter.kidscount.org/
<table>
<thead>
<tr>
<th>State</th>
<th>Type of support for medical response</th>
<th>Source of Funding</th>
<th>Mandatory participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>Education and exam review for CAC medical providers by child abuse program at children’s hosp.</td>
<td>State appropriation</td>
<td>No</td>
</tr>
<tr>
<td>Indiana</td>
<td>CW contract with child abuse program at children’s hospital to fund consult on cases statewide.</td>
<td>State budget for child welfare</td>
<td>Yes for certain types of abuse</td>
</tr>
<tr>
<td>New York</td>
<td>Education and support for medical providers (CHAMP). On-line network</td>
<td>State budget for Dept of Health</td>
<td>No</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Training for CW on medical issues of abuse. Network of trained medical providers (CMEP).</td>
<td>State child welfare budget (other)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Oregon</td>
<td>MDT designates trained medical provider for Child Abuse Intervention Center’s (CAC) in state.</td>
<td>Dept of Justice (see “Karly’s Law”)</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas</td>
<td>Medical guidelines distributed by CAC state chapter. TX SANE’s certified through AG’s office.</td>
<td>State appropriation supports CAC’s * AG’s office for SANE</td>
<td>No</td>
</tr>
<tr>
<td>Utah</td>
<td>Medical provider in CAC’s placed by children’s hospital</td>
<td>AG funds Children’s Justice Centers *</td>
<td>No (?)</td>
</tr>
</tbody>
</table>

*State funding is not sole source of funding for the CAC’s in the state*

More Challenges

- Pace of child abuse pediatricians retiring may outpace new fellowship grads for the next several years.
  - Workforce shortage.
- Stress on child welfare/judicial system
  - Decrease federal matching $$$’s
  - Staff/leadership turnover
- Funding--federal
- Funding--state
- Funding--local
Report from the Task Force on the Prevention of Sexual Abuse of Children

2012
A Message to the Governor, General Assembly and State Board of Education—

In the last few months and years, Missourians have been confronted by the reality that child sexual abuse has occurred in homes, schools, places of worship and institutions throughout the state and nation. From Penn State to the Boy Scouts, child molesters have been allowed access to children and with alarming frequency, institutions chose to cover up the abuse rather than stop the abuse from occurring.

The Task Force on the Prevention of Sexual Abuse of Children was created in statute during the 2011 Missouri legislative session and was charged with studying and identifying strategies for preventing child sexual abuse. The Task Force met throughout 2012 and conducted four public hearings, receiving testimony from 35 experts in the field of child sexual abuse.

The Task Force was directed to provide recommendations to the Governor, General Assembly and the State Board of Education and as such, the Task Force asks these entities to carefully consider the report and begin to craft solutions to address child sexual abuse. The Task Force maintains that all individuals and organizations have a responsibility to protect children—and the state’s elected officials and General Assembly have a responsibility to create laws and allocate funding to the systems that protect children. Leadership by the State of Missouri also has the power to fundamentally change the culture in Missouri so that all adults, youth-serving organizations, schools and communities begin to form protective barriers around children.

The wake up call has sounded—there is no Missourian who can claim that they are unaware of the epidemic of child sexual abuse. Missouri must have the courage to openly discuss and address child sexual abuse or we will be as guilty as the adults who chose to protect their institutions at the expense of children.

Within our reach is the opportunity to become a state that is nationally known for protecting and prioritizing children. Children who grow up with bodily and psychological integrity become productive adults with the full capacity to serve their families, communities and state. A report is only a report—the real work of protecting children is just beginning. The Task Force asks the Governor, General Assembly, State Board of Education and all Missourians to help unlock the unrealized potential that comes from protecting children from sexual abuse.
Task Force Members

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Division Chief, Division on Child Abuse and Neglect
Children’s Mercy Hospital

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Maryland Heights Police Department

TEC CHAPMAN
Chief Program Officer,
Missouri School Boards’ Association

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9th Senatorial District

Senator BOB DIXON
30th Senatorial District

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100th House District

Representative STACEY NEWMAN
73rd House District

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Counseling/School Climate Facilitator,
Rockwood School District

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Executive Director,
Missouri KidsFirst

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Missouri Coalition Against Domestic & Sexual Violence

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Family Violence Resource Prosecutor,
Missouri Office of Prosecution Services

EMILY VAN SCHENKHOF, MPH and
MARISSA GUNTHER, MSW, LMSW
of Missouri KidsFirst staffed the Task Force.

Acknowledgements

The Task Force gratefully acknowledges the following organizations for their contribution to the Task Force on the Prevention of Sexual Abuse of Children:

- Missouri KidsFirst for leading and staffing the Task Force
- The Children’s Trust Fund for financially supporting the Task Force efforts
- Great Circle for designing the Task Force Report
- Missouri State University, Kirksville El Kadir Shrine Club, the Missouri Legislative Black Caucus Foundation Conference and St. Louis Children’s Hospital for each hosting a public hearing of the Task Force on the Prevention of Sexual Abuse of Children

The Task Force would also like to acknowledge the following individuals for their contribution to the Task Force Report:

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JOE LARAMIE, LT. [Retired]
Internet Crimes Consultant

December 2012
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Alliance for Southwest Missouri

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Sergeant, Hamilton Police Department

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Missouri Office of Prosecution Services

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Missouri Department of Corrections

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Executive Editor, Springfield News-Leader

TIFFANI STONE
Survivor

MARK WEBB
Chief of Police, Marionville Police Department

PATRICIA WEBB, DNP, APRN, CPNP-PC
Pediatric Nurse Practitioner, The Child Advocacy Center, Inc.

BILL WHITE, MA, LPC
Children's Program Coordinator, Phelps County Crisis Services

MELODY YANCEY
Designated Principal Assistant,
Children's Division, Department of Social Services
Child sexual abuse is a silent epidemic in Missouri and throughout the nation. Studies suggest that twenty-five percent of girls and sixteen percent of boys experience sexual abuse during their childhood years.¹

Child sexual abuse is any interaction between a child and an adult (or an older juvenile) in which the child is used for the sexual gratification of the adult. It can include contact (touching of the vagina, penis, breast or buttocks, oral-genital contact or sexual intercourse) and non-contact behaviors (voyeurism, exhibitionism, or exposing the child to pornography). Force, as it is typically understood, is often not involved, but perpetrators use deception, threats and other forms of coercion.²

Children are most often molested by someone they know. A third or more of victims are abused by a family member, and only seven percent are molested by a stranger. Seventy-five percent of abuse occurs inside of homes, behind closed doors.³

Child sexual abuse can be particularly damaging because it tends to be chronic in nature. It is not typically a one-time event; a child experiences the abuse over and over again and lives in a state of fear and terror. Children who are being abused often face significant barriers to disclosing the abuse, including shame and guilt, fear of not being believed, fear of bodily harm or being removed from the home as a result of threats from and manipulation by perpetrators.⁴

The consequences of being sexually abused are significant. Some of the psychological impacts include low self-esteem, anxiety and depression.⁵ Other long-term effects include increased risk for experiencing teen pregnancy,⁶ drug and alcohol abuse and adoption of other health risk behaviors.⁷ Additionally, children who are sexually abused are at increased risk of perpetrating sexual abuse as they age, resulting in cycles of perpetration in families and communities.⁸

Only a fraction of those who commit sex offenses are held accountable for their crimes. The Center for Sex Offender Management estimates that only a third of sexual abuse crimes are reported to law enforcement.⁹ Additionally, many child victims of sexual abuse do not receive appropriate medical evaluations or the necessary mental health therapy.

Executive Summary

Community-Based Child Sexual Abuse Prevention
RECOMMENDATION 4.1
Community-based child abuse prevention education needs to be expanded and be comprehensive in nature.

RECOMMENDATION 4.2
All schools and youth-serving organizations should have specific child sexual abuse prevention policies.

RECOMMENDATION 4.3
Existing state child abuse prevention programs should include programming targeted at preventing child sexual abuse.

RECOMMENDATION 4.4
Expand home-visiting programs and specifically include child sexual abuse prevention in these programs.

Professional Training and Technical Assistance
RECOMMENDATION 4.5
Create and implement standardized training for all mandated reporters.

RECOMMENDATION 4.6
Fund the creation and implementation of standardized, discipline-specific training for members of the multi-disciplinary team (MDT) and judges.

RECOMMENDATION 4.7
Identify and fund discipline-specific expert technical assistance for MDT members.

Multi-Disciplinary Team Excellence
RECOMMENDATION 4.8
Establish discipline-specific best practices or standards for multi-disciplinary teams, law enforcement, prosecutors and medical providers.

RECOMMENDATION 4.9
Establish mechanisms for addressing the secondary trauma experienced by individuals who work to address and prevent child sexual abuse.

RECOMMENDATION 4.10
Assess for and address domestic violence when investigating child sexual abuse and providing services to victims and caregivers.

Mental Health Services and Treatment
RECOMMENDATION 4.11
Identify and fund evidence-based early intervention and treatment for youth with illegal/inappropriate sexual behaviors.

RECOMMENDATION 4.12
Identify and fund the expansion of mental health services to children who have been sexually abused.

Awareness
RECOMMENDATION 4.13
Create and fund a child sexual abuse public awareness campaign.

Funding
RECOMMENDATION 4.14
The General Assembly should consider increased investment in preventing child sexual abuse in order to reduce the substantial financial, health and social costs associated with childhood trauma.

RECOMMENDATION 4.15
Private foundations in Missouri should increase funding to prevent and address childhood trauma.

Statutory Changes
RECOMMENDATION 4.16
Submit to Missouri voters a proposed constitutional amendment allowing evidence of signature crimes, commonly referred to as propensity evidence, to be used in child sexual abuse cases.

RECOMMENDATION 4.17
Modify 210.115 RSMo. to require mandatory reporters to directly report suspected child abuse and neglect to Children’s Division.

RECOMMENDATION 4.18
Clarify the term “immediately” in the mandatory reporting statute, 210.115 RSMo., and school reporting statute, 167.117 RSMo.

RECOMMENDATION 4.19
Clarify 544.250 RSMo. and 544.280 RSMo. to allow for hearsay evidence at preliminary hearings.

RECOMMENDATION 4.20
Amend 491.075.1 RSMo. to clarify that the statute allows for the use of child witness statements relative to prosecutions under Section 575.270.

RECOMMENDATION 4.21
Modify the definition of deviate sexual intercourse in 566.010 RSMo. to include genital to genital contact.

RECOMMENDATION 4.22
Modify 556.037 RSMo. to eliminate the statute of limitations for the prosecutions of first-degree statutory rape and first-degree statutory sodomy.

Issues for further study
Evidentiary standard used by Children’s Division.

Suspended Imposition of Sentence (SIS) and Suspended Execution of Sentences (SES) in child sexual abuse cases.

Clarification of the optimal process for co-investigation by law enforcement and Children’s Division.
Community-Based Child Sexual Abuse Prevention

RECOMMENDATION 1
Community-based child sexual abuse prevention education needs to be expanded and be comprehensive in nature.

Child sexual abuse prevention is the responsibility of every adult. However, child sexual abuse education is currently offered in isolated locations throughout Missouri. In order for community-based education to be successful, efforts must be comprehensive in nature and target children, parents, staff in youth-serving organizations and schools and the community at large.

CHILDREN
Children need to be taught basic and age-appropriate information on boundaries, inappropriate touches and their right to determine who touches them and how. Even a simple strategy such as teaching a child the anatomically correct terms for their body parts decreases the chances that someone will molest them because that child now has the language to describe what is happening to them.

PARENTS
For some adults, being a protective parent comes naturally because it was modeled by caregivers in their formative years. Other parents need more assistance in learning how to become protective parents. One of the most important strategies for parents is to observe and monitor the relationships their children have with adolescents and adults.

STAFF AND VOLUNTEERS IN YOUTH-SERVING ORGANIZATIONS AND SCHOOLS
All organizations that serve children and families must operate under the assumption that some people who sexually abuse children may want to work for them. These organizations have an obligation to create an environment that is inhospitable to people who want to sexually violate children. These environments must be nurtured from the top, with leaders who understand the risk and actively work to train staff and volunteers and institute child protection policies. Staff and volunteers should be taught about organizational expectations for appropriate adult and child interactions and how to identify and respond to potentially problematic behaviors.

COMMUNITY
Our communities must reinforce the behaviors that we want to see in Missouri homes and youth-serving organizations and schools. Community leaders and elected officials can play a vital role in beginning to discuss the importance of ending the silence that allows sexual abuse of children. Leaders can advocate for youth-protection policies and training in organizations funded by local, state and federal tax dollars, and boards of directors can ask their organizations to implement child sexual abuse prevention strategies. All Missourians can listen and act on gut feelings that an adult may be crossing boundaries with a child. Ultimately, all these actions together create cultural norms where individuals, families, organizations and communities are forming protective barriers around children and identifying and responding to problematic behaviors.

“We need to teach our children to raise their voices and keep them raised until somebody listens.”
— KATHLEEN HANRAHAN
Director,
YWCA St. Louis Regional Sexual Assault Center

“We while lived with my biological mother, I was sexually abused by three different men. When I was approximately 8 years-old, I was sexually abused by my babysitter. He first drew descriptive pictures of sex acts, then had me strip in front of him, and he also touched me inappropriately and made me touch him. He would tell me if I told I would get in trouble, and he rewarded me when I performed sexual acts. I did not tell for what seems like a long time. When I finally told my biological mother, she told me it was my fault I was being abused because I was ‘enticing’ him to abuse me. She then continued to use the same babysitter and the abuse continued.”
— TIFFANI STONE
Survivor

Please see APPENDIX A for more information on community-based child sexual abuse prevention strategies.
SPECIAL POPULATIONS

Because child sexual abuse happens to children from all socio-economic and ethnic groups, it is important that we target our efforts at all children and adults in Missouri. Attitudes that child sexual abuse does not occur in specific communities are ill-informed and harmful to children.

At the same time, certain groups can be at greater risk for abuse and deserve special consideration when designing and implementing interventions. Children with disabilities are at a particularly high risk for being sexually abused because of the vulnerabilities created by their disability. Children with disabilities also have additional barriers in disclosing abuse. Individuals and agencies that work with this population have a particular obligation to actively address child sexual abuse in ways that are developmentally appropriate.

Children living in poverty are often at increased risk for child sexual abuse. This does not mean that poor people are more likely to abuse their children than families with resources. Families living in poverty often have to rely on sub-standard childcare which can increase a child’s risk for being sexually abused. When individuals can’t afford childcare and don’t have a strong family or support network, they are more inclined to leave their child with a “helpful” neighbor, boyfriend or partner. Sexual predators often seek out families in crisis because they know these families are more likely to have a decreased capacity to protect their children. Finally, the isolation and lack of resources that result from poverty can make it more difficult for help to reach children being harmed.

RECOMMENDATION 42

All schools and youth-serving organizations should have specific child sexual abuse prevention policies.

Schools and youth-serving organizations should have child protection policies that focus on appropriate adult and child boundaries and adult and child situations. Policies, if enforced, can help set organizational norms that minimize opportunities for children to be harmed by caretakers, teachers or volunteers. These policies, coupled with staff education, also equip adults to identify and respond appropriately to children who are being abused outside of the school or organizational environment.

Please see the CDC’s Preventing Child Sexual Abuse Within Youth-Serving Organizations: Getting Started on Policies and Procedures for examples of youth protection policies.

RECOMMENDATION 43

Existing child abuse prevention programs should include programming targeted at preventing child sexual abuse.

There are currently many child abuse prevention activities occurring throughout the state. Unfortunately, few programs directly address child sexual abuse. Professionals who may be skilled in discussing strategies for coping with a colicky infant are not as comfortable coaching parents on how to protect their child from sexual abuse.

State agencies also could play an instrumental role in encouraging or requiring state and federally funded maternal and child health programs to include specific components designed to address child sexual abuse.

RECOMMENDATION 44

Expand home-visiting programs and specifically include child sexual abuse prevention in these programs.

Home-visiting programs are interventions where trained professionals come into the homes of families and provide social support, case management and education about child development and parenting over an extended period of time. Although many evidence-based home-visiting models are used in Missouri, the Task Force specifically heard considerable testimony on the Nurse Family Partnership as a strategy that has potential for preventing child abuse.

However, the home-visiting models being used in Missouri do not actively include curriculum or specific components on child sexual abuse. There are also few programs nationally that specifically address child sexual abuse. The strength of Missouri’s home-visiting programs provides an excellent opportunity to adapt an existing successful program to make it more responsive to the needs of Missouri’s children and families.


Task Force Recommendations

RECOMMENDATION #5
Create and implement standardized training for all mandated reporters.

PROFESSIONALS
Individuals who are mandated to report child abuse and neglect to the Children's Division of the Department of Social Services under 210.115 RSMo. often receive little to no training on child abuse and neglect. Professionals identified in 210.115 RSMo. should receive regular training on the signs and symptoms of child abuse, the roles and responsibilities of a mandated reporter, how to report and how to respond to a child victim.

The Task Force does not recommend that training be mandated through statute, but instead recommends that licensing and credentialing organizations require a specified minimum amount of continuing education credits on a bi-annual basis about child abuse and neglect and professional obligations under 210.115 RSMo.

PRESERVICE TRAINING
Young professionals in college or training programs in child serving sectors or law enforcement training academies (e.g. future child care workers, counselors, teachers, social workers, physicians, nurses, criminal justice professionals, clergy) should receive training on child abuse and neglect and the obligations of mandated reporters. This could be accomplished through expanding Child Advocacy Studies (CAST) programs in colleges and universities in Missouri. CAST programs, ranging from undergraduate certificates and minors to majors and Masters programs, are established or are being established in 23 states, including Missouri.

Please see APPENDIX B for recommended guidelines for mandated reporter training.

RECOMMENDATION #6
Fund the creation and implementation of standardized, discipline-specific training for members of the multi-disciplinary team (MDT) and judges.

There is considerable variation in the effectiveness of our responses to child sexual abuse throughout the state. Some communities aggressively investigate and prosecute child sexual abuse cases while some have a very limited response. Child Advocacy Centers—places where children go to talk to a trained professional about abuse and that assist in coordinating the co-occurring Children's Division and law enforcement investigation—are not utilized in all jurisdictions. Members of the MDT in all counties in Missouri need to receive training on how to investigate and prosecute cases of child sex abuse. Additionally, members of the MDT should receive training on vicarious or secondary trauma and medical forensics.

The Task Force recommends that organizations that oversee training and continuing education for members of the MDT require practitioners to receive regular training on child sexual abuse and how to effectively respond to, investigate and prosecute child sexual abuse.

Please see APPENDIX C for recommended guidelines for multi-disciplinary team training.

THE FOLLOWING PROFESSIONALS ARE IDENTIFIED IN 210.115 RSMO. AS MANDATED REPORTERS:
Physician, medical examiner, coroner, dentist, chiropractor, optometrist, podiatrist, resident, intern, nurse, hospital or clinic personnel, health care practitioner, psychologist, mental health professional, social worker, day care center worker, juvenile officer, probation or parole officer, jail or detention center personnel, teacher, principal or other school official, minister, law enforcement officer, or other person with the responsibility for the care of children.

“Who makes the police be the police?”
— MARK WEBB
Chief of Police,
Marionville Police Department
MEMBERS OF THE MULTI-DISCIPLINARY TEAM TYPICALLY INCLUDE:
Law Enforcement, Children’s Division, Juvenile Officers, Prosecution, Medical, Mental Health, Victim Advocacy and Child Advocacy Center.
An MDT is a group of professionals who represent various disciplines and work collaboratively to assure the most effective coordinated response possible for every child suspected of being abused. The purpose of interagency collaboration is to coordinate interventions in order to reduce trauma to children and families and improve services, while preserving and respecting the rights and obligations of each agency to pursue their respective mandates. Collaborative response begins with case initiation and is promoted through understanding and exploring case issues. Insight from each MDT representative provides the environment for a coordinated, comprehensive, compassionate professional response.

“The highest quality medical expertise should be available to every child, every family, every investigator and every prosecutor. Availability should not depend on the good will volunteerism of the provider, the willingness of the individual investigators to use that expertise, and although this expertise should be convenient to the family, the willingness to utilize that expertise should not be based on the investigator’s convenience. Should this be the time to re-evaluate Missouri’s need for a more robust medical response system to all forms of child abuse? I believe yes.”
— Adrienne Atzemis, MD
Child Abuse Pediatrician,
Washington University School of Medicine and St. Louis Children’s Hospital Child Protection Program

RECOMMENDATION 4.7
Identify and fund discipline-specific expert technical assistance for MDT members.
Each member of the MDT needs access to professionals, with discipline-specific credentials, who have the time and expertise to provide expert consultation. For instance, a prosecutor who has never tried a child sexual abuse case should be able to reach out to a resource prosecutor who can provide them with technical assistance on how to try the case. This resource is currently available but could be expanded. For some professions, expert consultants are not available or known to practitioners in the field.

Multi-Disciplinary Team Excellence

RECOMMENDATION 4.8
Establish discipline-specific best practices or standards for multi-disciplinary teams, law enforcement, prosecutors and medical providers.
Uniform standards for how to investigate, prosecute and forensically evaluate child sexual abuse cases would provide needed clarity to practices that differ considerably from county to county.

Please see APPENDICES D & E for recommended guidelines for law enforcement and prosecutorial practice.

RECOMMENDATION 4.9
Establish mechanisms for addressing the secondary trauma experienced by individuals who work to address and prevent child sexual abuse.
Practitioners who work directly with children who have been sexually abused often experience compassion fatigue or secondary trauma. Committed and skilled professionals often make the difficult choice to leave the field because the personal toll is too high, resulting in a critical loss of expertise. The Task Force was particularly concerned by the 37 percent turnover rate for front-line Children’s Division investigators. Some options for addressing secondary trauma include actively incorporating training on dealing with trauma exposure in all child welfare service systems and rewarding professionals who stay in the field with financial incentives and professional recognition.

RECOMMENDATION 4.10
Assess for and address domestic violence when investigating child sexual abuse and providing services to victims and caregivers.
There is a high co-occurrence of child abuse and domestic violence. Systems cannot effectively serve children if the needs of their primary caregivers are not simultaneously addressed. Multi-disciplinary teams must assess for domestic violence and should build collaborative relationships with domestic violence service providers in their area.

**Task Force Recommendations**

**Mental Health Services and Treatment**

**RECOMMENDATION 11**

Identify and fund evidence-based early intervention and treatment for youth with illegal/inappropriate sexual behaviors.

Youth who commit sexually inappropriate or illegal offenses are fundamentally different from adult offenders in that they have tremendous rehabilitative potential. Often children or adolescents who harm younger children were victimized themselves and never received appropriate therapeutic treatment. Studies have shown that juveniles who receive treatment demonstrate very low recidivism rates for sexual crimes. Effective treatment protocols for youth have been developed in Missouri and across the nation; however, very few youth currently access these services.

Missouri’s juvenile justice and social service systems need to re-examine how juveniles who commit sexually inappropriate or illegal behaviors are investigated, evaluated and treated. Juveniles can sometimes fall through the cracks as Children’s Division is not charged with investigating cases where the person committing the offense does not have care, custody and control of the child; law enforcement investigation may be limited depending on the relative youth of the perpetrator and the Juvenile Office typically does not investigate unless they are considering pursuing a status offense. It is imperative that one of the three agencies interview an alleged perpetrator under the age of 14 or the victim, so an opportunity for treatment, protection and prevention is not missed.

**RECOMMENDATION 12**

Identify and fund the expansion of mental health services to children who have been sexually abused.

All children who have been sexually abused deserve to be provided with an appropriate therapeutic intervention. Children who have been sexually abused face an increased risk for future victimization and for perpetrating abuse against other children as they age. Mental health treatment for sexually abused children should be evidence-based and trauma-focused, including skill-building to manage emotions and cope with stress, parental or caregiver involvement and direct discussion of the abuse history.

Currently, there is little state investment in mental health services for these children and no system set up to ensure that, once identified, children are able to receive care. A coordinated network of mental health providers—ensuring appropriate referral, standards of practice and training and technical assistance for providers—would greatly enhance service provision and care to children in Missouri.

Please see APPENDIX F for recommended guidelines for mental health practice.

“Youth who commit sexually inappropriate or illegal offenses are fundamentally different from adult offenders in that they have tremendous rehabilitative potential.”
— JERRY DUNN, PhD
Executive Director, Children’s Advocacy Services of Greater St. Louis

“I studied 74 child molesters over a three-year period, from 2003 to 2005. They were incarcerated at eight different prisons in the state of Missouri. There was a mixture of both pedophile offenders and situational offenders. I found that with the pedophile offenders, most of them became aware of a sexual attraction toward children during their teenage years. The majority of these offenders began acting out sexually with younger children while they were still teenagers. Some of them got caught. For those that did get caught, some of those cases were not handled appropriately and their sexual offending continued well into adulthood. When I say that they were not handled appropriately—parents became aware but did not take it seriously, parents did not seek counseling after promising to do so, law enforcement agencies and/or courts did not recognize or appreciate the seriousness of these crimes, there was no court ordered treatment or counseling, etc.”

— BILL CARSON
Deputy Police Chief, Maryland Heights Police Department

The Springfield News-Leader has launched a public-service journalism project, Every Child, to focus public attention on critical challenges facing children, foster discussion and build on existing initiatives.

An Every Child community advisory committee, which includes representatives from the business, government, education, nonprofit, law enforcement, health and faith sectors, serves to educate and advise journalists and help engage other stakeholders and the general public in a discussion and, ultimately, action.

“Many studies show links between victimization from child sexual abuse and a wide-array of long- and short-term physical and mental health problems. A reduction in child sexual abuse and exploitation will lead to a reduction in those health care costs.”

— National Plan to Prevent the Sexual Abuse and Exploitation of Children

**Task Force Recommendations**

**Awareness**

**RECOMMENDATION 3 1 3**

*Create and fund a child sexual abuse public awareness campaign.*

Although awareness does not prevent violence, it is a necessary foundation for prevention efforts. The silence and discomfort surrounding child sexual abuse prohibits adults and organizations from proactively adopting protective practices. Additionally, many adults have no knowledge about what to do when they suspect a child is being harmed. Increased public awareness about the need to confront the silence and stigma of sexual abuse of children and what to do when confronted with abusive behavior could lay the foundation for a climate where sexual abuse of children is less likely to occur.

**Funding**

**RECOMMENDATION 3 1 4**

*The General Assembly should consider increased investment in preventing child sexual abuse in order to reduce the substantial financial, health and social costs associated with childhood trauma.*

The Task Force on the Prevention of Sexual Abuse of Children maintains that protecting children from sexual abuse is worthy of a meaningful investment from the state of Missouri. Almost all of the recommendations in this report will require funding in order to be implemented. Child sex crimes and their prevention are fundamental concerns for state government because child sexual abuse is a crime and public safety threat. Sexual abuse of children also drives spending in the state budget with unresolved sexual trauma resulting in significant costs to the Department of Social Services, Department of Mental Health and the Department of Corrections. Rather than investing large amounts of money in treating dysfunction the state could spend smaller amounts addressing and preventing childhood trauma.

Currently, there is a small amount of federal and non-general revenue state funding in the Missouri budget dedicated to supporting community-based child abuse prevention initiatives, education and awareness. There is also a more sizable amount of federal and state funding directed at home-visiting programs, which have the potential to prevent child sexual abuse if modifications are made to the programming and curriculum used by home-visiting models. The Task Force recommends that the state consider investing funding in amounts commensurate to the importance of this issue. Additionally, the Task Force suggests that the percentage of existing funding specifically dedicated to child sexual abuse increase.

Another opportunity for expanding funding for child sexual abuse prevention exists in expanding the use of local sales taxes to fund services for children, as authorized in 67.1775 RSMo. Six counties in Missouri, most recently Boone County in the 2012 November election, have passed voter-approved one-quarter of a cent city or county sales taxes that can be used to support services to children, including counseling, family support and temporary residential services to juveniles. The Task Force encourages communities to enact funding mechanisms to serve children and fund child sexual abuse prevention with these funding streams.

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Private foundations in Missouri should increase funding to prevent and address childhood trauma.

Childhood trauma has a substantial impact on the health and wellness of society. Many foundations contribute significant funds to improving the health of Missourians, but currently there is limited foundation support for addressing child sexual abuse. In addition, child sexual abuse is not a subject with which many corporate foundations are eager to be associated. The Task Force encourages private donors and foundations in Missouri to recognize child sexual abuse as a significant public health issue and a key driver of disease and dysfunction in our state and to explore creating funding streams that address the factors that cause this violence.

It is the responsibility of all individuals and organizations in Missouri to respond to the crisis of child sexual abuse confronting our state. Both the public and private sectors have a role to play in funding programs and initiatives that prevent sexual abuse and protect children.

Statutory Changes

Submit to Missouri voters a proposed constitutional amendment allowing evidence of signature crimes, commonly referred to as propensity evidence, to be used in child sexual abuse cases.

Missouri's Supreme Court has ruled that it is unconstitutional to introduce evidence of similar crimes against other victims in child abuse cases. Prosecutors should be allowed to introduce evidence of past sex crimes against other children in pending cases in order to show that the defendant has an established pattern of behavior. For example, perpetrators will sometimes claim they were drunk or have no memory of anything sexual happening with a child; because there is often no physical evidence, it becomes a child's word against an adult's and as a result, prosecutors are unable to get to the evidentiary standard of beyond a reasonable doubt. However, if prosecutors were able to introduce evidence that the perpetrator had committed similar crimes against other victims, they might be able to proceed with prosecution. The Federal Rules of Evidence, along with several other states, allow this type of evidence. The Task Force believes Missouri voters should have the opportunity to decide whether or not evidence of similar crimes against other victims should be allowed in child sexual abuse cases.

Modify 210.115 RSMo. to require mandatory reporters to directly report suspected child abuse and neglect to Children's Division.

Current Missouri law allows mandatory reporters to report suspected child abuse and neglect to a “designated agent” in their organization. Unfortunately, the Task Force has found that sometimes this results in reports not being made as individuals in an institution’s chain of command can disagree with the need to make a report. Additionally, prosecutors are often hesitant to prosecute failure to report because the precise failure in the chain of command is hard to identify. The Task Force recommends that the mandatory reporting statute, 210.115 RSMo., be modified to require direct reporting and/or clarification of the person or persons responsible for mandatory reporting in an organizational setting.

"It should be made clear that there is both a legal and moral duty to report child abuse and not just to an up-the-line supervisor. There is simply too much at stake to pass the buck."

— DAN PATTERSON
Greene County Prosecuting Attorney
**RECOMMENDATION 4.18**
Clarify the term “immediately” in the mandatory reporting statute, 210.115 RSMo., and the school reporting statute, 167.117 RSMo.

210.115 RSMo. and 167.117 RSMo. require that individuals report suspected abuse “immediately” to Children’s Division. Immediately should mean as soon as reasonably possible after learning of the possible crime, and in the cases of schools, should be defined as prior to the school conducting its own investigation.

**RECOMMENDATION 4.19**
Clarify 544.250 RSMo. and 544.280 RSMo. to allow for hearsay evidence at preliminary hearings.

544.250 RSMo. and 544.280 RSMo. currently are being interpreted inconsistently around the state. In some circuits, courts are not allowing prosecutors to use hearsay evidence, or forensic interviews, in preliminary hearings. In some of these circuits, no grand jury is available to the prosecutor, thus the perceived rule against hearsay evidence at preliminary hearing effectively requires the victim to confront the abuser in open court, exposing the victim to additional public scrutiny, trauma, embarrassment and fear, long before trial. This limitation on evidence at preliminary hearing is not interpreted as necessary for due process, nor is it constitutionally required.

**RECOMMENDATION 4.20**
Amend 491.075.1 RSMo. to clarify that the statute allows for the use of child witness statements relative to prosecutions under Section 575.270.

491.075.1 RSMo. currently has been interpreted inconsistently around the state. Manipulation and intimidation of children are typical dynamics of child sexual abuse. Many abusers use coercion to keep a child silent about the abuse. In some circuits, courts have not allowed prosecutors to use child witness statements about the abuser’s intimidation and manipulation to try to dissuade the child witness from testifying. A statutory amendment to include 575.270 RSMo. in the types of prosecutions listed in 491.075.1 RSMo. should alleviate this problem.

**RECOMMENDATION 4.21**
Modify the definition of deviate sexual intercourse in 566.010 RSMo. to include genital to genital contact.

The current definition of deviate sexual intercourse, the behavior that constitutes statutory sodomy, does not include genital to genital contact. This contact is prohibited under the current definition of child molestation, but it is a lesser charge than statutory sodomy.

**RECOMMENDATION 4.22**
Modify 556.037 RSMo. to eliminate the statute of limitations for the prosecutions of first-degree statutory rape and first-degree statutory sodomy.

Currently the statute of limitations for sexual offenses involving a person under eighteen is 30 years (556.037 RSMo.) There is no statute of limitations for forcible rape, attempted forcible rape, forcible sodomy, attempted forcible sodomy and kidnapping. The first-degree statutory sex crimes are just as serious as these crimes and should not have a statute of limitations.
Task Force Recommendations

Issues for further study

The Task Force recommends that the following issues, discussed in public hearings and at Task Force meetings, receive additional attention and study. The Task Force urges the recently created Joint Committee on Child Abuse and Neglect to consider the following issues.

EVIDENTIAL STANDARD USED BY CHILDREN’S DIVISION

Children’s Division currently uses preponderance of the evidence, defined in 210.110 RSMo. and further described in 210.145 RSMo., as the standard that must be reached in order to determine, or substantiate, that child abuse has occurred. This standard can be difficult to reach in cases of child sexual abuse where often the only evidence available is a child’s disclosure. Because of the incredible importance of balancing child protection with due process, the Task Force recommends additional study and inquiry as to whether or not preponderance of the evidence is the best standard to be used by Children’s Division.

SUSPENDED IMPOSITION OF SENTENCE (SIS) AND SUSPENDED EXECUTION OF SENTENCES (SES) IN CHILD SEXUAL ABUSE CASES

Currently Missouri courts may grant Suspended Impositions of Sentence and Suspended Execution of Sentences to individuals convicted of child sex crimes. Because of the serious nature of these crimes, SISs and SESs do not seem to be appropriate criminal justice outcomes. However, the Task Force recognizes that reducing prosecutorial discretion could result in the unintended consequence of more child sex abuse charges being dropped. Instead, the Task Force recommends that appropriateness of SIS and SES in child sexual abuse cases be considered further by lawmakers in Missouri.

CLARIFICATION OF OPTIMAL PROCESS OF LAW ENFORCEMENT AND CHILDREN’S DIVISION CO-INVESTIGATION

Missouri law requires that child sexual abuse cases be co-investigated by law enforcement agencies and Children’s Division. Additionally, these cases also should be referred to a Child Advocacy Center for a forensic interview and other services the child may need. However, the reality of co-investigation varies considerably from county to county and these cases often do not receive the follow through and specialized investigation required. Co-investigation processes should be clarified, with established guidelines and utilization of Child Advocacy Centers.
— APPENDICES —

Recommended Guidelines for Child Sexual Abuse Prevention

The purpose of the appendices is to provide parents, youth-serving organizations, schools, multi-disciplinary team members, law enforcement, prosecuting attorneys, mental health professionals and community leaders with implementation standards for the Report’s recommendations.

Task Force members and stakeholders developed the appendixes using evidence-based research, expertise of Task Force members and stakeholders, verbal and written testimony provided at four public hearings and written testimony from stakeholders who did not appear in-person at the public hearings.

APPENDIX A
CHILD SEXUAL ABUSE PREVENTION EDUCATION ........ PGS 18-19

APPENDIX B
MANDATED REPORTER TRAINING ...................................... PG 20

APPENDIX C
MULTI-DISCIPLINARY TEAM TRAINING ....................... PGS 21-22

APPENDIX D
LAW ENFORCEMENT ...................................................... PG 23

APPENDIX E
PROSECUTING ATTORNEYS ............................................. PG 24

APPENDIX F
MENTAL HEALTH PRACTICE ............................................. PG 25-26
It is the responsibility of all adults to protect children from being sexually abused. We must teach our children that the abuse is not their fault, no matter what they've been taught or told in the past.

Child sexual abuse prevention education programs need to be comprehensive—targeting anyone who has the potential to be abused or the potential to protect a child or report abuse. To be truly comprehensive, training must be provided for:

- **CHILDREN:** starting at age 3 and continuing at least through elementary school.
- **PARENTS:** of all children, beginning prenatally.
- **YOUTH-SERVING ORGANIZATIONS AND SCHOOLS:** educate new and ongoing staff and volunteers to prevent, recognize and respond to child sexual abuse within their organization.
- **COMMUNITY:** educate community leaders and public officials to model and reinforce behaviors we want to see in individuals, families, youth-serving organizations, schools and communities.

Sexual abuse prevention education with children should:

- Begin at an early age—3 years-old has been shown to be an effective age to begin child sexual abuse prevention education.
- Teach the difference between appropriate and inappropriate touches and boundaries in a developmentally appropriate manner.
- Teach response skills that are empowering.
- Instruct children about how to, why it is necessary, where and to whom they can report.
- Be ongoing in multiple sessions during preschool and elementary years.
- Comprise various methods, approaches and techniques of teaching for all types of learners.
- Include interactive activities giving children the opportunity to work through and demonstrate mastery of the concepts being taught.

Parent education for protecting children should include information about:

- The adult responsibility to protect children from sexual abuse.
- The importance of being careful about which adults have access to your children and how care and safety should be monitored.
- The dynamics of child sexual abuse, including:
  - Definitions of abuse
  - Signs and symptoms
  - Normal sexual behaviors and inappropriate sexual behaviors
  - Child sexual development
  - Anatomical language
  - Red flags of people who sexually abuse
  - Red flags in a child’s behavior
- The “grooming” process and signs.
- How to talk to children about sexual abuse.
- How to handle and be sensitive to disclosures, including believing and empowering children.
- The importance of children having choice and autonomy over their bodies.
- How to teach children the intrinsic value of their bodies.
- How to act on suspicious behavior.
- How to address social norms that perpetuate child sexual abuse, including secrecy and denial.
- Community resources and social networks available to parents.

**REFERENCES**


Education with staff in youth-serving organizations and schools should include:

- Training of all staff and volunteers, including those who work directly with children, staff who are responsible for enforcing child sexual abuse policies and procedures, and organizational management.
- Training should occur during orientation and be reinforced every 3 years.
- Training and education should include these components:
  - Adult responsibility to prevent child sexual abuse.
  - The dynamics of child sexual abuse, including:
    - Definitions of abuse
    - Signs and symptoms
    - Normal sexual behaviors and inappropriate sexual behaviors
    - Child sexual development
    - Anatomical language
    - Red flags of people who sexually abuse
    - Red flags in a child’s behavior
  - The dynamics of coercive control:
    - Child sexual abuse is a violation of power; the abuser holds the power and the abused child is disempowered.
    - The abuser will use manipulative and threatening tactics to control the child and to ensure secrecy and continuation of the abuse.
  - The dynamics of victimization.
  - Discussion and recognition of a perpetrator’s desire to work for youth-serving organizations and schools in order to attain access to children.
  - Appropriate adult and child interactions with children and youth.
  - How to identify and respond to risky situations, such as unsupervised one adult/one child interactions.
  - How staff and volunteers can responsibly respond to harmful behavior.
  - Importance of open communication and transparency within organizations, specifically addressing secrecy and denial.

Training and education components continued…

- How to speak to children in an age appropriate way about child sexual abuse.
- How to respond appropriately to disclosures of child sexual abuse.
- Training and materials that outline the organization’s policies and procedures that prevent and respond to child sexual abuse.
- The recognition that youth-serving organizations and schools acting as positive, caring and nurturing environments for children are a protective factor against child sexual abuse.
- The mandated reporting process (see APPENDIX B).
- Staff and volunteer discomfort with discussion about child sexual abuse.

Community education for protecting children should address:

- Educating community leaders and public officials to recognize child sexual abuse as a public health issue and its effect on entire communities.
- Supporting organizational and legislative policies that address the norms, behaviors and practices that lead to child sexual abuse.
- Educating on the economic impact of child sexual abuse.
- Educating and dialogue that addresses silence and denial.
- Engaging parents and communities to gather and share educational information, and support prevention efforts.
- Encouraging leaders and public officials to advocate for policies that protect youth in organizations that receive local, state and federal tax dollars.
- Encouraging government agencies to support and disseminate child sexual abuse information on websites and by other media.
  - Disseminate well-developed and tested educational messages through public service announcements using mass media, social media and personal networks that lead to social change.

REFERENCES


Training should be required for all pre-service professionals who could potentially be hired in a position where they will be a mandated reporter. This should apply to all students who are being educated in any and all higher education programs or courses of study. The training should comprise all topics noted below. Additionally, the passing of a competency test requirement is strongly recommended. All mandated reporters should be trained prior to licensure or certification. If not licensed or certified, training should be within 6 months of employment and/or engagement in youth-serving activities.

Professionals who are mandated reporters should receive training about child sexual abuse and reporting responsibilities on a regular basis. Training should address a demonstrated understanding about professional responsibility and the response systems in place in Missouri.

- All mandated reporters should be required to receive a minimum of 3 hours every other year of continuing education about child sexual abuse.
- Professional licensure requirements that sanction mandated reporting training should be taken every other year with proof of attendance and possibly include a competency test with passing score.

All youth-serving organizations and schools should work with members of their community multi-disciplinary teams or other national, state or local resources to ensure that appropriate training is provided (see section on State and National Resources).

Mandated reporter orientation, continuing education curriculum and materials should include:

- Adult responsibility to prevent child sexual abuse.
- The dynamics of child sexual abuse, including:
  - Definitions of abuse
  - Signs and symptoms
  - Normal sexual behaviors and inappropriate sexual behaviors
  - Child sexual development
  - Anatomical language
  - Red flags of people who sexually abuse
  - Red flags in children’s behavior
- The dynamics of coercive control, including:
  - Child sexual abuse is a violation of power; the abuser holds the power and the abused child is disempowered.
  - The abuser will use manipulative and threatening tactics to control the child, to ensure secrecy and continuation of the abuse.
- How to respond to and skills for handling child sexual abuse disclosures.
- List of professionals who are mandated reporters as defined by Missouri statute.
- Procedures for reporting child abuse.
- How to follow up with members of the appropriate multi-disciplinary team.
- Criminal penalties for non-reporting and immunity.
- Safety planning for victims and non-offending caregivers.
- The training might include information on the following, with specific designations per profession:
  - Legal definitions and statutes pertaining to child sexual abuse.
  - The hotline and child abuse investigation process.
  - Child Advocacy Center model of responding to child sexual abuse.
  - Multi-disciplinary team approach and identifying the role of Child Advocacy Centers, Children’s Division, prosecution and law enforcement in child sexual abuse cases.
  - The dynamics of victimization.
  - Negative organizational policies and procedures that result in victim tampering, a delay in reporting or failure to report.
  - Need for appropriate medical examination and where to find medical providers.
  - Address any discomfort with discussion about child sexual abuse.

REFERENCES


Multi-disciplinary team members and frontline investigation staff should receive a minimum of 8 hours of ongoing continuing child abuse education, including at least 4 hours of cross discipline training, each year. Team members' training should include a nationally recognized, evidence-based forensic interview technique, such as ChildFirst/Finding Words.

Multi-disciplinary team members and frontline employees should participate in orientation and training within 1 month of working directly with children. To address the high turnover rate of frontline team members, orientation should include attendance at a case review meeting.

All members of the multi-disciplinary team should receive mandated reporter training (see APPENDIX B).

Multi-disciplinary team orientation, training, curriculum and materials should include:

- Child Advocacy Center model, including the history and purpose.
- Information on multi-disciplinary team agencies and contact persons, including but not limited to:
  - Children’s Advocacy Center
  - The Prosecuting Attorneys’ Offices
  - Law Enforcement Agencies
  - Children’s Division
  - SAFE-CARE Providers
  - Victim Services
  - Juvenile Office/Family Court
  - Domestic Violence/Sexual Assault Services
  - Mental Health Professionals
  - Other Support Services
- Existing practices, protocols and agreements of the multi-disciplinary team, including information in accordance with the National Children’s Alliance certification requirements.
- Specialized training for each professional role, and cross training of professional roles, to ensure understanding of each discipline and the team’s responsibility for investigating, prosecuting and providing treatment for the victim and non-offending caregiver.
- Importance and implementation of early intervention of child sexual abuse.
- The dynamics of coercive control, including:
  - Child sexual abuse is a violation of power; the abuser holds the power and the abused child is disempowered.
  - The abuser will use manipulative and threatening tactics to control the child, to ensure secrecy and continuation of the abuse.
- The dynamics of domestic violence.
- Understanding different cultural needs of communities and the relevance of cultural competency.
- The need for appropriate medical examination and where to find medical providers.
- Safety planning for victims and non-offending caregivers.
- Common goals of child and non-offending caregiver safety and well-being, trauma reduction, and importance of collaboration for effective investigation and prosecution.
- Information about youth offenders and where to make referrals for treatment.
- Relevant child abuse statutes and regulations.
- The differences between a Children’s Division investigation and law enforcement investigation.
- Estimated timelines for investigation and prosecution.
- Evidence collection, collateral witnesses and other possible sources of corroboration.
- Protocols on how to handle cross-jurisdictional cases.
- The crime of witness intimidation and how to prevent it.
- Vicarious trauma and compassion fatigue of multi-disciplinary team members.

REFERENCES


REFERENCES


Each department should assign personnel to follow up and investigate all reports of child sexual abuse.

All designated personnel should become familiar with Juvenile Court procedures, Children's Division procedures, Child Advocacy Center procedures, and meet with local child abuse multi-disciplinary team members as part of the orientation process.

All law enforcement personnel designated as child abuse investigators should be required to attend a minimum of 16 hours of child sexual abuse training. Training should include a nationally recognized, evidence-based forensic interview technique, such as ChildFirst/Finding Words.

How to investigate Child Sexual Abuse continued…

- Understand digital forensic capabilities and know proper digital evidence procedures.
- Understand offender characteristics and use appropriate interview techniques.
- Separate incident report filed for each investigation initiated, independent of action taken or report written by Children's Division.
- Forensic interviews should be conducted at an accredited Child Advocacy Center within 72 hours of initial report to law enforcement agency, absent extenuating and unusual circumstances.
- Warrant application made to prosecutor, within a reasonable time frame, not later than 45-60 days after the investigation is initiated, absent extenuating and unusual circumstances, recognizing the continued trauma of an ongoing criminal case and reducing trauma to the child.
- Evidence of witness intimidation fully documented.
- Corroborating statements, collateral witnesses and other possible sources of corroboration obtained to the fullest extent possible to achieve maximum potential for effective prosecution.

- All sworn law enforcement personnel, including commanders and front line supervisors should receive a minimum of 4 hours of training during each Police Officers Standards in Training (POST) reporting period on the following topics:

  - Child sexual abuse investigation principles:
    - The multi-disciplinary team approach
    - Child abuse victim interview procedures
    - Child abuse victim and offender characteristics
    - Forensic interview procedures
    - Crime scene procedures
    - Digital evidence capabilities and procedures
    - Incident report procedures

### REFERENCES


RSMo 573-038; Property and material constituting child pornography to remain in custody of state


APPENDIX E
Recommended Guidelines for Prosecuting Attorneys

- Prosecutors should be required to attend a minimum of 20 hours of child sexual abuse training prior to their first child sexual abuse trial. Training should include a nationally recognized, evidence-based forensic interview technique, such as ChildFirst/Finding Words.

- Prosecutors should attend a minimum of 3 hours continuing education on child sexual abuse each year.

- New prosecutors should sit as second chair during a child sexual abuse case prior to sitting as first chair.

- Victims and non-offending caregivers should be notified of the status of the filing decision within a reasonable time frame; but not later than 72 hours absent extenuating and unusual circumstances after the warrant application is presented to the prosecutor’s office by law enforcement.

- Victims and non-offending caregivers should be notified within a reasonable time frame of warrants filed, or “Not Filed” and decisions made; but not later than 45-60 days after the investigation is initiated, absent extenuating and unusual circumstances, so as to recognize the continued trauma of an ongoing criminal case and to reduce the trauma to the child and non-offending caregivers.

- Cases should be finally disposed within 1 year after the investigation is initiated, absent extenuating and unusual circumstances, so as to recognize the continued trauma of an ongoing criminal case and to reduce the trauma to the child and non-offending caregivers.

- Prosecutor should meet in person with victims, non-offending caregivers and witnesses prior to depositions, hearings and trials. It is the prosecutor’s role to inform victims, non-offending caregivers and witnesses of the nature of the questions and setting of depositions, hearings and trial.

- Prosecutor should personally establish rapport with victims and non-offending caregivers prior to trial.

- A support person is allowed in depositions, hearings and trials during victim’s testimony.

- The defendant is excluded from deposition.

- Prosecutor takes an active role ensuring that multi-disciplinary team members are in compliance with National Children’s Alliance standards, which include:
  - Having multi-disciplinary team agreement in place.
  - Compliance with victim rights statutes.
  - Attend forensic interviews when possible.
  - Attend case reviews when possible.

- Evidence of witness intimidation should be aggressively pursued.

- Corroborating statements, collateral witnesses and other possible sources of corroboration utilized to the fullest extent possible to achieve maximum potential for effective prosecution.

- Victims and non-offending caregivers’ long term well being and safety should be considered during the prosecution approach and decisions.

- Pretrial motions, including applicable protective orders for victim confidentiality and comfort, be filed whenever possible.

- Victims should visit the courtroom prior to hearings and trials.

- Victims be allowed to sit with a support person in direct line of sight. The defendant should be situated to be with minimal visibility to the victim. The victim can be instructed on what to do during breaks and side bar conferences.

- Victims, non-offending caregivers and witnesses should be provided with a comfortable and safe place in the courthouse during court proceedings and trials.

REFERENCES


Just as child sexual abuse is a complex and sensitive issue, so is the response and treatment of children who have been sexually abused. There is hope for children who have experienced sexual abuse. With the right kind of help, children can recover and live normal and happy lives. Evidence exists for the effectiveness of trauma-specific treatment for children who have experienced sexual abuse.

Programs informed by an understanding of trauma respond best to children's needs and avoid engaging in re-traumatizing practices. As a result, policy makers and providers should promote training on trauma-informed care.

Practices considered evidenced-based and trauma-specific include these components:

- Build skills at the start of treatment, which will help a child deal with difficult feelings and cope with stress. The child can then use these skills for the rest of his or her life to manage stressful experiences and situations.
- Involve the parent or caregiver in the treatment process.
- Documented evidence that the interventions used are effective for treating the targeted symptoms and have been effective with the specific population.

Critical practice to assure children have the best mental health outcomes include:

- Critical practice for the youth-serving organizations and schools:
  - Foster a system of care or network of multi-discipline providers across the state that support, develop, and implement a trauma-informed approach. These providers could work to:
    - Enhance case management and referral protocol to ensure children receive treatment from mental health professionals qualified to provide a trauma-specific intervention.
    - Establish a requirement for providers to be licensed clinical professionals and maintain documentation verifying they have completed required training in an evidence-based, trauma-specific model of therapy.
    - Identify and make available trauma specific services or interventions for non-offending family and caregivers.
    - Develop and support the mental health workforce to provide specialized, evidence-based, trauma-specific therapies for children who have been sexually abused.

- Critical practice for youth-serving organizations and schools:
  - Promote child serving agencies (for example, law enforcement, child protective services, schools, childcare centers, and early learning programs, as well as shelters) across the continuum to become trauma informed systems and organizations. This means the entire culture has shifted to reflect a trauma approach; looking at all aspects of programming through a trauma lens, constantly keeping in mind how traumatic experiences impact consumers.
  - Increase access to evidence-based trauma-specific services and interventions.
  - Promote trauma-responsive training opportunities for all individuals and organizations involved in the child sexual abuse investigation process.
  - Develop and support the child-serving workforce (to include: teachers, school staff, judges, attorneys, law enforcement, social workers, physicians, nurses, dentist, clergy and others) to have the training, skills and capacity to respond to children and families in a trauma-responsive manner.

- Critical practice for mental health providers:
  - Involve non-offending caregivers and family members in the planning and provision of services as appropriate.
  - Demonstrate evidence of a specialized knowledge base and maintain documentation of ongoing education regarding the state of science in the treatment of child abuse.
  - Provide trauma-specific services and interventions to children who have been sexually abused. Examples of trauma-specific services and interventions are identified below:
    - Alternatives for Families – A Cognitive Behavioral Therapy (AF-CBT)
    - Parent-Child Interaction Therapy (PCIT)
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
    - Other trauma-specific services and interventions can be found on Substance Abuse and Mental Health Service Administration (SAMSHA) National Registry of Evidence-Based Programs and Practices at http://www.nrepp.samhsa.gov/Index.aspx or http://www.nctsn.org.

APPENDIX F
Recommended Guidelines for Mental Health Practice
Glossary of terms proposed by the Substance Abuse and Mental Health Service Administration (SAMSHA) workgroup provided below:

- **TRAUMA-INFORMED APPROACH:** realizes the prevalence and impact of trauma; recognizes the signs of trauma in staff, clients and others; and responds by integrating knowledge about trauma into policies, procedures, practices and settings.

- **TRAUMA-SPECIFIC SERVICES or INTERVENTIONS:** are designed to directly address the impact of trauma and facilitate trauma recovery.

- **TRAUMA AWARE:** aware of trauma and seeks out information.

- **TRAUMA-SENSITIVE:** start applying the concepts of trauma to their setting.

- **TRAUMA RESPONSIVE:** begin to respond differently, making changes in behavior.

- **TRAUMA-INFORMED CARE:** the entire culture has shifted to reflect a trauma approach.

REFERENCES


State and National Resources for Child Sexual Abuse Prevention

American Academy of Pediatrics (AAP)
141 Northwest Point Boulevard
PO Box 927
Elk Grove Village, IL 60007
Phone: 847-434-4000
www.aap.org

American Professional Society on the Abuse of Children (APSAC)
350 Poplar Avenue
Elmhurst, IN 60126
Phone: 630-941-1235
Fax: 630-359.4274
apsac@apsac.org
www.apsac.org

Childhelp
15757 North 78th Street
Scottsdale, AZ 85260
Phone: 480-922-8212
Fax: 480-922-7061
TDD: 800-2AC-HILD
www.childhelp.org

California Evidence-Based Clearinghouse for Child Welfare
Chadwick Center for Children and Families
Rady Children’s Hospital - San Diego
3020 Children’s Way, MC 5131
San Diego, CA 92123
www.cebc4cw.org

Centers for Disease Control and Prevention (CDC)
Rape Prevention and Education (RPE) Program
1600 Clifton Rd.
Atlanta, GA 30333
Phone: 800-232-4636
www.cdc.gov

Child Welfare Information Gateway
Children’s Bureau/ACYF
1250 Maryland Avenue, SW Eighth Floor
Washington, DC 20024
Toll-Free: 800-394-3366
www.childwelfare.gov

CornerHouse
2502 10th Avenue
Minneapolis, MN 55404
Phone: 612-813-8300
Fax: 612-813-8330
info@cornerhousemn.org
www.cornerhousemn.org

Darkness to Light
7 Radcliffe Street, Suite 200
Charleston, SC 29403
Phone: 843-965-5444
Fax: 843-965-5449
Toll Free: 866-367-5444
stewards@d2l.org
www.darkness2light.org

Generation Five
2 Massasoit Street
San Francisco, CA 94110
Phone: 415-285-6658
Fax: 415-861-6659
info@generationFIVE.org
www.generationfive.org

Great Circle
330 N. Gore Ave
St. Louis, MO 63119
Phone: 314-968-2060
www.great-circle.org

Midwest Regional Child Advocacy Center
347 North Smith Avenue
Gardenview Medical Building, Suite 401
St. Paul, MN 55102
Phone: 1-888-422-2955
Fax: 651-220-7637
www.mrcac.org

Missouri Coalition Against Domestic and Sexual Violence
217 Oscar Drive, Suite A
Jefferson City, MO 65101
Phone: 573-634-4161
www.mocadsv.org

Missouri Department of Health and Senior Services
920 Wildwood Drive
Jefferson City, MO 65109
Phone: 573-751-6400
www.health.mo.gov

Missouri Department of Social Services
Children’s Division
205 Jefferson Street, 10th Floor
PO Box 88
Jefferson City, MO 65103
Phone: 573-522-8024
www.dss.mo.gov/cd
Missouri Department of Social Services
Children's Division
Child Abuse and Neglect Hotline
24 Hour Hotline: 1-800-392-3738
www.dss.mo.gov/cd/can.htm

Missouri Children's Trust Fund
Harry S Truman Office Building, Room 860 301
West High Street; P.O. Box 1641
Jefferson City, MO 65102
Phone: 573-751-5147
Fax: 573-751-0254
www.ctf4kids.org

Missouri Department of Mental Health
Phone: 1-800-364-9687
Fax: 573-751-8224
www.dmh.mo.gov

Missouri KidsFirst
(Prevent Child Abuse Missouri)
520 Dix Road, Suite C
Jefferson City, MO 65109
Phone: 573-632-4600
Fax: 573-632-4601
www.missourikidsfirst.org

Missouri Internet Crimes Against Children (MOICAC) Task Force
St. Charles County Sheriff’s Department
101 Sheriff Dierker Court
O’Fallon, MO 63366
Phone: 636-949-3020 Ext 4447
www.moicac.org

Missouri Office of Prosecution Services (MOPS)
P.O. Box 899
Jefferson City, MO 65102
Phone: 573-751-0619
www.mops.mo.gov

Missouri School Boards Association (MSBA)
2100 I-70 Drive Southwest
Columbia, MO 65203
Phone: 800-211-6722
Fax: 573-445-9981
info@msbanet.org
www.msbanet.org

National Center for Child Traumatic Stress (NCCTS)
NCCTS – University of California, Los Angeles
11150 W. Olympic Blvd, Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

NCCTS – Duke University
411 West Chapel Hill Street, Suite 200
Durham, NC 27701
Phone: 919-682-1552
Fax: 919-613-9898
www.nctsn.org

National Center for Missing and Exploited Children
Charles B. Wang International Children’s Building
699 Prince Street
Alexandria, VA 22314
Phone: 703-224-2150
Fax: 703-224-2122
www.missingkids.com

National Child Protection Training Center (NCPTC)
2324 University Avenue, West, Suite 105
St. Paul, MN 55114
Phone: 651-714-4673
Fax: 651-714-9098
admin@ncptc-jwrc.org
www.ncptc.org

National Children's Advocacy Center (NCAC)
Administrative Offices
210 Pratt Avenue
Huntsville , AL 35801
Phone: 256-533-KIDS (5437)
Fax: 256-534-6883
webmaster@nationalcac.org
www.nationalcac.org

National Children's Alliance
516 C Street, NE
Washington DC, 20002
Phone: 800-239-9950
Fax: 202-548-0099
www.nationalchildrensalliance.org

National Coalition to Prevent Child Sexual Abuse and Exploitation
Preventtogether@gmail.com
www.preventtogether.org
State and National Resources for Child Sexual Abuse Prevention

National District Attorneys Association (NDAA)
99 Canal Center Plaza, Suite 330
Alexandria, VA 22314
Phone: 703-549-9222
Fax: 703-836-3195
www.ndaa.org

National Domestic Violence Hotline
PO Box 161810
Austin, TX 78716
Hotline: 800-799-SAFE
Phone: 512-794-1133
www.thehotline.org

National Resource Center for Child Protective Services (NRCCPS)
925 #4 Sixth Street NW
Albuquerque, NM 87102
Phone: 505-345-2444
Fax: 505-345-2626
www.nrccps.org

National Sexual Violence Resource Center (NSVRC)
123 North Enola Drive
Enola, PA 17035
Phone: 717-909-0710
Fax: 717-909-0714
www.nsvrc.org

Prevent Child Abuse America (PCAA)
500 North Michigan Ave, Suite 200
Chicago, IL 60611
Phone: 312-663-3520
Fax: 312-939-8962
mailbox@preventchildabuse.org
www.preventchildabuse.org

Prevention Institute
221 Oak Street
Oakland, CA 94607
Phone: 510-444-7738
Fax: 510-663-1280
prevent@preventioninstitute.org
www.preventioninstitute.org

Rape, Abuse and Incest National Network (RAINN)
(National Sexual Assault Hotline)
2000 L Street, NW Suite 406
Washington, DC 20036
Hotline: 1-800-656-HOPE
phone: 202-544-3064
fax: 202-544-3556
info@rainn.org
www.rainn.org

Safe Start Center
Phone: 1-800-865-0965
info@safestartcenter.org
www.safestartcenter.org

Stop It Now!
351 Pleasant Street, Suite B319
Northampton, MA 01060
Phone: 413-587-3500
Toll-Free: 888-773-8368
info@stopitnow.org
www.StopItNow.org
June 17, 2013

Dear Health Care Provider:

Child victims of sexual abuse will present to the medical community in many different ways. The Missouri Department of Health and Senior Services and the medical community share the responsibility of ensuring that every potential child sexual abuse victim has access to child-focused medical care appropriate for their immediate and ongoing needs.

A Medically-Based Screening Protocol for the Medical Response to Child Sexual Abuse/Assault was written and distributed through the joint efforts of the Department of Health and Senior Services, the Missouri Sexual Assault Forensic Examination-Child Abuse Resource and Education (SAFE-CARE) Network Advisory Council, and Missouri’s Child Abuse Medical Resource Centers (St. Louis Children’s Hospital, Cardinal Glennon Children’s Medical Center, and Children’s Mercy Hospital). The intention of this document is to guide the decision-making involved in directing the initial medical response to a potential child sexual abuse victim toward either necessary emergency care or non-emergent comprehensive care by a provider with the necessary training and resources. The document includes:

1) An overview of the protocol with information on available resources;
2) A copy of the Child Sexual Abuse/Assault Screening Protocol Flow Chart, which has been laminated with the intention that it be posted in a work area for quick accessibility;
3) Two pages of additional information; and
4) A page describing the development and background of this document.

You have been identified as an individual or institution that may be responsible for directing potential child sexual abuse victims into the medical system, via either a medical clinic, urgent care center, emergency care, or investigative agency. We ask that you review the enclosed document and share it with others within your institution.

Victims of child sexual abuse and the families who care for them will look to you for guidance and support through what will likely be a long and difficult journey. It is our goal to encourage and assist you in those efforts. The enclosed document is just one way to offer you that assistance. If you have questions about the enclosed document, please direct them to Mary List, Department of Health and Senior Services at (573) 751-6266 or mary.list@health.mo.gov. If you would like to learn more about training available to providers of medical care for sexually abused children, please contact Darla Vader, Missouri KidsFirst at (573) 632-4600 or darla@missourikidsfirst.org.

Respectfully,

Harold Kirbey, Director
Division of Community and Public Health
Department of Health and Senior Services

Adrienne D. Atzemis, MD, FAAP, Lead Author
Assistant Professor of Pediatrics
Washington University School of Medicine
St. Louis Children’s Hospital

www.health.mo.gov

Healthy Missourians for life.
The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for health.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.
Jim Anderst, MD, MSCI
Chief, Division on Child Abuse and Neglect
Children's Mercy Hospitals and Clinics
Kansas City, Missouri

Claudia Preuschoff, MD, FAAP
Chair, SAFE-CARE Advisory Council
Poplar Bluff Pediatric Associates
Poplar Bluff, Missouri

Timothy Kutz, MD
Director, Division of Child Protection
Cardinal Glennon Children’s Medical Center
Saint Louis University School of Medicine
A Medically-Based Screening Protocol for the Medical Response to Child Sexual Abuse/Assault

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the Appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

The Missouri Sexual Assault Forensic Examination-Child Abuse Resource and Education (SAFE-CARE) Network is a network of medical providers who have received specialized training in the medical evaluation of child maltreatment. These SAFE-CARE providers can provide comprehensive, state-of-the-art medical evaluations to alleged child victims in a child-friendly setting and will frequently collaborate with local agencies responsible for child maltreatment investigations.

To find a SAFE-CARE Provider serving your community, call 800-TEL-LINK (800-835-5465). TEL-LINK is the Missouri Department of Health and Senior Services’ toll-free information and referral line for maternal and child health care. TEL-LINK is answered weekdays from 8:00 a.m. to 5:00 p.m. Central Standard Time. Recorded messages are taken at other times; these calls will be returned during normal business hours.

A medically-based screening process can guide health providers and community partners in determining whether a child requires an immediate medical examination by an emergency health provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by being offered a medical evaluation by a SAFE-CARE Network provider during regular clinic hours.

While most child victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

- The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 3 days (or other locally determined interval up to 7 days).
- The alleged assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
- The child complains of pain in the genital or anal area.
- There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency mental health or social interventions include, but are not limited to:

- Intervention is needed emergently to assure the safety of the child.
- The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.

The Child Abuse Medical Resource Centers share responsibility of training, support, and mentoring of medical professionals working with child physical and sexual abuse issues. Medical providers in need of expert consultation or patient transport may call the 24-hour access lines maintained by these Resource Centers for assistance:

- St. Louis Children’s Hospital: Children’s Direct Access Line 800-678-HELP (800-678-4357)
- SSM Cardinal Glennon Children’s Medical Center: Access Center 888-229-2424
- Children’s Mercy Hospital Kansas City: 800-GO-MERCY (800-466-3729)
A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

Could the contact have resulted in transfer of biologic evidence?

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

Is the child at risk of pregnancy?
- female with signs of pubertal development (such as breast development) and
- penile-vaginal contact is suspected

Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Is the child experiencing symptoms of pain or bleeding?

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Is an emergent intervention needed to assure the safety of the child?

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

Emergency medical care should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

Emergency mental health care should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.

Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.
A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Victims of child sexual abuse present for medical care in many different ways. Some children will tell someone they trust about the abuse. A child does not have to repeat the disclosure to a medical provider to be offered appropriate medical care. A provider must remember that children frequently do not disclose all aspects of the abuse immediately. Some children do not disclose sexual abuse but other credible evidence is obtained or found, such as a witness disclosure or photographs of abuse are found. Providers should use the best and most complete information available in determining the need for emergency medical services.

Frequently, a concerned adult will request a medical evaluation for sexual abuse because of non-specific indications (such as a behavior change) or a strong distrust of a specific person or people in the child’s life. These medically-based screening guidelines will still apply for this patient population, but decisions to perform acute medical interventions should be based on more specific indications that an abusive event has occurred.

Make a Child Abuse/Neglect Report to Missouri Children’s Division.

If a child has disclosed sexual abuse, sexual abuse was witnessed, or there is some other credible reason to believe that a child was sexually abused, then a mandated reporter must report the case to Missouri Children’s Division as directed by Missouri Revised Statute 210.115. It is not the reporter’s responsibility to prove that abuse has occurred prior to making a report. In fact, delaying a mandated report to perform an independent investigation may result in criminal charges and civil liability.

The Children’s Division Child Abuse and Neglect Hotline Unit (CA/NHU) accepts reports of suspected child abuse, neglect, or exploitation. Reports are received through a toll-free telephone line, which is answered seven days a week, 24 hours a day. The toll-free number is 800-392-3738. Persons calling from outside Missouri should dial 573-751-3448.

Trace Evidence Collection:
Could the contact have resulted in transfer of biologic evidence?
Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval)?

Indications that trace evidence collection may provide forensically valuable information include:

1. Debris or body fluid is visible on child’s body or clothing, -or-
2. The contact included possible body fluid (semen, blood, saliva) or debris transfer,
   a. This includes (but is not limited to) a perpetrator licking, biting, or using genitals to touch a child anywhere on their body.
   b. Remember that a child may not disclose or have knowledge of all details of an abusive act; therefore, do not use an assumption of “no ejaculation” or “no penetration” as a reason to defer trace evidence collection.
   -or-
3. Acute genital injury indicating an abusive event is detected during physical examination, regardless of history provided.
Local Child Abuse Multi-Disciplinary Teams (MDTs) composed of local representatives from law enforcement, Children’s Division, Child Advocacy Centers, and medical providers will determine how long after an alleged sexual abuse event trace evidence collection will be recommended. Each MDT will use information from local crime laboratories to assist in determining how likely it is that trace evidence collection may lead to a forensically relevant positive result.

When determining how long after an alleged abusive act trace evidence should be collected, use your local MDT agreed upon interval, which may range from 1-7 days, depending on the age of the child and the nature of contact.

1. After 24 hours, the likelihood of obtaining trace evidence from a young child’s body is low.
2. It is well established that trace evidence collection from anywhere on or in a child is never indicated past 7 days.
3. Clothing and bedding from a scene may yield positive results even years after the crime has occurred. Encourage law enforcement investigators to collect evidence from the scene or clothing as soon as possible.

Is the child at risk of pregnancy?
Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Pregnancy prophylaxis is available and should be offered to females who meet the following criteria:

1. History of menarche or has a Sexual Maturity rating (breast or pubic hair) of 3 or greater, and
2. Suspected penile-vaginal contact, with or without a history of penetration, condom use, or ejaculation, and
3. Contact occurred in the previous 5 days.

Is the child experiencing symptoms of pain or bleeding?

Current anogenital pain or bleeding may represent a traumatic injury from sexual abuse/assault or other medical condition which requires emergency medical intervention. A history of distant anogenital pain or bleeding, now resolved, typically does not require emergency medical care; but that historical information should be communicated to the medical provider responsible for the scheduled comprehensive medical evaluation.

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

An appropriate medical or mental health provider should evaluate any concern that a child’s behavior or emotional state represents a danger to themselves or others (including but not limited to suicidal/homicidal thoughts). Emergency care may include crisis counseling, mental health evaluation, and/or treatment plan.

Is an emergent intervention needed to assure the safety of the child?

A child victim of sexual abuse should be protected from possible perpetrators during the investigation. If a child remains at risk for sexual abuse, Missouri Children’s Division and local law enforcement should be notified to evaluate the circumstances and establish a safety plan.
Background: The SAFE-CARE Advisory Council provides guidance regarding services, education, networking, quality assurance, and consultation. Advisory Council members include professionals from nursing, medicine, social work, and child advocacy centers.

The SAFE-CARE Advisory Council has developed these recommendations to comply with Missouri Revised Statutes Section 334.950.4: “The SAFE CARE network shall develop recommendations concerning medically based screening processes and forensic evidence collection for children who may be in need of an emergency examination following an alleged sexual assault. Such recommendations shall be provided to the SAFE CARE providers, child advocacy centers, hospitals and licensed practitioners that provide emergency examinations for children suspected of being victims of abuse.”

References:


A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Make a Child Abuse/Neglect Report to Missouri Children’s Division 800-392-3738

Could the contact have resulted in transfer of biologic evidence?

- Yes
  - Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?
    - Yes: Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
    - No: Emergency medical care should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

- No
  - Is the child at risk of pregnancy?
    - No
      - Is the child experiencing symptoms of pain or bleeding?
        - No
          - Is the child displaying behavioral or emotional problems that put themselves or others in danger?
            - No
              - Is an emergent intervention needed to assure the safety of the child?
                - No: Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

    - Yes: Emergency mental health care should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.

    - Yes: Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.

  - Yes
    - Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?
      - Yes
        - Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
      - No
        - Emergency medical care should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

    - No: Is the child at risk of pregnancy?
      - No
        - Is the child experiencing symptoms of pain or bleeding?
          - No
            - Is the child displaying behavioral or emotional problems that put themselves or others in danger?
              - No
                - Is an emergent intervention needed to assure the safety of the child?
                  - No: Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

      - Yes: Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.

      - Yes: Emergency medical care should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
Child Sexual Abuse/Assault Medical Response Protocol

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

A medically-based screening process can guide medical professionals and community partners in determining whether a child requires an immediate medical examination by an emergency medical provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by contacting the nearest Children’s Advocacy Center (CAC) so that the child may be referred to a medical provider skilled in addressing non-acute child sexual abuse.

While most child abuse victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

- The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 3 days (or other locally determined interval up to 5 days).
- The reported assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
- The child complains of pain in the genital or anal area.
- There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency medical health or social interventions include, but are not limited to:

- Intervention is needed emergently to assure the safety of the child.
- The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.

The flowchart on the next page is meant to support medical professionals and facilities in their decision-making when a child presents to them with allegations, suspicions, or signs of child sexual abuse. The place where you, your institution, or community refers a child for acute sexual assault exams may vary depending on when the child presents to you. There is a place on the flowchart to fill in your local business-hours contact and the after-hours/weekend contact to whom you may refer a child for an acute sexual assault exam. For non-acute sexual abuse exams, your local Children’s Advocacy Center will be able to point you to the nearest provider or facility with specially-trained medical professionals and support specific to these children’s needs.

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1 This protocol has been a project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. It has been endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.
A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

**MANDATED REPORTING**—Make a child abuse/neglect report to CPS and law enforcement.

Could the contact have resulted in transfer of biologic evidence?

Could the contact have resulted in transfer of biologic evidence?

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 5 days)? Refer to additional info on trace evidence collection.

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 5 days)? Refer to additional info on trace evidence collection.

Is the child at risk of pregnancy?
- Female with signs of pubertal development (such as breast development) AND
- Penile-vaginal contact is suspected

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Is the child at risk of pregnancy?
- Female with signs of pubertal development (such as breast development) AND
- Penile-vaginal contact is suspected

Is the child experiencing symptoms of pain or bleeding?

Is the child experiencing symptoms of pain or bleeding?

Is the child experiencing symptoms of pain or bleeding?

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Is an emergent intervention needed to assure the safety of the child?

Is an emergent intervention needed to assure the safety of the child?

Is an emergent intervention needed to assure the safety of the child?

Contact your local CAC to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

Contact your local CAC to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

Contact your local CAC to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.

**CPS: Hotline 800-352-6513**

**State Police Detachment:** _____________________________

**Local CAC:** _____________________________

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact your local Children’s Advocacy Center (CAC) to determine appropriate follow-up care.

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact your local Children’s Advocacy Center (CAC) to determine appropriate follow-up care.

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact your local Children’s Advocacy Center (CAC) to determine appropriate follow-up care.

Emergency medical care to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact your local Children’s Advocacy Center (CAC) to determine appropriate follow-up care.

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Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact your local Children’s Advocacy Center (CAC) to schedule a comprehensive sexual abuse medical evaluation.
Victims of child sexual abuse present for medical care in many different ways. Some children will tell someone they trust about the abuse. A child does not have to repeat the disclosure to a medical provider to be offered appropriate medical care. A provider must remember that children frequently do not disclose all aspects of the abuse immediately. Some children do not disclose sexual abuse but other credible evidence is obtained or found, such as a witness disclosure or photographs of abuse are found. Providers should use the best and most complete information available in determining the need for emergency medical services.

Frequently, a concerned adult will request a medical evaluation for sexual abuse because of non-specific indications (such as a behavior change) or a strong distrust of a specific person or people in the child’s life. These medically-based screening guidelines will still apply for this patient population, but decisions to perform acute medical interventions should be based on more specific indications that an abusive event has occurred.

All medical providers are mandated reporters (West Virginia Code §49-6A-2). Any mandated reporter “who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources: Provided, That in any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint.”

It is the responsibility of the medical provider(s) evaluating the child to follow the mandated reporting statute. It is not the reporter’s responsibility to prove that abuse has occurred prior to making a report. In fact, delaying a mandated report to perform an independent investigation may result in criminal charges and civil liability. Use the chart below to fill in your local information. There is space on the flowchart above to document this information for quick access.

Indications that trace evidence collection may provide forensically valuable information include:

1. Debris or body fluid is visible on child’s body or clothing, -or-
2. The contact included possible body fluid (semen, blood, saliva) or debris transfer,
   a. This includes (but is not limited to) a perpetrator licking, biting, or using genitals to touch a child anywhere on their body.
b. Remember that a child may not disclose or have knowledge of all details of an abusive act; therefore, do not use an assumption of “no ejaculation” or “no penetration” as a reason to defer trace evidence collection—or-

3. Acute genital injury indicating an abusive event is detected during physical examination, regardless of history provided.

Local Child Abuse multidisciplinary investigative teams (MDITs) composed of local representatives from law enforcement, Child Protective Services (CPS), Children’s Advocacy Centers (CACs), prosecutors, mental health providers, and medical providers will determine how long after a reported sexual abuse event trace evidence collection will be recommended. MDITs will use information from the West Virginia State Police Forensic Laboratory to assist in determining how likely it is that trace evidence collection may lead to a forensically relevant positive result.

When determining how long after a reported abusive act trace evidence should be collected, use your local MDIT agreed upon interval, which may range from 1-5 days, depending on the age of the child and the nature of the contact.

1. After 24 hours, the likelihood of obtaining trace evidence from a young child’s body is low.
2. It is well established that trace evidence collection from anywhere on or in a child is never indicated past 7 days.
3. Clothing and bedding from a scene may yield positive results even years after the crime has occurred. Encourage law enforcement investigators to collect evidence from the scene or clothing as soon as possible.

Figure 5: See pg. 5

Figure 6: Is the child at risk of pregnancy? Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Pregnancy prophylaxis is available and should be offered to females who meet the following criteria:

1. History of menarche or has a Sexual Maturity rating (breast or pubic hair) of 3 or greater; and
2. Suspected penile-vaginal contact, with or without a history of penetration, condom use, or ejaculation; and
3. Contact occurred in the previous 5 days.

Figure 8: See pg. 5

Figure 9: Is the child experiencing symptoms of pain or bleeding?

Current anogenital pain or bleeding may represent a traumatic injury from sexual abuse/assault or other medical condition which requires emergency medical intervention. A history of distant anogenital pain or bleeding, now resolved, typically does not require emergency medical care, but that historical
information should be communicated to the medical provider responsible for the scheduled comprehensive medical evaluation.

**Figure 10:** See pg. 5

**Figure 11:** Is the child displaying behavioral or emotional problems that put themselves or others in danger?

An appropriate medical or mental health provider should evaluate any concern that a child’s behavior or emotional state represents a danger to themselves or others (including but not limited to suicidal/homicidal thoughts). Emergency care may include crisis counseling, mental health evaluation, and/or treatment plan.

**Figure 13:** Is an emergent intervention needed to assure the safety of the child?

A child victim of sexual abuse should be protected from possible perpetrators during the investigation. If a child remains at risk for sexual abuse, Child Protective Services and your state police attachment should be notified to evaluate the circumstances and establish a safety plan.

**Figures 5, 8, 10, 12, 14, 15:** Locating a medical provider with specialized training in identifying and treating child abuse.

**NOTE:** Always make sure to make a mandated report to CPS and law enforcement as soon as a child presents.

**Normal Business Hours (Monday-Friday, 9am-5pm):** Your local Children’s Advocacy Center (CAC) can assist you in referring to a medical provider with specialized training in identifying and treating child abuse in emergency and non-emergency situations. If your county falls outside of an official CAC service area, a child may still be able to receive courtesy services. Please call the CAC in your nearest neighboring county. If you need additional assistance in locating a provider, please call the West Virginia Child Advocacy Network at 304-414-4455 during normal business hours.

**After Business Hours:** Follow your facility’s protocols, make a mandated report to CPS and law enforcement, and follow up with your local CAC as soon as possible.
Background

The West Virginia Child Advocacy Network (WVCAN) and a multidisciplinary committee it has convened have adapted these guidelines from “A Medically-Based Screening Preotocol for the Medical Response to Child Abuse/Assault” with permission from Missouri’s Sexual Assault Forensic Exam-Child Abuse Resource and Education (SAFE-CARE) Network. http://health.mo.gov/living/families/injuries/safecare/

The SAFE-CARE Advisory Council provides guidance regarding services, education, networking, quality assurance, and consultation. Advisory Council members include professionals from nursing, medicine, social work, and child advocacy centers.

The SAFE-CARE Advisory Council developed these recommendations to comply with Missouri Revised Statutes Section 334.950.4: “The SAFE CARE network shall develop recommendations concerning medically based screening processes and forensic evidence collection for children who may be in need of an emergency examination following an alleged sexual assault. Such recommendations shall be provided to the SAFE CARE providers, child advocacy centers, hospitals and licensed practitioners that provide emergency examinations for children suspected of being victims of abuse.”

References


Thacheray JD, Hornor G, Benzinger EA, Scribano PV. Forensic Evid
Child Physical Abuse Medical Response Protocol

This protocol is intended to help health care providers identify children who may be victims of physical abuse and provides information on how to report suspected abuse, how to refer cases to a medical provider with specialized training in the identification and treatment of child physical abuse, and what steps to take in addition to serving that child’s basic medical needs. The guidelines below provide only general characteristics of accidental and non-accidental pediatric injury; the clinician must be guided by his or her professional assessment of individual case circumstances.

1 This protocol has been a project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. It has been endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.
All medical providers are mandated reporters (West Virginia Code §49A-6A-2), meaning suspected cases of child abuse must be reported to Child Protective Services (CPS) and law enforcement. It is not the reporter’s responsibility to prove that abuse has occurred prior to making a report.

If you need to make a referral for medical care, Children’s Advocacy Centers (CACs) can help you identify medical providers with specialized training in identifying and treating child abuse during normal business hours. If it is after business hours, follow your facility’s protocols, make a mandated report to CPS and law enforcement, and follow up with your local CAC as soon as possible. If you need additional assistance in locating a provider, please call the West Virginia Child Advocacy Network at 304-414-4455 during normal business hours.
### Suggestive of Non-Accidental Pediatric Injury

**MANDATED REPORTING**
- Child Protective Services: 800-352-6513 (Hotline)
- Local State Police Detachment: ____________________

To locate a medical provider with specialized training in identifying and treating child abuse, call your local CAC: ____________________

### INJURY STORY

**Story of injury circumstances presents persistent ambiguities, conflicts, contradictions:**
- Different stories from household members/incident witnesses
- Caretaker story changes significantly over time
- Story inconsistent with: injury type, injury severity, child’s expected post-injury behaviors, or expected injury location and distribution on the body
- Story circumstances inconsistent with age-appropriate child behaviors/capabilities

### CARETAKER BEHAVIOR

| Unusual caretaker behaviors manifest—violent or impaired behaviors / unexplained; inappropriate during patient presentation / hospitalization | Document thoroughly in chart, especially excited utterance, in quotes |
| Unexplained / inappropriately late presentation of child by caretaker to medical attention, or presents with injury complications such as infection |

### EXAM FINDINGS

<table>
<thead>
<tr>
<th>For non-mobile child presenting with SOFT TISSUE INJURY or FRACTURE:</th>
<th>For children &lt;1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Any soft tissue injury on a child that can’t cruise</td>
<td>• CT scan of the head without contrast</td>
</tr>
<tr>
<td>□ All fractures, fresh or healing, without a clear accidental explanation (e.g., car crash)</td>
<td>For Children 0-2 years:</td>
</tr>
</tbody>
</table>

#### Soft tissue inflicted injury characteristics in a cruising/walking child:

| □ Multiple grouped injuries anywhere and/or distributed over more than one body plane | | **All Children:** |
| □ Injury involving primarily posterior body surfaces, or the torso, neck, frenula (oral cavity), or ears | □ Bruising to body areas not directly overlying boney prominences |
| □ Bruising associated with localized petechial hemorrhages | □ Any injury that forms a pattern or shape |
| □ Soft tissue injuries involving more than one cause (e.g., burns and bruises together) | □ All immersion burns |
| □ All immersion burns | |

#### Infants and children with any of the following fractures:

| □ Displaced fracture, classic metaphyseal lesions | □ Save admit blood and all other first day bio samples |
| □ Presentation of fracture with healing changes (periosteal/callus formation) or malunion | |
| □ Skull fracture that is complex, diastatic, or associated with neurologic signs | |
| □ Fractures of ribs, scapula, vertebral processes, orbital fractures, multiple fractures of differing ages | |

#### Suspected intentional poisoning in infancy or early childhood:

| □ UDS positive for non-prescribed pharmaceuticals such as narcotics or benzodiazepines, or inappropriate over the counter medicine such as Benadryl, etc. | |
| □ Presentation of unexplained altered sensorium without anatomic findings | |
| □ Prior admission for drug toxicity | |
WEST VIRGINIA CAN STRENGTHEN THE MEDICAL RESPONSE TO CHILD ABUSE

2014 Project Report

WHY WV CAN INITIATED THE PROJECT
The West Virginia Child Advocacy Network (WVCAN) is composed of 20 Children’s Advocacy Centers across the mountain state. These CACs are invaluable community-based resources that serve children and families after concerns of child abuse and neglect arise. These services include forensic interviews, medical care, mental health care, and case coordination. However, the quality of child abuse-related medical care they can connect children to depends on where those facilities are located in the state. The goal of the WVCAN-initiated project is to give families equal access to specially-trained medical providers who work alongside CACs and other medical and non-medical members of the child protection community across the state. To facilitate this, new tools and guidelines must be developed, agency cultures must shift, and professionals must be supported so that every child abuse victim receives a basic standard of care.

WHAT WVCAN PROPOSES
- WVCAN recommends the creation of a statewide child abuse medical program, to be operated by a public agency, which systematically addresses current deficiencies by supporting the professional development of child abuse medical providers and by enhancing multidisciplinary team collaboration in the effort to improve the medical response to child abuse in West Virginia.
  - WVCAN believes that the WV Bureau for Public Health is the right agency to operate this program because of its mission to promote health equity and the protection and improvement of the health of all West Virginians.
- To build this program, WVCAN recommends the following:
  - West Virginia creates a sustainable network of specially-trained providers who meet national standards to whom CACs, CPS, law enforcement and medical facilities can immediately refer children and families.
  - Medical providers have access to ongoing education and support as well as opportunities for case review to improve quality and processes or medical care related to a team approach to child abuse, prevention, detection and prosecution.
  - Medical protocols and consistent guidelines are established and effectively disseminated statewide.
  - Medical and non-medical members of the child protection community work together on behalf of families and West Virginia’s future.
  - Our children have equal access to consistent, quality medical care regardless of where they live or the alleged abuse occurs.

The West Virginia Child Advocacy Network (WVCAN) is grateful to the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation for their support of this project.
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Who We Are

The West Virginia Child Advocacy Network (WVCAN) is the statewide coalition of all local Children’s Advocacy Centers (CACs) in the Mountain State. Founded in 2006 with a membership of 2 nationally-accredited centers and a handful of developing centers, today the WVCAN membership roster includes 20 established and developing centers in West Virginia’s major cities, as well as in small rural communities. Our membership reflects the vast diversity of West Virginia, all with their own unique approach to fulfilling a shared mission of protecting and providing for children. WVCAN offices are located in the Schoenbaum Center in Charleston, WV.

What We Do

WVCAN works side-by-side with 20 children's advocacy centers throughout the Mountain State to minimize trauma for abused children, break the cycle of abuse, and hold offenders accountable by offering services in the following five areas:

Community Awareness and Advocacy
We believe the foundation to eradicating child abuse is communities having the courage to talk about it and make it a priority. WVCAN works to increase public understanding about child abuse and the effectiveness of the children’s advocacy center intervention model through statewide awareness campaigns and educating policymakers.

Training & Technical Assistance
WVCAN provides tools and best-practice solutions to community-based CACs and multidisciplinary team professionals to ensure a cutting-edge response to emerging trends in child abuse.

Evaluation and Assessment: We believe ongoing success in the fight against child abuse requires continual evaluation of current efforts and exploration of new, more effective ways to do this work.

Funding
At the heart of our mission is a commitment to support the sustainability of local children’s advocacy centers so that they may continue to help young victims rebuild their lives.

Membership
We support the professionals doing this challenging work by providing communication platforms, networking opportunities, and valuable services.

CACs
WVCAN and its member CACs seek to provide a positive intervention for the children who are served by our network. CACs have two clients—the child victims and the Multidisciplinary Investigative Team (MDIT) that addresses the allegations of abuse. CACs provide a child-friendly facility where the professionals come to the children in a collaborative and coordinated response. CACs facilitate forensic interviews of child victims, provide victim advocacy and court preparation, provide or make referrals to therapy which is trauma-focused as well as tracking referrals for medical evaluations and assuring that
medical information is available to the MDIT. The CAC manages and tracks a case to its conclusion. Similarly, a CAC facilitates coordination between the MDIT professionals (prosecuting attorney, medical and mental health providers, CPS workers, Law Enforcement Officers, and victim advocates) who meet at least monthly to review open cases and make decisions about them. This process eliminates multiple interviews of the child and facilitating the sharing of information among the different professionals and agencies.

**Project Background**

With the exception of providers in Morgantown and Charleston, the vast majority of the medical professionals performing child abuse exams in other West Virginia communities are recruited and trained by developing CACs. Despite the best efforts of CACs in West Virginia, there are still many gaps in services and resources statewide. WVCAN has convened a multidisciplinary workgroup to explore solutions to the issues of accessibility and quality of child abuse medical care statewide.

Starting with its first meeting in early 2011, the WVCAN Medical Initiative Workgroup identified needs that must be addressed to ensure a standard quality of medical care for all abused children in West Virginia. This group initially included representatives from the Office of the Chief Medical Examiner, WV Child Fatality Review Team, WVU Medical School, WV Foundation for Rape Information and Services, the two pediatricians in WV with the Child Abuse Pediatric Subspecialty, and other medical providers currently doing child abuse examinations in the state. This group has expanded to include representatives from the WV Crimes Against Children Unit, WV Department of Health and Human Resources, WV Hospital Association, WV State Senate, and the Prosecuting Attorneys Institute.

**Child Abuse Medical Care**

**What’s the purpose of an exam?**

As part of the multidisciplinary model to helping child abuse victims, the medical evaluation has both therapeutic and forensic value. The child abuse medical evaluation serves many purposes including\(^1\):

- Help ensure the health, safety, and well-being of the child
- Diagnose, document, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Diagnose, document, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family.

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\(^1\) Standards for Accredited Members, National Children’s Alliance, revised 2011.
**Who can do child abuse exams?**

The National Children’s Alliance’s (NCA) standards for child abuse medical services focus on two requirements for providers—specialized training in the evaluation and treatment of child abuse and the need for these medical professionals to engage in ongoing quality improvement activities to remain current in the field. Physicians, nurse practitioners, physician assistants and nurses may all engage in medical evaluation of child abuse when they are able to meet these two criteria. The NCA Standards expand to specify what types of training and quality improvement activities meet these requirements.²

**What if a child is too young to disclose abuse?**

Child abuse can occur at any age and in any community, but the youngest children in our community are the most vulnerable. Child abuse investigations often revolve around a child’s disclosure, but common practice typically excludes children under 3 years of age from being interviewed by child protection professionals. The result is that the most vulnerable children are typically not receiving services at the outset of their abuse, meaning they may be left in an abusive situation for a long time unless one professional can demonstrate that abuse is occurring sooner³.

A study by the West Virginia Child Fatality Review Team (2009-2011) illustrates this vulnerability. Half of the children who died from caretaker maltreatment in this timeframe received medical evaluations due to concerns of abuse before their deaths. Their ages ranged from 2 days to 3 years, meaning they were too young to be interviewed by child protection professionals (See Appendix 7). Without a child’s disclosure to drive a child abuse investigation, one of the only ways to protect the youngest children from further abuse and death may be the diagnosis from a well-trained medical provider who recognizes the signs and symptoms of a child’s abuse before the child is subjected to further harm.

**Assessing WV’s Child Abuse Medical Resources**

A statewide resource assessment was conducted to find out where providers were located who regularly evaluate and treat suspected child abuse victims in West Virginia (See Appendix 1). WVCAN found that the quality and accessibility of child abuse medical services varies statewide. (See Appendices 2, 3, and 4) When children are not able to access high-quality child abuse medical care, misdiagnosis or uncoordinated team responses can leave victims unprotected from further trauma and injury. Access to child abuse medical services is vital to a child-focused community response to suspected abuse. Last year, 535 children received child abuse medical care through West Virginia’s CACs. However, not all children have access to the same standard of care in our state. With the exception Morgantown and Charleston, the majority of the medical professionals who are trained to perform child abuse exams elsewhere are recruited and trained by community-based CACs. Despite their best efforts of CACs across West Virginia, gaps in service and resources exist, often because clinicians lack appropriate training.

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² Standards for Accredited Members, National Children’s Alliance, revised 2011.
Other existing resources were also documented (See Appendix 5). WVCAN searched for existing educational venues, technological resources, and partnerships that could be utilized in the pursuit of improving West Virginia’s child abuse medical care.

Another part of this resource assessment consisted of identifying other states with systems in place to enhance the medical response to child abuse (See Appendices 1 and 6). By comparing West Virginia’s existing resources and processes with model systems in other states, the project was able to identify the ways in which West Virginia could improve. Through this multiple-method assessment, WVCAN and the workgroup it has convened have been able to generate recommendations and plans for improving West Virginia’s child abuse medical care.

West Virginia is Falling Behind

In 2011 West Virginia led the country in the number of child fatalities due to maltreatment at 4.16 deaths per 100,000 children in our state’s population⁴. In a retrospective review of child homicides, the West Virginia Child Fatality Review Team (2009-11) found that 20 of 33 child deaths were due to caretaker maltreatment. Half of them received medical attention before their deaths, but only 8 examinations produced findings that correctly identified likely abuse. Each child received an average of 2.2 medical visits with concerns of abuse prior to their deaths. However, none of these children in imminent danger were ultimately protected (See Appendix 7). While the fatalities caused by abuse are surely the most tragic mark that child abuse leaves on our society, the trauma endured by survivors for a lifetime is another important reason why our response to child abuse must continue to improve.

Based on the Midwest Regional Children’s Advocacy Center’s 2013 national survey regarding CAC-based medical trends, West Virginia lags behind the national average for getting child abuse victims the medical attention they need. Nationally, 35% of children served at CACs received medical evaluation⁵. The percentage of children served at West Virginia’s CACs who received medical evaluation was 20%, according to recent data compiled by WVCAN. The figure drops to 14% when data from the state’s only hospital-based CAC is eliminated. In addition, some communities in West Virginia where CACs exist have no providers who are trained to perform child abuse exams to which to refer their clients. In those situations, family members must travel long distances to find a qualified provider, an inconvenience further complicated because no formal network or list of trained providers exists and is therefore available to them.

In addition, some clients who have received medical services say improvements can be made. Data compiled from WVCAN surveys (July-Dec 2013) of non-offending caregivers point to poor access and lagging quality of abuse-related medical services. Of the 151 caregivers who were surveyed at 13 different CACs, 63% said his or her child was satisfied with the medical care received. 17% of caregivers surveyed said they were dissatisfied with the care their child received.

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⁵ Current Trends in Forensic Interviewing and Medical Services, Midwest Regional Children’s Advocacy Center 2013 Annual Survey Results; Standards for Accredited Members, National Children’s Alliance, revised 2013.
A Vision for Change

There are many barriers faced by children, families, and multidisciplinary teams who seek child abuse medical care in this state. The medical initiative workgroup has a vision for how to build on existing strengths and resources to improve the accessibility and quality of child abuse medical care in West Virginia.

<table>
<thead>
<tr>
<th>Current</th>
<th>Desired</th>
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</thead>
<tbody>
<tr>
<td>Today the quality of child abuse-related medical care depends on where a child lives in West Virginia.</td>
<td>All West Virginia children and families have equal access to consistent, quality medical care regardless of where the alleged abuse occurs.</td>
</tr>
<tr>
<td>A child abuse victim may be taken to several different medical providers and facilities as they, their families, and the professionals helping them struggle to find appropriate care.</td>
<td>CPS, law enforcement, and medical facilities can immediately refer children and families to a network of specially-trained providers meeting national standards after abuse is disclosed.</td>
</tr>
<tr>
<td>Due to burn-out and lack of support, West Virginia is losing providers who are trained to effectively determine when a child has been harmed or is at risk of being harmed.</td>
<td>Structured professional development activities, such as ongoing education and peer review, available to child abuse medical providers.</td>
</tr>
<tr>
<td>Poor communication or lack of coordination among members of the MDIT keeps children in danger longer which can lead to additional abuse, even death.</td>
<td>Medical protocols for child abuse examinations standardize care and minimize trauma for children.</td>
</tr>
<tr>
<td>Abuse is sometimes overlooked or misdiagnosed by medical providers, leaving children unprotected and in danger.</td>
<td>First-point-of-contact medical providers (pediatricians and ER staff) are trained to identify and treat physical abuse as part of a coordinated team response.</td>
</tr>
<tr>
<td>No single entity coordinates training, resources, and development.</td>
<td>A statewide child abuse medical program established and operated by a public agency.</td>
</tr>
</tbody>
</table>

Other states have found a solution and better outcomes for children in creating a statewide child abuse medical program that addresses these key issues (See Appendix 6 for state-by-state program details). Training medical professionals and investigators, ensuring payment for child abuse medical treatment, and structuring services so that all children receive a standard quality of services are critical components of any successful and enduring statewide programs for child abuse medical care.  

Common Themes of Child Abuse Medical Programs in Other States

Network of qualified medical providers
Most states that were examined had a way to designate specially-trained child abuse medical providers who meet national standards from other medical professionals. In some cases, this designation identifies a provider as a member of a branded network of child abuse medical providers who meet

certain training and professional development standards. In other cases, these providers are identified by being associated with a CAC or the local multidisciplinary team response. The identity and designation as a qualified provider has many benefits to the team response—multidisciplinary team members and the medical community do not have to make guesses when it comes to finding a qualified provider to examine a child abuse victim.

Training and/or ongoing education for medical providers
Some states formally deliver the initial medical training, which teaches providers the very basics of doing forensic medical exams. These trainings are usually meant to bring providers up to national standards for the basic education needed to perform child abuse medical exams. Most states provide ongoing medical training, either in person, via webinars, or through online coursework. These ongoing education opportunities update child abuse medical providers on changes and advancements in the field, and support their work within the multidisciplinary team response.

Training for non-medical multidisciplinary team members
States also train team members either in person or via webinars. Training for multidisciplinary team members often focuses on educating them about the medical exam, collecting evidence and communicating findings with medical professionals, and when/how to refer a child to specialized medical care.

State funding to reimburse providers for child abuse exams
Most states face challenges in adequately reimbursing child abuse medical providers for exams. Medical providers often rely on insurance, Medicaid, and/or Crime Victim Compensation programs for reimbursement. A shortcoming to these mechanisms is that a provider may bill at a certain amount, but they are not guaranteed to be reimbursed at that amount. Some states have additional pots of money to pay for exams, but these pots of money are often limited to certain types and certain parts of child abuse exams. For example, some of these funding sources will pay for the forensic part of the exam but not the rest of the medical evaluation.

State funding for infrastructure of statewide system as a whole
Statewide child abuse medical systems often receive state funding to cover the administrative cost of the programs. These funds will usually cover staff, training, technology needs (like telemedicine platforms), etc.

Formalized case consultation, networking, and/or peer review for medical providers
Each state has a different way of connecting child abuse medical providers to in-state experts (usually child abuse pediatricians) and to one another. Many states use web-based technology to facilitate these connections, and often for various purposes. Some programs offer (or require) peer review/consultation on exam findings for newer or non-expert providers. Others offer case reviews and education webinars in which medical providers (and sometimes multidisciplinary team members) can learn and network with one another.

Telemedicine-assisted (live) medical exams
Some states with very rural populations are utilizing telemedicine to facilitate live child abuse medical evaluations. An expert, usually a child abuse pediatrician, can observe and guide a remote provider during the exam. Sometimes this is used as a professional development and support tool for very new child abuse medical providers.
**Web-based programming**
The cutting edge of child abuse medicine relies heavily on web-based programming. Most states offer webinars, online materials, web-based peer review/case consultation, etc.

**Program Centralization**
Many of these programs are run through larger state agencies, universities, state chapters of CACs and/or some combination of the three.

<table>
<thead>
<tr>
<th>Comparison: Established Programmatic Resources of Statewide Child Abuse Medical Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State</strong></td>
</tr>
<tr>
<td>Network of qualified medical providers</td>
</tr>
<tr>
<td>Training and/or ongoing education for medical providers</td>
</tr>
<tr>
<td>Structured training for non-medical multidisciplinary team members</td>
</tr>
<tr>
<td>State funding to reimburse providers for child sexual abuse exams (acute and/or non-acute)</td>
</tr>
<tr>
<td>State funding to reimburse providers for child physical abuse exams</td>
</tr>
<tr>
<td>State funding for infrastructure of statewide system (partial or for whole system)</td>
</tr>
<tr>
<td>Formalized case consultation, networking, and/or peer review for medical providers</td>
</tr>
<tr>
<td>Telemedicine-assisted (live) medical exams</td>
</tr>
<tr>
<td>Web-based programming (peer review, consultation, networking, educational webinars, etc.)</td>
</tr>
</tbody>
</table>

* These are available in West Virginia, but not structured to be delivered in a consistent and systematic manner AND/OR they do not fully meet the existing needs in our state.

WVCAN recommends the creation of a statewide child abuse medical program, to be operated by a public agency, which systematically addresses current deficiencies by supporting the professional development of child abuse medical providers and by enhancing multidisciplinary team collaboration in the effort to improve the medical response to child abuse in West Virginia.
Key Issues & Recommendations

With information gathered from the resource assessment and dialogue with medical providers and multidisciplinary team members around the state, there are several key issues identified by the WVCAN medical initiative workgroup that must be addressed so that children and families have equal access to consistent, quality medical care regardless of where they live or where the alleged abuse occurs. To establish a sustainable statewide system that meets the needs of children, families, and child protection professionals, the following key issues must be addressed.

Identifying Qualified Medical Providers: WV creates a sustainable statewide network of specially-trained providers who meet national standards to whom CACs, CPS, law enforcement and medical facilities can immediately refer children and families.

Other statewide child abuse medical programs have at their core a cadre of medical providers who meet national standards and engage in ongoing professional development. These providers are members of an identifiable and branded network that child protection professionals (CPS, law enforcement, CACs, etc.) can immediately refer children and families to after an allegation of abuse or neglect. This eliminates any ambiguities in finding a medical professional with specialized training in identifying and treating child abuse.

A survey conducted by WVCAN indicates some WV communities refer children and families elsewhere for child abuse medical care, even when local resources are available. Sometimes children may be referred from one facility to another as professionals struggle to find a medical provider who is specially-trained, available, and willing to conduct a child abuse medical exam. West Virginia does not currently have a formalized and identifiable network of qualified medical professionals, but the development of one would simplify the process in which child protection professionals locate the nearest appropriate medical provider. In addition to developing this formal network of qualified providers, WVCAN also recommends the establishment of a standard of practice for child abuse medical providers in West Virginia.

Delivering Professional Development: Child abuse medical providers and multidisciplinary team members are supported with structured activities for ongoing professional development and support.

In addition to the medical and social concerns they must address, providers must also be able to effectively collaborate with other professional disciplines that help children and families through these crises. For all these reasons, specialized child abuse medical training is imperative to a provider’s ability to thoroughly address all the needs a child and family will have from them.

Professional development activities, such as ongoing education and expert review of case findings are critical to keeping child abuse medical providers up-to-date in their practice. Through engagement in these educational and quality-improvement activities, providers can continue to deliver the highest quality of care to child abuse victims and their families while working as a part of the multidisciplinary team. Likewise, educating non-medical team members about the medical component of child abuse investigation and treatment will enhance collaboration so that further abuse, ongoing safety concerns, mistaken accusations, and fatalities can be avoided. There is currently no system to deliver these activities in a consistent and structured manner to medical and non-medical professionals in West
Virginia, although there are resources available to help initiate these activities as part of an established professional development program. WVCAN recommends that the statewide child abuse medical system have a multi-faceted professional development arm that offers:

- Ongoing education for child abuse medical providers and multidisciplinary team members
- Peer review for child abuse medical providers
- Educational case review—informal online networking of West Virginia’s child abuse medical providers
  - Opportunity for medical providers to discuss de-identified cases with educational value
  - Platform for educational topic presentations
- Formal Case Consultation—a formal process by which medical providers and child protection professionals can access medical expertise on any child abuse case, as needed

**Standardizing Care:** *Establish protocols for medical providers, medical facilities, and multidisciplinary team members that standardize care and minimize trauma for children.*

Although local multidisciplinary teams establish their own protocols for the medical evaluation of suspected victims of child abuse, a child and family may come to the attention of these professionals in a number of ways. Sometimes local protocols leave gaps in care through certain situations. Ineffective collaboration between medical professionals, child protection workers, and law enforcement leads to compromised safety for children when abuse is misidentified or unrecognized. There are currently no statewide protocols or guidelines to help medical providers, medical facilities, and multidisciplinary team members understand when, where, and how to refer children to appropriate providers. There are also no protocols to establish a medical standard of care for child abuse victims.

Developing and implementing such protocols would help to standardize the response that children in West Virginia receive. WVCAN recommends the following:

- Develop statewide protocols that recommend a standard of medical care for children facing sexual and/or physical abuse.
- Develop statewide, discipline-specific protocols to identify and guide the referral of children to timely medical care from specially-trained child abuse medical providers.
- Develop tools, guidelines, and resources to allow for more efficient and thorough collaboration between child abuse medical providers and non-medical members of the multidisciplinary team when investigating and treating child abuse.
- These protocols/recommended methodologies be integrated into electronic medical records and/or hospital electronic administrative systems.

Additionally, WVCAN recommends further evaluation of the barriers that prevent children from receiving adequate child abuse medical. This information can be used to drive future development and programming of the statewide child abuse medical system.

**Planning for Financial Sustainability:** *Clear mechanisms to reimburse medical providers for care and to sustain the infrastructure of the statewide system, as a whole, must be established.*

West Virginia’s child abuse medical providers are currently billing private insurance and/or Medicaid for child abuse medical evaluation and treatment. There is still no simple way for providers to be reimbursed for this service. For example, money from West Virginia’s Forensic Medical Exam Fund can
only be used if a provider uses a rape kit. Children often delay disclosure of abuse beyond the time frame where physical evidence can be collected, making the fund inaccessible. Some states have set aside state dollars to help cover the costs of child abuse medical evaluations. Eventually a clear and potentially separate payment mechanism must be developed that fits the realities of how child abuse medical evaluations are performed in West Virginia.

The infrastructure of the statewide system, including the professional development programming, protocols that standardize care, maintenance of the network of providers, etc. must also be permanently housed and funded. For other statewide child abuse medical programs, state funding has been a critical component of success for the system as a whole. In the interest of long-term sustainability, WVCAN recommends that the infrastructure be housed within an appropriate state agency and ultimately supported by state funding.

**Supporting Local Development:** Local grassroots development of child abuse medical providers and programs around the state must be supported with technical assistance.

WVCAN believes that no child in West Virginia should have to travel more than an hour from home to receive medical care after an allegation of child abuse. Community-level efforts have been the main driving force behind the development of current child abuse medical resources around the state. When a community is interested in creating or strengthening their community’s medical response to child abuse, they must have access to information, technical assistance, and support as they work to identify, recruit, and train a new provider.

**Disseminating Resources:** All resources, protocols, and information related to the statewide child abuse medical system must be available online.

WVCAN recommends developing a web-based repository of information related to the statewide child abuse medical system. This includes the protocols and guidelines, a calendar of events, etc.

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Appendix 1

Methodology
To get a clearer picture on existing providers in the state, a survey of current child abuse medical providers was conducted to understand more about who in West Virginia is doing child abuse medical exams and where they are located. To supplement this, an assessment of existing resources in each county was also completed. Together, the survey and the county-specific assessments can highlight gaps throughout the state where, in general, medical services and providers exist but where children are not able to access child abuse medical care.

Survey Methodology
In conjunction with the child abuse pediatrician consulting for the project, the project director generated a brief survey to send to medical providers who conduct any type of child abuse medical exams. This survey asked about their level of practice, how long they had been doing child abuse medical exams, whether or not they used telemedicine in any way for child abuse medical work, whether or not they engaged in peer review for child abuse medical work, how children were typically referred to them for child abuse medical needs, and what these providers did when a child had positive signs of child abuse.

To locate providers who were currently doing child abuse medical work, the project director called each CAC to identify what provider(s) and/or facility they partnered with to meet the needs of the children served at their center. To meet accreditation standards, a CAC must have medical exams available to all children either on-site or through community linkages from providers with specialized training in the identification and treatment of child abuse. Additionally, the project director called each county Child Protective Services (CPS) office to determine where field workers take children for child abuse medical exams. All identified providers were contacted and asked to take the survey. Of 42 surveys sent, 29 were returned. Some of the respondents did not currently conduct child abuse medical exams or always referred to another provider/facility, which further helped the project identify gaps in knowledge and services (See Appendix 2).

Research Methodology
To discern current service levels and client satisfaction, current data from CACs was collected and analyzed. This includes annual service statistics for the most recent reporting year (July 2012—June 2013). Annual service statistics track demographic trends in CAC services, such as number of children served, their age, what types of concerns brought them to the CAC, whether or not the child disclosed, the number of children who receive CAC services such as a medical exam, and criminal justice outcomes. The majority of West Virginia’s CACs also participate in a nationally-modeled Outcome Measurement System (OMS). OMS measures satisfaction of non-offending caregivers and multidisciplinary team members with services received at the CAC or through CAC referrals. (See page 5)

Child population by county was estimated using Census data. The number of certain types of medical providers, such as pediatricians, was established by counting the number of providers per county on a mailing list of licensed physicians. (See Appendix 4)
Other models of statewide child abuse medical systems were explored by contacting directors of those programs. Typically, these directors would recommend contacting another 2-3 states with established or developing models. When calls were made, conversations typically focused on training and professional development for child abuse medical providers, how the system was administered, how children were referred to qualified providers, and how the system and child abuse exams are funded. (See Appendix 6)

This resource assessment also explored the current and possible uses of telemedicine as a tool to be used in the delivery of child abuse medical services. To do this, current telemedicine sites and programs in West Virginia were located. As this project made contact with other statewide child abuse medical systems, directors were asked if and how telemedicine was being used in their program. (See Appendices 5 and 6)
Appendix 2

Key Survey Findings

1. Some communities refer children to a provider located up to 2 hours away. This may be because there are no local providers able or willing to conduct a child abuse medical evaluation or the county may generally have limited medical resources.
   a. However, it was also shown that some counties that refer children to medical attention outside the local community are not necessarily counties lacking medical resources in general. These counties may have hospitals, primary care centers, and private practice physicians who could potentially be recruited and trained to provide child abuse medical evaluations.

2. Child protective services, law enforcement, and child advocacy center staff in the same county sometimes identified a different medical provider to whom they referred children for medical attention. It appears team communication is breaking down in several local communities when children are being referred to medical services.

3. Counties on the West Virginia border often have well-developed relationships with medical providers in other states. These providers are usually geographically closer than the nearest WV provider who can address child abuse.

4. A minority of current child abuse medical providers are receiving formalized peer review on their child abuse cases.

Level of practice of surveyed medical professionals in WV

*Note: Medical providers who responded to the survey and always refer children to another provider were not counted here. Additionally this list has excluded respondents who have left this area of practice since taking the survey. This list does not include all current child abuse medical providers in West Virginia—only those who responded to the survey.

- Medical Doctors
  - 2 Board-Certified Child Abuse Pediatricians
  - 4 Pediatricians (excludes above mentioned Child Abuse Pediatricians)
  - 3 Family Practice
  - 1 Forensic Pathologist
- 3 Sexual Assault Nurse Examiners (SANEs)
- 2 Forensic Nurse Examiners
- 1 Advanced-Practice Registered Nurse
- 2 Nurse Practitioners
- 1 Emergency Room Nurse
- 1 Registered Nurse
Training in Child Abuse Evaluation and Treatment

Current child abuse medical providers received training from a variety of different resources:

- Training received in residency
- Sexual assault nurse examiner (adult and/or pediatric) trainings
- Through resources provided through a CAC, such as the online Medical Training Academy
- American Academy of Pediatrics child abuse resource materials
- American Professional Society on the Abuse of Children (APSAC) Advanced Training Courses
- On-the-job training
- Board certification in child abuse pediatrics (2 providers at CAMC in Charleston)
- Ongoing training through American Nurses Association
- Forensic Nurse Practitioner training
- Training received at conferences

Limitations: This survey did not seek to document training certificates to ensure the provider was meeting national standards or the number of exams provided per year.
Appendix 3

Map of Current WV Providers

The map below outlines the location of medical providers who are consistently conducting child abuse medical exams in their community as of March 2014. The location of these providers is overlaid onto the current map of Children’s Advocacy Centers.
## Appendix 4: County by County Resources

<table>
<thead>
<tr>
<th>County</th>
<th>Child Population</th>
<th>Child Abuse Medical Providers</th>
<th>CAC</th>
<th>Hospitals</th>
<th>Primary Care Centers</th>
<th>Pediatrics</th>
<th>Family Practice</th>
<th>General Practice</th>
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<td>Pediatrists</td>
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<td>General Practice</td>
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</table>

**WVCAN Strengthen The Medical Response to Child Abuse - 2014**
<table>
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<tr>
<th>County</th>
<th>Child Population</th>
<th>Child Abuse Medical Providers</th>
<th>CAC</th>
<th>Hospitals</th>
<th>Primary Care Centers</th>
<th>Pediatricians</th>
<th>Family Practice</th>
<th>General Practice</th>
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<td>Tygart Valley</td>
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<td>4</td>
</tr>
</tbody>
</table>

* 3 providers in Winchester, VA serve multiple counties in the Eastern Panhandle.
Appendix 5

Other Resources Available

Resources are available to develop and support child abuse medical services in West Virginia. Some professional support activities, such as expert peer review of exam findings, are available online.

Training

- The National Children’s Advocacy Center offers an annual in-person Medical Training Academy. This training is specifically designed for medical professionals who have the responsibility for providing the medical evaluation for children who are suspected victims of child abuse. This training is appropriate for physicians, nurse practitioners, Sexual Assault Nurse Examiners (SANEs) or other registered nurses (RNs) with advanced training, and physician’s assistants with less than 2 years of experience in the field of child abuse evaluation.
- The Midwest Regional Children’s Advocacy Center offers an on-demand Online Medical Training Academy. Online Medical Training Academy is a rigorous set of online modules to prepare medical providers in correctly identifying and diagnosing child physical and sexual abuse. This training is appropriate for physicians, nurse practitioners, SANEs and other RNs with advanced training, and physician’s assistants that have experience in the field of child abuse evaluation.
- Pediatric Sexual Assault Nurse Examiner (SANE-P) trainings are available occasionally in-person in West Virginia and quarterly online through the Midwest Regional Children’s Advocacy Center.
- The Midwest Regional Children’s Advocacy Center also offers other online trainings on the medical evaluation of child abuse. Many of these web-based classes are free and available on-demand. Some of these webinars are meant for medical providers while others are meant for non-medical child abuse professionals to learn about the medical component of child abuse work.
- WVCAN will be hosting its first statewide conference in 2014 that will have a track specifically for child abuse medical providers. WVCAN’s 2014 Conference: The Team Response to Child Abuse is a 2-day multidisciplinary training opportunity for child abuse professionals in fields such as law enforcement, child protective services, mental health, medical, judicial, addictions, prevention, education and domestic violence. The conference’s medical track will include workshops on abusive head trauma, photo-documentation and history-taking in child abuse cases, variations of normal anogenital findings in children, and the child abuse medical provider in court. Some surrounding states host similar trainings for medical providers.

Peer Review

Independent review of medical exam interpretation is recommended by the National Children’s Alliance. The Midwestern Regional CAC offers myCasereview as an online anonymous expert review program. Participation in myCasereview is not to be utilized for “second opinions” or initial diagnoses. Rather, it is meant for medical peer review of examination findings in sexual abuse cases, to further facilitate accurate diagnoses by medical providers examining children who have been sexually abused. This professional development activity allows providers to work under the guidance of child abuse experts as they advance in their practice. WVCAN has some free case slots available for CAC-affiliated medical providers in West Virginia to allow them to access this tool.
Telemedicine

The field of child abuse medical evaluation is fast-evolving, and the practice is moving away from expensive culposcopic equipment and towards HIPAA-compliant web based platforms and standard digital cameras to document exams and share findings. Other states are using such platforms for peer review, expert consultation, remote preceptorship between new and advanced child abuse medical providers, and for training purposes (webinars). The two most common platforms are WebEx and TeleCAM. It is clear that such technologies will be critical tools in supporting the work of child abuse medical providers in West Virginia.

Model Protocols

The West Virginia Protocol for Responding to Victims of Sexual Assault, by the West Virginia Foundation for Rape Information and Services, Inc., contains a thorough chapter on child sexual abuse exams. This protocol does not contain a step-by-step process to guide medical providers in when to refer to an experienced and specially-trained provider. Missouri’s SAFE-CARE system (See Appendix 6) has a guideline that utilizes a flowchart as a quick-reference guide for medical providers when a child presents to them with suspicions or disclosures of sexual abuse. These guidelines, “A Medically-Based Screening Protocol for the Medical Response to Child Sexual Abuse/Assault,” help medical providers distinguish between acute and non-acute sexual assault and what to do for that child. The protocols also guide medical professionals in finding their nearest specially-trained provider.
http://health.mo.gov/living/families/injuries/safecare/

Maryland’s CHAMP program (See Appendix 6) has guidelines to help CPS and law enforcement decide when to seek medical consultation for suspected child abuse and neglect. Similar to Missouri’s program, Maryland’s also makes it easy for child protection professionals and the medical community to identify their nearest qualified provider.
http://mdchamp.org/resources/referral-guidelines
Appendix 6

Other States Assessed

Leaders from statewide child abuse medical programs from the following states were contacted: Missouri, Wisconsin, Florida, Indiana, Texas, Oregon, New York, Arkansas, North Carolina, Oklahoma, Utah, Maryland, and Georgia. These states had either established, fledgling, or developing programs. Each program is unique in the way it strengthens the state’s medical response to child abuse, although common themes did arise (discussion below).

Arkansas

Support for Health-Involved Professionals at Safety Centers

This program, administered through the University of Arkansas for Medical Sciences, helps meet the training and peer review needs of child abuse medical providers. Child sexual abuse medical exams in Arkansas are largely done by pediatric sexual assault nurse examiners (pSANEs), many of whom work through CACs. Peer review is done individually as needed, and in groups quarterly. Telemedicine plays a key role in this system, and CACs that do on-site medical exams have a unit to do video conferencing around the state.

Florida

Child Protection Teams

Florida’s Child Protection Teams (CPTs) are led by a medical director, and are a component of a multidisciplinary team. CPTs launched in 1981 before the widespread development of CACs in the state, but they now often work in close collaboration. Agencies bid for the CPT contract, and sometimes a CPT is run through the local CAC. When a local CPT is located somewhere other than the local CAC, they must at least have a working agreement together. The Department of Health (DOH) manages the program, and there is one CPT in each district of the Department of Children of Families (which is part of the DOH). Medical providers within the system have 2-3 meetings per year, and peer review is done during those meetings. The CPT medical directors are reimbursed $35,000 per year through DOH funds for 1 day per week of work related to the CPTs (many of the physicians are private practice and this is not their full-time job). Local medical providers and facilities know to refer to these specialized providers as the CPT medical directors are branded as local experts. The CPT program office develops handbooks and procedures and manages the data system, CPT-IS. Each team can enter information and pull out reports from CPT-IS, and this is how child abuse referrals are processed once they are called into the hotline.

Georgia

Leadership in improving Georgia’s medical response to child maltreatment largely comes from hospital-based CACs. Georgia’s child abuse medical providers are networked through peer review and webinars, and working towards formalizing their network in other ways. As a national leader in the use of telemedicine and web-based programming, medical providers and MDIT members in the state receive
ongoing education via monthly webinars. There are periodically conferences run by the hospital-based CACs that also deliver ongoing medical education. Medical providers have access to online group peer reviews and one-on-one peer reviews. For one-on-one peer reviews, the medical provider at the CAC based at Children’s Healthcare of Atlanta can either use telemedicine to facilitate a live remote child abuse exam or review findings on a store-and-forward basis (non-live). Although many of these activities are donor-funded, there has been some state funding to help establish and maintain telemedicine sites that are used for child abuse medical exams and care. The Georgia Partnership for Telehealth oversees most telemedicine sites/programs (of different kinds) around the state, and CACs/child abuse medical providers partner with them in some of these initiatives.

**Indiana**

*Advancing the Medical Role in Child Protection*

This program is supported by a grant through the state’s Department of Child Services, and administered through Indiana University and their staff of 4 child abuse pediatricians. This program currently has ten community-based physicians who serve as ‘champions’ to further medical education and offer support/consultation to their local communities. Participating physicians are paid $15,000 per year for their role in helping their local communities and for conducting child abuse exams, and are required to participate in ongoing training, child protection teams, and child fatality review teams. The 10 physicians address their local community’s needs and are available for education, consultation, etc. Although local child protection professionals and investigators can contact their nearest contracted physician (among the 10) for consultation, questions can also be directed towards the child abuse pediatricians if something cannot be addressed locally. At least one of the four child abuse pediatricians is always on call to do consultations for child protection professionals. It is mandatory for Department of Children and Families case workers to consult the child abuse pediatricians on fractures and burns in any child under age 3 and head/neck injuries for any child under age 10. The child abuse pediatrician can help ensure that the child receives the proper evaluation and treatment, with consultation usually done over the phone and through sharing photographs of children’s injuries. Among the four child abuse pediatricians, they conduct 3000 consults per year for physical abuse and 1000 for sexual abuse, and conduct 750-800 exams. This program also offers training (typically regional, in person) to members of the multidisciplinary team, the medical community, and the general public in the recognition and reporting of child abuse. Depending on the community, these physicians may be the provider to a local CAC, and the program as a whole collaborates with CACs. The four child abuse pediatricians are the official medical providers for multiple CACs.

**Maryland**

*The Maryland Child Abuse Medical Professionals’ Network (CHAMP)*

This program came into existence in 2005 through legislation and funding to develop expertise to guarantee that children get medical treatment from specialized providers. Today, CHAMP provides training three times per year for medical providers who are members of the network of specially-trained medical professionals. The program utilizes a web-based HIPAA-compliant program (TeleCAM) to upload a child’s medical history and exam photodocumentation so that child abuse medical providers can get quick-time consultation from program faculty, who are experts in the field. It is administered through the medical school at the University of Maryland with money through the state’s Department of Health.
On the program’s website, there are referral guidelines to help CPS and law enforcement decide when to seek medical consultation for suspected child abuse and neglect and a map to help professionals locate the nearest CHAMP provider.

**Missouri**  
*Sexual Assault Forensic Exam-Child Abuse Resource and Education (SAFE-CARE)*

This program is housed in Missouri KidsFirst, which is the state chapter of CACs as well as a chapter of Prevent Child Abuse America. SAFE-CARE delivers basic and ongoing training to medical providers, teaching them how to conduct child abuse exams as well as keeping them up-to-date in their practice. Training for non-medical multidisciplinary team members is also available 2-4 times per year that also includes a component to educate team members about the medical component of child abuse investigations. The SAFE-CARE network of providers consists of medical professionals who meet national standards for basic training and programmatic standards for ongoing education and mentoring. The mentoring program, Quality Improvement System (QIS), connects SAFE-CARE providers to in-state child abuse pediatricians for peer review and case consultation via a HIPAA-compliant web-based platform. This program has also established protocols that direct medical providers and facilities to refer children to SAFE-CARE providers for non-acute sexual abuse care since these providers have specialized training in identifying and treating child abuse. State funding for training comes through the Missouri Department of Health and Senior Services, whereas providers are reimbursed for child sexual abuse exams from state funds through the Department of Public Safety.

**New York**  
*Child Abuse Medical Providers (CHAMP)*

The CHAMP program was established in 1997 with a grant from the state’s Department of Health. One of the first projects was to develop the comprehensive web-book, Child Abuse Evaluation & Treatment for Medical Providers (www.ChildAbuseMD.com). The second website provides child abuse information for medical professionals and non-medical members of multidisciplinary teams (www.CHAMPprogram.com). Online coursework is available free of charge, and some of it offers continuing medical education (CME) credits and American Board of Pediatrics Maintenance of Certification (MOC) for a fee. Medical providers who are ‘CHAMP-trained’ maintain that designation through ongoing education, and are part of a recognized ‘brand’ of specially-trained providers to whom child protection professionals and the medical community can turn to. CHAMP providers can also apply for mentorship through the program. With a grant from the state’s Department of Health, a system of case review was developed, but funding dissolved in recent financial crises and the program is not operational now. Currently the program is funded at $75,000 per year to improve the state’s response to suspected child abuse. Activities include: 6 educational webcasts that offer CME credit (open to providers out of state), maintenance and expansion of the network of medical provider, monitoring of continuing education requirements for active CHAMP medical providers, scheduling of mentorships and tracking medical resident rotations, and weekly informal case discussion via webcast for CHAMP Mentors.
North Carolina

Child Medical Evaluation Program (CMEP)

Established in 1976, CMEP is a cooperative effort of the University of North Carolina School of Medicine’s Department of Pediatrics, the NC State Division of Social Services, the NC Legislature, local Departments of Social Services, and local medical and mental health providers. The CMEP staff has developed a statewide network of local providers who perform medical and psychological assessments of children referred by Division of Social Services agencies to help determine the presence or extent of abuse and neglect. These medical providers may or may not be associated with a CAC. For quality assurance, new providers have their first 5 cases reviewed by a child abuse pediatrician, then all CMEP providers submit 2 cases per year for review and must have 10 hours of child abuse continuing medical education every 2 years. The state network of CACs has an annual conference that delivers basic child abuse medical training and can bring providers up to national standards (not paid for by CMEP funding), plus an annual 1-day update medical training. The big CAC conference also trains non-medical multidisciplinary team members on the medical component of child abuse cases. Providers are reimbursed for services through a contract with the State Office of Social Services and/or Medicaid.

Oklahoma

Oklahoma’s chapter of CACs facilitates quarterly peer review for all child abuse medical providers. All CACs have a video conferencing unit, and the peer review program is run in partnership with the Oklahoma Health Sciences Center. Members of the multidisciplinary team are also invited to watch the peer review and review questions. Consultation is done informally with an in-state pediatrician. The state also has a memorandum of understanding meant to limit serial examinations of children by emphasizing a team decision when referring a child to medical care.

Oregon

Child Abuse Multidisciplinary Intervention (CAMI) Program

In 1997, the state legislature allocated funds to this program for the establishment of regional centers and the expansion of community child abuse assessment services throughout the state. There are currently 5 regional CACs that facilitate training and peer review for child abuse medical providers throughout the state. The program also has a document published by the State Office of Services to Children and Families to guide medical providers in the evaluation of sexual abuse. When a child presents with suspicious injuries that are found in the course of an investigation, and it is unclear how they occurred or suspected to be from abuse, Karly’s Law mandates a particular response from investigators. They must immediately photograph the injuries or obtain them from someone else, the multidisciplinary team must identify the local child abuse medical provider, and within 48 hours that child must be examined.

Texas

Texas has some existing resources and programs already in place to enhance the medical response to child abuse, but is working to further strengthen the state’s medical response. The state legislature mandated the creating of the Medical Child Abuse Resources and Education System (MEDCARES) which provides grants to improve medical evaluations of child abuse. Grantees are located at major children’s
hospitals, and the specially-trained medical professionals there can provide child abuse exams, training to MDIT members, and consultation. The Forensic Assessment Center Network (FACN) collaborates closely with MEDCARES, and provides 24-hour consultation and recommendations to CPS workers, nurses, and administrators in cases of suspected abuse. That network consists of physicians from six medical schools in Texas, and all of the state’s counties are divided into districts covered by these providers. However, similar to WVCAN’s findings, Children’s Advocacy Centers of Texas, Inc. (CACTX) found that only 21% of CAC-served children in Texas were receiving child abuse medical care, as opposed to the national average of 35%. With funding through the Children’s Justice Act, CACTX partnered with the Child and Family Research Institute at the University of Texas at Austin to develop a comprehensive statewide and literature assessment. The report, Child Abuse Medical Evaluations in Texas: Current Practices and Challenges, outlines findings from literature reviews, statewide discipline-specific focus groups, and statewide surveys that aimed to find out what challenges the child protection system faced in delivering child abuse victims to medical care. Based on the findings, the report also makes recommendations for improving the rate of medical evaluations for child abuse victims in Texas.

**Utah**

Unlike the more typical stand-alone 501c3 model of CACs, all of Utah’s CACs are government entities (and are called CJC’s). The program consists of state-funded contract between CJC’s and a children’s hospital. A portion of the money pays child abuse medical providers’ salaries. All providers who are contracted to this program have access to initial and ongoing training, and they receive 100% peer review of case findings by a child abuse pediatrician. Peer review and consultation is facilitated via a web-based HIPAA-secure platform, TeleCAM. Occasionally, new providers will receive in-person mentoring. They are also increasing efforts to network these providers for peer-to-peer conversation and to train multidisciplinary team professionals on the medical component.

**Wisconsin**

*Wisconsin Child Abuse Network (WI CAN)*

WI-CAN is a developing collaborative and educational network of medical providers and investigators (child protective service workers and law enforcement professionals) dedicated to increasing the use of medical expertise in child abuse investigations to improve the accuracy of investigations and the safety of children and families. This network provides monthly webinars to medical providers and investigators, with a primary focus on physical abuse topics and developing topics in child sexual abuse. Funding from the Department of Children and Families supports the online platform for these webinars. The program also provides web-based peer review for child abuse exams.
Appendix 7

West Virginia Child Fatality Review Team Findings—Retrospective Review of 2009-2011 Child Homicides

<table>
<thead>
<tr>
<th>The Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Homicides in WV (2009-2011)</td>
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<tr>
<td>Child Homicides due to caretaker maltreatment</td>
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<tr>
<td>Maltreated children who received medical attention due to concerns of abuse before their deaths</td>
</tr>
<tr>
<td>Age range</td>
</tr>
<tr>
<td>Average age</td>
</tr>
<tr>
<td>Average number of medical visits per child for concerns of abuse prior to death</td>
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</table>

<table>
<thead>
<tr>
<th>Characteristics of Prior Medical Contacts (N=22)</th>
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</thead>
<tbody>
<tr>
<td>Medical visits resulting in referral to CPS</td>
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<tr>
<td>Visits to the emergency room</td>
</tr>
<tr>
<td>Visits to a pediatrician</td>
</tr>
<tr>
<td>Visit with “forensic” doctor (child died prior to consult opinion)</td>
</tr>
<tr>
<td>Findings: Likely child abuse</td>
</tr>
<tr>
<td>Assessments by physicians untrained in the recognition of child abuse</td>
</tr>
</tbody>
</table>

* CPS determined that 3 of these 10 children were in imminent danger, but ultimately none of them were protected.

How did we fail them?

Failure to determine imminent danger

- Facial bruising of non-cruising infant
- Facial bruising and petechiae
- Bilateral ear bruising in an infant
- Facial bruising and “limp” in a toddler
- Bilateral facial bruising due to a “fall”
- Determination of failure to thrive: child returned to caretaker
- Serious burn with delayed presentation to medical care
- Multiple (5) visits to emergency room for physical trauma

Uncoordinated protection efforts

- Poor documentation of injuries
- Failure to provide comprehensive injury investigation and share findings
- Failure to provide protective hospitalization
TEXAS MEDICAL EVALUATION REFERRAL GUIDELINES
When to Refer Children for Medical Evaluations: Guidelines for Texas Children’s Advocacy Centers

March 2014

Endorsed by the Texas Pediatric Society and the Children’s Hospital Association of Texas
Acknowledgements

The guidelines and best practices contained herein were developed to assist Texas children’s advocacy centers and their multidisciplinary teams in determining when to refer children of alleged sexual and physical abuse and neglect for medical evaluations. Child Abuse Pediatricians, Sexual Assault Nurse Examiners and other certified medical professionals who are members of the Texas Pediatric Society and/or the Children’s Hospital Association of Texas contributed to the content of this publication and formally endorse these recommendations.

Children’s Advocacy Centers™ of Texas, Inc. is particularly grateful to James Lukefahr, M.D., with the University of Texas Health Science Center in San Antonio, and Bryan Sperry, M.S., president of Children’s Hospital Association of Texas, who led the effort and contributed valuable time and expertise in the development of these guidelines. Dr. Lukefahr headed the subcommittee of the Texas Pediatric Society that was specifically formed to develop content and obtain input from other child abuse experts. Mr. Sperry conducted several meetings of member children’s hospitals to focus almost exclusively on discussion of the various drafts of the guidelines.

This final product is a significant step toward ensuring consistent, comprehensive treatment for all children of suspected abuse and CACTX appreciates the endorsement of these organizations and the important work they do for the children of Texas.
When to Refer Children for Medical Evaluations: Guidelines for Texas Children’s Advocacy Centers

OVERVIEW

Medical evaluations are a critical piece of both the therapeutic and criminal justice responses to the suspected sexual and physical abuse of children, as well as in cases of neglect. A medical evaluation assesses the child’s emotional and physical health, while also providing crucial forensic findings that will aid in the investigation of concerns of abuse.

These guidelines have been developed for use by children’s advocacy centers and their multidisciplinary teams for determining which children of suspected sexual or physical abuse or neglect would benefit most from a medical evaluation. While the primary focus of the guidelines is to ensure that the emotional, psychological and medical needs of the child are met, there are also important secondary considerations for the investigative and prosecutorial processes, for the following reasons:

- The information provided by a child to a doctor or nurse during a medical evaluation may be an exception to the evidentiary hearsay rule (A child sometimes discloses additional information to a medical examiner that he or she did not reveal during the forensic interview).
- When a child has disclosed an act that could have resulted in injury or infection, but is not subsequently referred for a medical evaluation, the child's disclosure may be made to appear less credible. The implication is that the non-medical MDT members did not consider the disclosure concerning enough to complete the evaluation for potential residual problems.

RESPONSE LEVELS

Note that these guidelines are divided into three different response levels to be used in determining the need for a medical evaluation. They include:

- **Criteria A:** When a child is first encountered by a non-medical MDT member and has not yet had a medical evaluation after an injury or an outcry of abuse.

- **Criteria B:** When a child has been treated for suspected abusive injuries by a medical provider, including a first responder (EMS), who is not part of the MDT. Review of the case by the MDT’s medical consultant is recommended.

- **Criteria C:** Other specific situations that should be reviewed with the MDT medical consultant to determine the need for medical evaluation.
**SEXUAL ABUSE**

**Criteria A:** For a child first encountered by a non-medical MDT member and who **has not yet had a medical evaluation** after an outcry of sexual abuse:

<table>
<thead>
<tr>
<th>Criteria A – Sexual Abuse:</th>
<th>Referral for Complete Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact of abuser’s mouth with child’s genitals or anus at any time</td>
<td>Indicated if reported by child or witnessed by another individual</td>
</tr>
<tr>
<td>Contact of abuser’s genitals with child’s genitals or anus at any time</td>
<td>Indicated if reported by child or witnessed by another individual</td>
</tr>
<tr>
<td>Contact of abuser’s hands or fingers with child’s genital or anus</td>
<td>Indicated if child reports pain or bleeding with event OR if concern child made incomplete disclosure</td>
</tr>
<tr>
<td>Any of the above types of contact, having occurred <strong>within the past 96 hours and thus likely requiring forensic evidence collection</strong></td>
<td>Urgent referral to Sexual Assault Nurse Examiner program or Child Abuse Pediatrics medical facility affiliated with MDT.</td>
</tr>
</tbody>
</table>
| Risk for partial or incomplete disclosure or recantation, regardless of type of contact reported by child. | Examples of risk factors:  
  ▪ Caregiver does not believe child  
  ▪ Child is protecting the alleged abuser  
  ▪ Child is reluctant to talk (based on forensic interview)                                                                                                            |
| Preteen sibling of a preteen child confirmed to have STD                                 | Examination and testing indicated                                                                                                                                                                                                     |

**Criteria B:** For a child who has **already been treated by a medical provider**, who is not part of the MDT. It is recommended that the MDT medical consultant review case and medical information and determine the need for follow up. Some children will need an examination by a clinician with expertise in child abuse, some will need a record review by a clinician with child abuse expertise, and some will need no further medical assessment.

<table>
<thead>
<tr>
<th>Criteria B-Sexual Abuse</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child examined and report initiated by a non-MDT provider for genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child</td>
<td>Prompt review by MDT medical expert recommended to assess likelihood of sexual abuse and possible need for further examination, testing, or treatment.</td>
</tr>
<tr>
<td>Child or adolescent diagnosed by a non-MDT medical provider with an abnormal examination or an STD</td>
<td>Prompt review by MDT medical expert recommended to assess likelihood of sexual abuse and possible need for further examination, testing, or treatment.</td>
</tr>
</tbody>
</table>
PHYSICAL ABUSE/NEGLECT

Criteria A: For a child first encountered by non-medical MDT members and who has *not yet had a medical evaluation* for his/her injury or outcry of physical abuse or neglect

<table>
<thead>
<tr>
<th>Criteria A – Physical Abuse/Neglect:</th>
<th>Referral for Complete Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child is 0-6 months of age</td>
<td>Indicated for any injury</td>
</tr>
</tbody>
</table>
| Patterned bruises, lacerations or burns (Examples: belt loop, cigarette burn, curling iron, etc.) | ▪ Indicated if child has limited verbal skills (age 5 or under or speech-delayed)  
▪ Indicated if injuries are widespread or causing pain |
| Child states he/she has been hit in the face, hit with an object, whipped, punched, slapped, kicked or beaten. | ▪ Indicated if child has limited verbal skills (age 5 or under or speech-delayed)  
▪ Indicated at any age if injuries are visibly widespread or causing pain  
▪ Indicated if witnessed by someone else |
| Child appears malnourished or starved and/or demonstrates deprivational behaviors. | Examples:  
▪ Child begs for food or eats out of the trash.  
▪ Infants who chew excessively on objects or hands. |
| Siblings or housemates of children with injuries or conditions that are being evaluated for serious abuse or neglect | ▪ Highest priority: infants under 2 years  
▪ Next highest: preschool children (age 5 or under) |
| Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures chest or abdominal injuries. | Emergency situation: EMS transfer to nearest hospital |
| Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive. | Emergency situation: EMS transfer to nearest hospital |

Criteria B: For a child who has *already been treated by a medical provider*, including a first responder (EMS), who is not part of the MDT. It is recommended that the MDT medical consultant review case and medical information and determine the need for follow up. Some children will need an examination by a clinician with expertise in child abuse, some will need a record review by a clinician with child abuse expertise, and some will need no further medical assessment.

<table>
<thead>
<tr>
<th>Criteria B-Physical Abuse/Neglect</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe injury or condition that required medical attention or hospitalization and that initiated a report to CPS or law enforcement</td>
<td>Includes but not limited to: head trauma; burns; fractures; chest or abdominal injuries</td>
</tr>
</tbody>
</table>
**SEXUAL ABUSE, PHYSICAL ABUSE, OR NEGLECT:**

**Criteria C:** Other specific situations that should be reviewed on a *case-by-case basis* with the MDT medical consultant to determine need for medical evaluation or additional medical testing.

<table>
<thead>
<tr>
<th>Criteria C – Cases to be Reviewed by MDT Medical Consultant</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child displays abnormal sexualized behaviors.</td>
<td></td>
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<tr>
<td>Child has been exposed to pornography.</td>
<td></td>
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<tr>
<td>Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).</td>
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<tr>
<td>Domestic or other violence has occurred in the home.</td>
<td>Examples of other violence: gang involvement, home invasion.</td>
</tr>
<tr>
<td>Child expresses fear or appears fearful of the parent or caregiver.</td>
<td></td>
</tr>
<tr>
<td>Child was left unsupervised in environments that are potentially dangerous or lethal.</td>
<td></td>
</tr>
<tr>
<td>Child was not being protected and/or basic needs were not being met.</td>
<td>Examples: soft drink in baby bottle; child found alone in street.</td>
</tr>
<tr>
<td>Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment.</td>
<td></td>
</tr>
<tr>
<td>Caregiver or investigator expressed a request for examination or a serious concern not included in other criteria.</td>
<td></td>
</tr>
<tr>
<td>Drug-endangered children.</td>
<td>Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home.</td>
</tr>
</tbody>
</table>
| Child exposed to an alleged or reported perpetrator of other children. | ▪ May occur with a victim’s siblings or step-siblings.  
▪ Children of an alleged or reported perpetrator may have been sexually abused and have their own reasons for denial.* |

* **Important Note:** A child’s denial of sexual abuse when circumstances suggest it may have occurred is much more likely when the child:
  ▪ Is a relative or close associate of the suspected perpetrator – someone the child (or family) may wish to protect.
  ▪ Bonds with the alleged perpetrator (e.g., child may have low self-esteem/self-confidence, be overly trusting or naïve, or be affection- or approval-seeking).
  ▪ Has cause for fear and anxiety due to a history of physical abuse, spousal violence, or significant family dysfunction.
  ▪ Has a parent who is non-believing or not supportive of the child’s disclosure or other evidence that abuse has occurred (STDs, genital injury). In these cases, the child may give a partial disclosure or recant.
WHO CAN PERFORM A MEDICAL EVALUATION FOR ABUSE OR NEGLECT?

A medical evaluation should be performed by a professional with experience in child sexual and/or physical abuse. Typically, these professionals are:

- Licensed physicians who specialize in Child Abuse Pediatrics;
- Registered nurses who focus on pediatrics and who are certified as Forensic Nurse Examiners or Sexual Assault Nurse Examiners; or
- Mid-level practitioners (PNPs or PAs) who focus on pediatrics and have advanced training in child abuse/neglect.

In addition to gathering evidence for forensic purposes, the medical evaluation should also include assessment and treatment of such health problems as injuries, sexually transmitted diseases, pregnancy, and mental health needs of the child and family.

RESOURCES FOR TRAINING, SPECIALIZED EXAMINATION, OR CASE REVIEW

- **MEDCARES (Medical Child Abuse Resource and Education System) of Texas:** Statewide regionalized network of Child Abuse Pediatrics centers of excellence and emerging centers that offer direct services, including comprehensive medical evaluations in an inpatient or outpatient setting and access to subspecialties like radiology, toxicology, neurology, trauma care, and burn care. Depending on the type of maltreatment, a child could require access to specialized equipment and/or the care of additional specialized medical professionals. These facilities are equipped to handle such needs or have relationships in place to ensure the child receives the full spectrum of care. In addition, the medical professionals in the MEDCARES network provide education and training to those who work on the front lines with children at risk (such as law enforcement, case workers, members of the judiciary) as well as other members of the public (parents, teachers, students, medical professionals). For more information, to discuss a case, or to request an examination of a child, contact the nearest children’s hospital or refer to the MEDCARES website at: [http://www.dshs.state.tx.us/mch/medcares.shtm/](http://www.dshs.state.tx.us/mch/medcares.shtm/)

- **Forensic Assessment Center Network:** Detailed case review by child abuse pediatricians, available to CPS investigators. [https://www.facntx.org](https://www.facntx.org). (Note: not all child abuse pediatricians in the state are affiliated with FACN; a case reviewed by a MEDCARES-affiliated child abuse pediatrician would usually not need re-review through FACN.)
Children’s Advocacy Centers of Texas (CACTX): Statewide non-profit membership association representing all local children’s advocacy centers in Texas. CACTX works with communities that are interested in starting a CAC and provides the following services to established CACs and Multidisciplinary Teams:

- Training and technical assistance
- Funding
- Monitoring for adherence to the Texas Family Code Chapter 264 and Texas Standards for CACs
- Legislative Advocacy
- Community Awareness

For more information on CACTX services and to find a local CAC, please go to: www.cactx.org

REFERENCES/RESOURCES

The following resources were used in developing the criteria in this document:

- Reference Card for hospital emergency room personnel developed by James Lukefahr MD, Nancy Kellogg MD and Kathleen Buckley CPNP; UT Health Science Center-San Antonio.
- ChildSafe (San Antonio Children’s Advocacy Center) MDT Protocol, developed by Nancy Kellogg, MD.
- “The 5 “Ps””, developed by Jerry Jones MD and Karen Farst MD, UAMS Center for Children at Risk.
THE 5 P’S REFERENCE SHEET
The 5 P’s is a guideline for which children benefit most from a medical examination after a disclosure of possible sexual abuse. Some of the indications have to do with identifying children who may have acute or healed injuries (pain, bleeding, etc.) while some of the indications have to deal with identifying children that may have infections or pregnancy as a result of sexual contact. Healed injuries and sexually transmitted infections can be identified many months after the last contact (without the victim being aware there is a problem). Teens disclosing prior abuse (even if they have initiated their own legal-consensual sexual activity) may still benefit from an exam to address pregnancy and infection issues in the non-acute period if disclosure was delayed.

Beyond addressing the health needs of the child, these indications are also important considerations in the investigation as well. If a child has disclosed an act that could have resulted in injury or infection and then is not referred for a medical evaluation, the child’s disclosure may be made to appear less credible if the team did not consider the disclosure concerning enough to complete the evaluation for potential residual problems.

1. **PENILE CONTACT or painful attempted penetration by any object**
   - Penile contact with the genitalia, anus or mouth of a possible victim poses a risk of a STD, whether or not penetration clearly occurred.
   - Painful contact or an attempt to put a finger or object into the genital or anal area of a child suggests injury may have occurred.

2. **PHYSICAL SIGNS AND SYMPTOMS**
   - Child displays sexualized behavior
   - Presence of symptoms: Genital or anal pain, discharge, sores, bleeding, or painful urination are consistent with an injury or STD

3. **PERPETRATOR-EXPOSED CHILDREN**
   - A victim’s siblings or step-siblings who were exposed to the alleged perpetrator commonly have been sexually abused in spite of denials.
   - Siblings of a child with a STD are often infected.
   - Children of a suspected perpetrator often have been sexually abused and have their own reasons for denial.

4. **PREDISPOSITION OF A CHILD TO DENY**
   - Denial of sexual abuse when circumstances suggest it may have occurred is much more likely when a child:
     - Is a relative or close associate of the suspected perpetrator, one the child (or family) may wish to protect.
     - Is likely to bond with the alleged perpetrator: low self-esteem, trusting, naïve, little self-confidence, affection or approval-seeking, obeys others
     - Has cause for fear and anxiety: history of physical abuse, spousal violence, or significant family dysfunction.
     - Models the suspected perpetrator by displaying sexualized behavior

5. **PARENT OR PATIENT CONCERNS (or gut feeling of investigator)**
   - Parent (guardian) or investigator remains concerned.
   - All parents and child victims should be offered medical evaluations as history is sometimes incomplete and children who have suffered abuse often have unmet physical and mental health issues requiring assessment and referral.

*****************************************************************************

A medical evaluation should be performed by a professional with experience in child sexual abuse. It should also provide evaluation and treatment of such health problems as injuries, sexually transmitted diseases, pregnancy, unrealistic physical concerns of parents, and mental health needs of the child and family.

Authored by Drs. Jerry Jones and Karen Farst, UAMS Center for Children at Risk (unpublished)