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Medical Evaluation of Suspected Child Sexual Abuse: 2009 Update

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Introduction

In the field of medical evaluation of suspected child sexual abuse, research studies and expert opinion have provided the basis for several revisions of an approach to interpreting medical and laboratory findings in children who may have been sexually abused. A description of a current revision was published in the Summer 2005 issue of the *APSAC Advisor* (Vol. 17, No. 3). The most recent version of this approach was published in 2007 after a process of consensus development (Adams et al., 2007). This article describes new studies published since the 2007 paper was submitted, describes recently completed systematic reviews of older studies, and makes suggestions for updating the Approach to Interpretation table.

Healing of Acute Trauma in Prepubertal Girls

McCann, Miyamoto, Boyle, and Rogers (2007a) reported on a review of 113 cases of prepubertal girls who had photo-documentation of acute trauma to the genital tissues and who had at least one follow-up examination to determine healing. The cases were gathered from multiple sites in a retrospective manner, preventing any standardization of examination method, photo-documentation methods, or the number and timing of follow-up examinations.

In the review of photographs, the authors identified and classified 40 lacerations of the hymen among the prepubertal girls, and 35 (88%) were in the posterior/inferior location below the 3 o'clock–9 o'clock line. At the time of the follow-up examination, it was found that 75% of the acute, partial tears through more than 50% of the width of the hymen had healed to be notches extending through 50% or more of the width of the hymen.

When the hymen tear was classified as being a tear all the way through the hymen and into the fossa (transection with extension), 74% of these tears at the follow-up examinations were complete clefts/transections after healing. Of note, none of the hymen injuries resulted in scars at the follow-up examinations.

In another paper, McCann and colleagues (2007b) reported that deep lacerations of the posterior fourchette or perineum in prepubertal girls took 2–3 weeks to heal, but the majority of abrasions, contusions, and submucosal hemorrhages of the genital tissues healed within days.

An important finding, reported in both of the previously referenced papers, is that many injuries to the hymen and to other genital tissues had healed completely at the time of follow-up examination, leaving no sign of the previous injury. In a few cases, even significant hymen lacerations healed to leave no clear sign of injury. Therefore, in cases where an examination is conducted several days, weeks, or months after the suspected episode of sexual abuse and no clear sign of injury to the genital tissues is evident, the possibility of previous injury cannot be ruled out. Therefore, if a child describes an incident of abuse that caused pain or bleeding, or both, an examination done weeks later could very well be normal. However, the fact that injuries can heal completely, or heal as superficial or deep notches in the hymen, does not allow one to conclude that all notches in the hymen were caused by penetration.

Importance of Child's History

Although the Approach to Interpretation table focuses on medical examination findings and laboratory test results, it is widely accepted that in most cases of suspected sexual abuse, there will not be signs of significant injury, healed trauma, or sexually transmitted infections. The child's medical history is key in helping to determine if a child had specific symptoms around the time of the episode of alleged abuse that could help validate the child's description of the abuse experience.

DeLago, Deblinger, Shroeder, and Finkel (2008) reviewed the medical records of 161 girls ages 3–18 years who were evaluated for suspected abuse and who had disclosed specific types of genital contact. All patients were asked open-ended, non-leading questions about body sensations during the history obtained by the medical provider. If a child disclosed genital contact, she was asked: "How did that feel?" If necessary, the doctor would ask follow-up questions, such as: "Did it bother your body, your feelings, or both?"

Genital symptoms were reported by 60% of the girls, and the symptoms of dysuria and genital pain were significantly more

common in girls reporting genital-genital contact compared with other types of genital contact, when controlling for age. This study highlights the importance of a complete medical history and review of symptoms when children are evaluated for suspected sexual abuse. Even if someone else takes the detailed history of the episode of possible abuse, the medical provider needs to ask the child directly about how his or her body felt during and after the abusive episode. Although there may not be any signs of injury on examination, the medical provider can correlate the child's description of symptoms to the description of the acts the child experienced and can testify to that in court.

Evaluating the Data From Research Studies

A systematic review by Berkoff and colleagues (2008) of more than 1,500 published articles and book chapters identified ten research studies of prepubertal children selected for non-abuse, and one case control study of girls ages 3–8 years with and without a history of vaginal penetration. The review was conducted as an attempt to determine the utility of the genital examination in prepubertal girls in identifying non-acute sexual abuse. The criteria for inclusion in the systematic review were that studies had to contain data on pubertal status or age or both, have sufficient data for statistical analysis, use a well-described or reproducible examination technique, and include a reference standard to determine whether the child had or had not been sexually abused.

The findings of a deep notch in the inferior hymen, transection of the hymen, and perforation of the hymen were not found in the studies of non-abused children and were specific for a history of sexual abuse in the case-control study. None of these findings had high sensitivity to detect abuse, however, because they were rare in children who gave a history of penetration. The authors concluded that these three findings "suggest genital trauma from sexual abuse" (p. 2790).

Comparable systematic reviews are needed of published research studies reporting medical examination findings in other types of patients. What is the positive predictive value of the finding of a deep hymen notch in an adolescent, or the finding of anal dilation in a child examined acutely or non-acutely following alleged anal penetration? Additional research is needed to answer both of these questions, but a careful review of published papers could help provide a more evidence-based approach to interpreting medical examination findings. The results of such a systematic review might indicate that the approach to interpreting some of the findings cited in the table should be reassessed.

Conditions Mistaken for Abuse

Many conditions such as labial adhesions, vaginal discharge, genital bumps and ulcers; skin conditions such as lichen sclerosus; unusual conditions such as urethral prolapse, perineal groove/failure of midline fusion, and others can be mistaken for signs of trauma or infection. In a study of pattern recognition (Muram & Simmons, 2008) among residents and faculty in pediatrics, family medicine, emergency medicine, and gynecology at a major teaching hospital, color photographs of common pediatric gynecologic conditions were shown to residents and faculty physicians. The mean correct response rate was 42% for residents and 58% for faculty. Photographs of urethral prolapse, labial adhesion, and uncomplicated vulvovaginitis were often incorrectly identified as being signs of suspected abuse.

It is clear that physicians who are asked to examine a child's genitalia for routine care or to evaluate complaints or symptoms must have basic knowledge of normal anatomy and common and uncommon conditions that may affect the appearance of the genital or anal tissues. A specific category of conditions commonly mistaken for signs of abuse has been added to the Approach to Interpretation table to increase awareness in health care professionals who examine children for possible abuse.

Herpes Simplex Virus Type 1 and 2 (HSV-1, HSV-2) In an article published in 2008, I reviewed studies related to herpes simplex infections in children and the seroprevalence of HSV-1 and HSV-2 in children of different ages. There are no case control studies of genital herpes or positive antibodies for HSV-2 in children with and without concerns for sexual abuse. In the reviewed studies, investigators typically reported histories of sexual abuse most commonly in children who were 5 years of age or older, who had HSV-2 cultured from genital lesions, and who did not have oral lesions (Adams, 2008). The suggestions for interpreting genital herpes infections have been changed slightly in Table 1.

Genital Warts Genital warts in children represent infections that could have been transmitted by sexual contact. Multiple studies of newborn infants, mothers and fathers, and children without a concern of abuse have shown evidence of human papilloma virus (HPV) DNA on the skin, mucous membranes, or both (Shapiro & Makoroff, 2006). It likely that the virus itself can be spread by caretaking activities and perinatal exposure, and this could result in the development of warts in the genital or anal area in infants and young children. Children with anogenital warts who are outside the age range where someone is assisting them with toileting hygiene and who do not have warts on other parts of their bodies deserve a very careful evaluation for suspected sexual abuse. While each case should be evaluated on its own merits, it is reasonable to recommend reporting to child protective services if lesions of HPV are found in an older child, even if the child denies a history of sexual abuse.

The Importance of Accurate Interpretation of Medical Findings Most examinations for signs of sexual abuse are done

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Table 1. Approach to Interpretation of Medical Findings in Suspected Child Sexual Abuse: 2009

This table lists medical and laboratory findings; however, most children who are evaluated for suspected sexual abuse will not have signs of injury or infection. The child's description of what happened to him or her and the child's report of specific symptoms in relationship to the events described is an essential part of the full medical evaluation.

Findings Documented in Newborns or Commonly Seen in Non-abused Children

The presence of these findings generally neither confirms nor discounts a child's clear disclosure of sexual abuse.

Normal variants

1. Periurethral or vestibular bands
2. Intravaginal ridges or columns
3. Hymenal bumps or mounds
4. Hymenal tags or septal remnants
5. Linea vestibularis (midline avascular area)
6. Hymenal notch/cleft in the anterior (superior) half of the hymenal rim (prepubertal girls), on or above the 3 o'clock–9 o'clock line with patient supine
7. Shallow/superficial notch or cleft in inferior rim of hymen below 3 o'clock–9 o'clock line
8. External hymenal ridge
9. Congenital variants in appearance of hymen, including crescentic, annular, redundant, septate cribiform, microperforate, and imperforate
10. Diastasis ani (smooth area)
11. Peri-anal skin tag
12. Hyperpigmentation of the skin of labia minora or peri-anal tissues in children of color, such as Mexican-American and African-American children
13. Dilation of the urethral opening with application of labial traction
14. "Thickened hymen" (May be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma. The latter is difficult to assess unless follow-up examination is done.)

Findings commonly caused by other medical conditions

15. Erythema (redness) of the genital tissues (May be due to irritants, infection, or dermatitis.)
16. Increased vascularity ("dilatation of existing blood vessels") of vestibule and hymen. (May be due to local irritants or normal pattern in the non-estrogenized state.)
17. Labial adhesion (May be due to irritation or rubbing.)
18. Vaginal discharge (There are many infectious and non-infectious causes. Cultures must be taken to confirm if caused by sexually transmitted organisms or other infections.)
19. Friability of the posterior fourchette or commisure (May be due to irritation, infection, or an examiner's traction on the labia majora.)
20. Anal fissures (Usually due to constipation, peri-anal irritation.)
21. Venous congestion or venous pooling in the peri-anal area (Usually due to positioning of child; also seen with constipation.)

Conditions Mistaken for Abuse*

22. Urethral prolapse*

23. Lichen sclerosus et atrophicus*

24. Vulvar ulcers (May be caused by many types of viral infections, including Epstein-Barr virus (EBV) and influenza, or by conditions such as Behcet's disease or Crohn's disease.)*

25. Failure of midline fusion, also called perineal groove*

26. Rectal prolapse (often caused by infection, such as Shigella sp.)*

27. Complete dilation of the internal and external anal sphincters, less than 2 centimeters in AP diameter, revealing the pectinate line*

28. Partial dilation of the external anal sphincter, with the internal sphincter closed, causing the appearance of deep folds in the peri-anal skin that can be mistaken for signs of injury*

29. Marked erythema, inflammation, and fissuring of the peri-anal or vulvar tissues due to infection with Group A beta hemolytic streptococci*

***Changes from the version published in 2007 are in *bold italics*. Adapted from: Adams et al. (2007, 163–172).**

Indeterminate Findings: Insufficient or Conflicting Data From Research Studies, or No Expert Consensus

These physical and laboratory findings may support a child's clear disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure. Report to Child Protective Services may be indicated in some cases.

30. Deep notches or clefts in the posterior/inferior rim of hymen that extend through more than 50% of the width of the hymen
31. Deep notches or complete clefts in the hymen at the 3 o'clock or 9 o'clock location in adolescent girls
32. Marked, immediate anal dilation to an AP diameter of 2 cm or more, in the absence of other predisposing factors such as chronic constipation, sedation, anesthesia, and neuromuscular conditions
33. Genital or anal condyloma accuminata in child, in the absence of other indicators of abuse. ***Lesions appearing for the first time in a child older than 5–8 years may be more suspicious for sexual transmission.****
34. Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse. ***Isolated genital lesions caused by HSV-2 in a child older than 4–5 years may be more suspicious for sexual transmission.****

Findings Diagnostic of Trauma and/or Sexual Contact

The following findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless a clear, timely, plausible description of accidental injury is provided by the child and/or caretaker. ***Photographs or video recordings of these findings should be reviewed by an expert in sexual abuse evaluation for a second opinion to assure accurate diagnosis.****

Acute trauma to external genital/anal tissues

35. Acute lacerations or extensive bruising of labia, penis, scrotum, peri-anal tissues, or perineum (May be from unwitnessed accidental trauma or from physical or sexual abuse.)
36. Fresh laceration of the posterior fourchette, not involving the hymen (Must be differentiated from dehisced labial adhesion or failure of midline fusion (see #25). Posterior fourchette lacerations may also be caused by accidental injury or by consensual sexual intercourse in adolescents.)

Residual (healing) injuries

These rare findings are difficult to assess unless an acute injury was previously documented at the same location.

37. Peri-anal scar (May be due to other medical conditions such as Crohn's disease, accidental injuries, or previous medical procedures.)
38. Scar of posterior fourchette or fossa (Pale areas in the midline may also be due to linea vestibularis or labial adhesions.)

Injuries indicative of blunt force penetrating trauma (or from abdominal/pelvic compression injury if such history is given)

39. Extensive bruising on the hymen
40. Laceration (tear, partial or complete) of the hymen (acute)
41. Peri-anal lacerations extending deep to the external anal sphincter (not to be confused with partial failure of midline fusion)
42. Hymenal transection (healed). An area between 4 o'clock and 8 o'clock on the rim of the hymen, where it appears to have been torn through, to or nearly to the base, so there appears to be virtually no hymenal tissue remaining at that location. This finding has also been referred to as a "complete cleft" in sexually active adolescents and young adult women.
43. Missing segment of hymenal tissue. Area in the posterior (inferior) half of the hymen, wider than a transection, with an absence of hymenal tissue extending to the base of the hymen, which is confirmed using additional positions or methods.

Presence of infection confirms mucosal contact with infected and infective bodily secretions; contact most likely to have been sexual in nature

44. Positive confirmed culture for gonorrhea, from genital area, anus, or throat, in a child outside the neonatal period
45. Confirmed diagnosis of syphilis, if perinatal transmission is ruled out
46. Trichomonas vaginalis infection in a child older than 1 year of age, with organisms identified by culture or, in vaginal secretions, by wet mount examination
47. Positive culture from genital or anal tissues for Chlamydia, if child is older than 3 years at time of diagnosis and if specimen was tested using cell culture or comparable method approved by the Centers for Disease Control
48. Positive serology for HIV if perinatal transmission, transmission from blood products, and needle contamination have been ruled out

Diagnostic of sexual contact

49. Pregnancy
50. Sperm identified in specimens taken directly from a child's body

***Changes from the version published in 2007 are in *bold italics*. Adapted from: Adams et al. (2007, 163–172).**

Table 2. Results of an Online Survey of 100 Members of the Ray E. Helfer Society, Spring 2009

Experience level:
a) Conduct more than 20 evaluations per month:.....32
b) Conduct 10–20 evaluations per month: 35
c) Conduct fewer than 10 evaluations per month 25
d) Not currently clinically active 8

Supervise or review others cases?
a) No 13
b) Fewer than 10 cases per month.....38
c) Review 10–20 cases per month 35
d) Review more than 20 cases per month.....14

Familiar with the Approach to Interpretation table published in 2007?
a) Yes 96
b) No or unsure 4

Should the table be updated based on research findings?
a) Yes 16
b) No.....23
c) Possibly.....36
d) Unsure 25

Agree with "Indeterminate" for deep notch in posterior hymen, prepubertal girl?
a) Yes 53
b) No.....40
c) Unsure.....7

If you don't agree, how should it be interpreted?
a) I do agree.....50
b) Should be considered more normal 3
c) Should be considered suspicious for trauma.....32
d) Should be considered suggestive of trauma 11
e) Other..... 4

Agree with "Indeterminate" for deep notch in posterior hymen, adolescent girl?
a) Yes 66
b) No.....26
c) Unsure.....8

If you don't agree, how should it be interpreted?
a) I do agree.....65
b) Should be considered more normal 8
c) Should be considered suspicious for trauma.....14
d) Should be considered suggestive of trauma 8
e) Other.....5

How should condyloma accuminata in a child be interpreted?
a) Indeterminate for sexual transmission, regardless of age of the child 20
b) Indeterminate, less worrisome if <2 yrs old.....33
c) Indeterminate, more concerning if child older than 5–8 years 49
d) Other 6

How should genital herpes simplex infection in a child be interpreted?
a) Indeterminate for both HSV-1 and HSV-2.....41
b) Genital HSV-2 more suspicious for sexual transmission.....18
c) Both HSV-1 and HSV-2 more suspicious if child is outside age range where caretaker is performing genital hygiene on child 40
d) Other 7

Continued from page 3

some time after the last incident of abuse, and this is one of the main reasons why abnormal genital findings are rare. Because most examinations are normal or show signs that could have explanations other than abuse, many physicians and nurses who provide sexual abuse medical evaluations may have limited experience with cases of acute trauma. The National Children's Alliance (NCA) has published revised medical standards for members who work in accredited facilities, which recommend photo-documentation as the standard of care. Peer review of medical findings is strongly encouraged. Medical providers at these accredited facilities and in other settings now have the opportunity to obtain timely, anonymous expert review of sexual abuse medical findings via the TeleHealth Institute for Child Maltreatment's (THICM) new Web-based system.

Digital images of examination findings in either photographs or video clips can be uploaded to the Web site, along with the medical history and the examiner's interpretation of the findings. When a case is posted, a physician from a panel of national experts will be notified to review the case anonymously and will

send a response within 48 hours. The expert will provide an opinion as to whether or not he or she agrees with the examiner's interpretation of the medical findings, or may recommend that additional photo-documentation is necessary in order to provide a review. There is a minimal $25 per case charge to the examiners who want to take advantage of this resource as part of quality improvement activities for child sexual abuse medical evaluations.

The purpose of THICM is to make child sexual abuse expert review available to all Child Advocacy Center medical providers and to other providers who perform child sexual abuse medical evaluations throughout the United States regardless of location. However, it must be cautioned that the service is designed solely to provide reviews by an expert for educational and quality improvement purposes. It is not intended for initial diagnostic or treatment purposes or to serve as a second opinion for a specific case. This service is not a replacement for a consultation or meant to address issues related to a specific patient. More information is available at the Web site: http://www.thicm.org.

How Well Do Experts Agree?

As a follow-up to an online survey assessing agreement on medical findings, conducted in 2007, I recently did a short survey of physician experts in child sexual abuse medical evaluation. One hundred members of the Ray E. Helfer Society responded to all items on a 12-question survey conducted via the Helfer Society listserv. The results are shown in Table 2. Because the listing of findings in Table 1 includes those findings for which there is no consensus among experts as to their interpretation with respect to trauma or abuse, it appears that all findings listed there currently should still be considered indeterminate.

Conclusion

Efforts are currently underway to perform a systematic review of published research and expert opinion to help determine the diagnostic significance of specific acute genital and anal injuries, non-acute findings in adolescents, anal findings in both children and adolescents, and specific sexually transmitted infections. These reviews may provide evidence suggesting that some of the findings listed in Table 1 should be interpreted differently.

Medical providers and other members of multidisciplinary teams working with children who may have been sexually abused are advised to remember that medical findings are rarely the most important part of an evaluation for suspected sexual abuse. The absence of signs of injury in a child who gives a clear disclosure of sexual abuse, even if the contact involved vaginal or anal penetration and resulted in symptoms of pain or bleeding or both, does not mean that the child was not abused in the manner he or she described. Studies have documented rapid and complete healing of both major and minor genital and anal injuries following sexual assault (McCann et al., 2007a; McCann et al., 2007b). If medical findings are identified that are felt to be signs of trauma or sexually transmitted infections, it is advisable for providers either to seek a second opinion from an expert consultant or to utilize the anonymous expert review services through www.thicam.org, as a quality assurance method.

There have been a few minor changes to the 2007 table presented here, and more changes may be necessary as researchers conduct new studies and publish systematic reviews of previously published literature. Medical providers are invited to contact Dr. Adams with comments and suggestions at jadams@ucsd.edu.

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Strategies to Prevent Child Maltreatment and Integration Into Practice

By Vincent J. Palusci, MD, MS, and Michael L. Haney, PhD, NCC, LMHC

Introduction

Preventing child abuse and neglect spares children physical and psychological pain and improves their long-term health outcomes. Dubowitz (2002) noted that prevention "is intuitively and morally preferable to intervening after the fact." Therefore, the potential for harm to adults from child maltreatment calls us to action. Early intervention may be more effective in preventing abuse and neglect, may save money for society, and may improve peoples' overall health and well-being, perhaps the most important goals a society can accomplish.

There is increasing evidence to demonstrate the elements of successful interventions, the populations and programs of most benefit, and the best implementation research to demonstrate that we have met our goals. This article reviews current strategies in child abuse prevention and guides professionals in the integration of prevention activities into their daily work.

The Case for Prevention

Recent research has identified the physical and mental conditions increasingly being associated with adverse childhood experiences, such as physical abuse, sexual abuse, and neglect. Neurologic imaging and traumatology studies have delineated the chronic physiologic and structural changes that occur after chronic stress and abuse (De Bellis, 2005; Eluvathingal et al., 2006). Chronic stress and abuse are also associated with specific disease processes and poor mental health outcomes in adults. These adverse childhood experiences (ACES) have been associated with increased rates of teen pregnancy, promiscuity, depression, hallucinations, substance abuse, liver disease, chronic obstructive pulmonary disease, coronary artery disease, and identifiable permanent changes in brain structure and stress hormone function (Anda et al., 2002; Dube, Anda, Felitti, Chapman, & Giles, 2003; Felitti et al., 1998; Middlebrooks & Audage, 2008). Although treatment after the fact can improve mental and physical health and prolong life and productivity, the direct and indirect costs of child maltreatment for both children and adults in lost health, pain, and suffering themselves warrant our taking action to prevent child abuse and neglect.

There is increasing evidence supporting the effectiveness of several universal and selective prevention interventions (Mikton & Butchart, 2009). However, a comprehensive assessment of prevention strategies should also include an analysis of cost and of potential financial benefit (Plotnick & Deppman, 1999). Robert Caldwell (1992) estimated that the costs of a home visitor program in Michigan would be 3.5% of the $823 million estimated cost of child abuse, and small reductions in the rate of child maltreatment were thought to make prevention cost-effective. Also in Michigan in 2002, the estimated yearly loss of tax revenue and productivity due to child maltreatment rose to $1.8 billion (Noor & Caldwell, 2005).

The National Research Council (1993) and others studied clinical conditions associated with abuse and neglect, including depression, posttraumatic stress disorder, and conduct disorders, all of which compound any direct physical injuries inflicted on individual children. Associated trauma and increased risk of low academic achievement, drug use, teen pregnancy, juvenile delinquency, and adult criminology were also noted. Deborah Daro (1988) estimated a national and direct juvenile delinquency cost of $14.9 million based on incidence and the delinquency rate among adolescent victims. She concluded that 1% of severely abused children suffer permanent disability. Daro's cost analysis projected that the national cost and future productivity loss of severely abused and neglected children is between $658 million and $1.3 billion each year, as of 1988, assuming that their impairments would reduce their future earnings by as little as from 5% to 10%.

However, drawing from Maxfield and Widom's work (1996), Fight Crime: Invest in Kids (Alexander, Baca, Fox, Frantz, Huffman et al., 2003) noted that child abuse and neglect costs Americans at least $80 billion annually and affects taxpayers as well as those being directly affected. Prevent Child Abuse America (Wang & Holton, 2008) used "conservative" estimates to calculate direct and indirect costs as $103.8 billion in 2007. Potential benefits of prevention include mitigating the direct costs of child maltreatment as well as improving all of our lives through increased productivity and decreased crime and need for social services (Alexander et al., 2003).

Definitions

Child maltreatment prevention is endorsed by all those who are familiar with the problems associated with child maltreatment, and efforts aimed at preventing abuse are promoted by agencies, governmental officials, and individual practitioners. Unfortunately, beyond a blanket endorsement of the concept, there are many different ideas about what prevention actually means and what activities are considered effective. Definitions vary, yet three categories of prevention are generally described:

1. Primary: Efforts aimed at the general population for the purpose of keeping abuse from happening.
2. Secondary: Efforts aimed at a particular group with increased risk to keep abuse from happening.
3. Tertiary: Efforts aimed at preventing abuse from happening again to those who have already been victimized. This level of prevention may include treatment for the original abuse.

The Centers for Disease Control and Prevention (CDC, 2007) have emphasized that abuse operates in a societal context and requires an entire spectrum of necessary prevention strategies over time, thinking of prevention in terms of WHEN does it occur (before or after abuse), WHO is the focus of prevention (everyone, those at greatest risk, and those who have already experienced abuse), and WHAT is the level of influence and points for intervention (individual, relationship, community, society). These efforts are based on Bronfenbrenner's ecological model, which promotes intervening at the individual, relationship, community, and societal levels (Bronfenbrenner, 1977; Zielinski & Bradshaw, 2006). Approaches implied from these new labels emphasize a shift away from risk reduction as the predominant prevention approach and toward promotion of positive social change. Some argue that prior definitions limited prevention strategies by focusing primarily on potential individual targets of abuse and how to intervene, rather than the environmental and societal context that supports and even condones abusive acts.

Definitions of prevention based on timing can also be considered:

1. Primary: This is taking action *before* abuse has occurred to prevent it from happening.
2. Secondary: This level of prevention is intervening *right after* abuse has occurred.
3. Tertiary: Tertiary prevention is seen as that which takes the long view and works *over time to change conditions* in the environment that promote or support abusiveness.

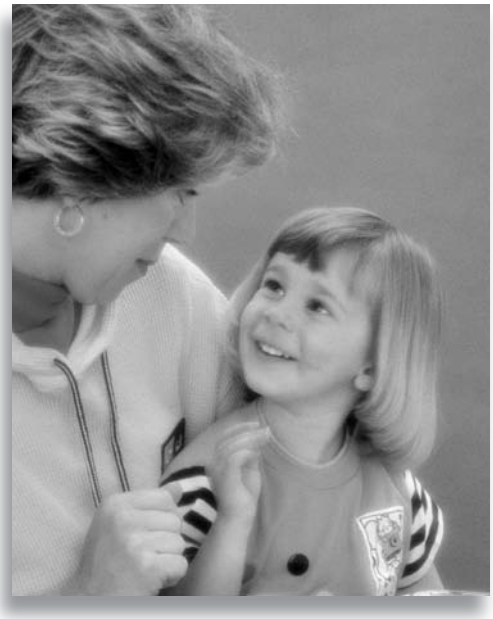
Physicians and other medical professionals have been invited to become more active in prevention as part of this definitional shift. For example, the National Sexual Violence Resource Center (2006) has recently published information about how to involve a broader constituency in prevention through using the "Spectrum of Prevention." Prevention is explicitly not the responsibility of any one agency, profession, or program but is framed as the responsibility of all to create a society less conducive to child maltreatment. In this paradigm, individual skill development, community and provider education, coalition building, organizational change, and policy innovations are all part of the prevention solution.

Successful and Promising Child Maltreatment Prevention Strategies

Although several strategies are reported to prevent child maltreatment, the effectiveness of most programs is still not known (MacMillan, Watlen, Fergesson, Leventhal, & Taussig, 2009). Home visiting programs are not uniformly effective; parenting programs appear to improve parenting but not necessarily reduce child maltreatment; some family programs are successful in reducing physical abuse but not neglect; and sexual abuse educational programs have created controversy despite some promising results. One suggested strategy is to tailor programs to one or more levels of intervention, given our understanding that child maltreatment occurs because of many factors simultaneously on the parental, child, family/relationship, community, and societal levels (World Health Organization & the International Society to Prevent Child Abuse and Neglect, 2006). We will now review successful and promising prevention strategies to assist professionals in sorting through myriad intervention models and potential outcomes.

Home Visiting Home visiting programs aim to prevent child abuse and neglect by influencing parenting factors linked to maltreatment: (1) inadequate knowledge of child development, (2) belief in abusive parenting, (3) empathy, (4) sensitive, responsive parenting, (5) parent stress and social support, and (6) the ability to provide a safe and stimulating home environment. By changing these factors, home visiting programs also seek to

improve child development and health outcomes associated with abuse and neglect. They have noted reductions of 40% of child maltreatment in certain models (Sweet & Appelbaum, 2004; Olds, 2006; Gomby, 2007). In a comprehensive review, Gomby (2005) examined the findings from 12 recent meta-analyses and other studies that used rigorous research methods, including randomized trials and quasi-experimental designs. Home visitation programs were most effective when they targeted families with many risk factors and used highly trained professionals who carefully followed a research-based model of intervention. Long-term follow-up with low-income single mothers who received home visitation services suggested that these programs are also effective in reducing child abuse and neglect in families where domestic violence is *not* present, decreasing the number of subsequent pregnancies, arrest rates, and the amount of time on welfare (Olds, Eckenrode, Henderson, Kitzman, Powers, & Cole, 1997; Eckenrode et al., 2000). Home visiting by nurses has been consistently effective at reducing preterm and low-weight births, increasing well child care medical visits and reducing deaths and hospitalizations for injuries and ingestions (Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Schuster, Wood, Duan, Mazel, Sherbourne, & Halfon, 1998; Barlow, Davis, McIntosh, Jarret, Mockford, & Stewart-Brown, 2007; Caldera, Burrell, Rodriguez, Crowne, Rohde, & Duggan, 2007; Olds et al., 2002; King et al., 2001; Donovan et al., 2007; MacMillan, Thomas, Walsh, Boyle, Shannon, & Gafni, 2005). The findings have been replicated in a population of medically at-risk infants, where home visiting using paraprofessionals was associated with lower use of corporal punishment, greater safety maintenance in the home, and fewer reported child injuries (Bugental & Schwartz, 2009).



Some programs such as Healthy Families America (HFA) have used paraprofessionals to provide services (Duggan et al., 2004). In a more recent randomized trial of HFA in New York, mothers in the program committed only one-quarter as many acts of serious abuse and neglect as did control mothers in the first 2 years (Dumont et al., 2008). An evaluation of Healthy Families Florida found that the program using paraprofessionals has had a positive impact on preventing child maltreatment, showing that children in families who completed treatment or had long-term, intensive intervention experienced significantly less child maltreatment than did comparison groups who had received little or no service. This effect was accomplished in spite of the fact that, in general, participants were at significantly higher risk for child maltreatment than the overall population. According to Williams, Stern & Associates (2005), Healthy Families Florida participants had 20% less child maltreatment than all families in their target service areas. In addition, families who completed the program fared much better than their comparison group counterparts and were more likely to read to their children at early ages. Also, Healthy Families positively affected self-sufficiency, defined as *employment*. The program met or exceeded its goals for preventing maltreatment after program completion, provision of immunizations and well-baby checkups, increasing time between pregnancies, and participant satisfaction with services (Williams, Stern & Associates, 2005).

The Nurse-Family Partnership (NFP) is an evidence-based nurse home visitation program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. NFP models have been evaluated longitudinally across three sites using randomized trials (Olds, 2006) and have been replicated in 250 counties. One analysis showed that for every $1 spent on the NFP, there were $4 in savings for taxpayers (Alexander et al., 2003). Other specific programs have been reviewed, but overall, it is difficult to show improvements in key outcomes such as child abuse and neglect (Rigney & Brown, 2009). Perhaps results aren't forthcoming because the programs have wide variability in the job description of the home visitor, program implementation, and costs, which makes comparison difficult.

Family Wellness Programs Family wellness programs, including a variety of parent and family interventions, have been demonstrated to have some positive effects. These programs range from short-term counseling to parenting classes, sometimes with home visiting and sometimes with intensive "wrap-around" services for families at high risk for maltreatment. Many of these have been grouped together, making assessment problematic, but early meta-analyses show promising reductions in child maltreatment (MacLeod & Nelson, 2000). Intensive family preservation programs with high levels of participant involvement, an empowerment/strengths-based approach, and social support were more effective. In one study, programs designed to meet families' basic concrete needs and to provide mentoring were more effective than parenting and child development programming, and center–based services were more effective than home-based ones (Chaffin, Bonner, & Hill, 2001). In one series of 1,601 inner-city clients with moderate risk, programs that helped families meet basic needs and provided mentoring were found to be more effective than parenting or child development programming (Chaffin et al., 2001). At-risk

parents who do not receive parent coaching or education have higher rates of child maltreatment, parent arrest, and child hospitalization for violence (Alexander et al., 2003).

Family-Based Parenting Interventions Parenting programs, delivered by health visitors, have been found to improve child mental health and behavior, and reduce social dysfunction among parents in one randomized controlled trial (Patterson, Barlow, Mockford, Klimes, Pyper, & Stewart-Brown, 2002). A meta-analysis of parent training, a subset of parent interventions, has concluded that training can change childrearing strategies as well as modify parents' attitudes and perceptions (Lundahl & Harris, 2006). However, parent training models often differ, which precludes direct comparisons. Parent training can include reviewing child development, teaching and practicing specific skills, identifying and addressing maladaptive behaviors, and supporting parents in managing their own emotions and responding to stress. Effect sizes overall were thought to be moderate, with outcomes affected by how training was delivered and under what conditions. Finally, family socioeconomic status, relationship with the trainer, inclusion of fathers, the need for additional child therapy, inclusion of a home visitor, proper length, delivery mode, and delivery setting must also be addressed to maximize potential outcomes.

A more recent CDC meta-analysis of parent training programs (2009) looked at program components and delivery methods that had the greatest effect on child behavior and parent skills. It concluded that teaching parents emotional communication skills and positive child interaction skills, while requiring practice with their children during each session, was the most effective in helping them to acquire effective parenting skills and behaviors. Teaching parents about the correct use of time out, to respond consistently to their child, to interact positively with their child, and to require practice were all associated with decreases in children's externalizing behaviors (CDC, 2009).

In another model, Palusci, Crum, Bliss, and Bavolek (2008) found that parents with a variety of problems, including incarceration, substance abuse, and stress, had improved empathy, understanding of child development, and other skills after an 8-week program of interactive classes using a family nurturing program. The "Triple P" system was designed as a comprehensive, population-level system of parent and family support with five intervention levels of increasing intensity and narrowing population reach. The system combines various targeted interventions to ensure a safe environment, including promoting learning, using assertive discipline, maintaining reasonable expectations, and taking care of oneself as a parent. These principles then translate into 35 specific strategies and parenting skills. A recent large-scale randomized trial of the system noted lesser increases in substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries in the intervention counties (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

Health-Based Services Health services during the prenatal period and early childhood have generally not been shown universally to result in reduced child abuse and neglect, but a recent randomized trial in an inner-city clinic with high-risk families was able to show lower rates of maltreatment, CPS reports, harsh punishment, and improved health services after an intervention of pediatric resident education in a primary care medical setting (Dubowitz, Feigelman, Lane, & Kim, 2009). It is often not possible during the prenatal and immediate postnatal periods to reliably identify families who will go on to maltreat their children, suggesting that anticipatory guidance for all families offers a better chance of reducing child maltreatment and violence (Brayden et al., 1993; Peters & Barlow, 2004). There are several barriers (time, training, culture, sensitive issues) to widespread implementation that can be addressed by identifying potential strategies, such as the use of handouts and local news stories, to begin a dialogue during routine pediatric visits (Sege, Hatmaker-Flanigan, De Vos, Lenn-Goodman, & Spivak, 2006). There remain several high-risk groups that will need special, focused attention by the health care system. Addicted mothers, for example, need access to drug and alcohol treatment programs that can prevent neurologic damage to fetuses (such as fetal alcohol syndrome), and neurologic damage at birth interacts with deficient parenting to multiply the risk of criminality and maltreatment (Alexander et al., 2003). Mental health services need to be available for depressed or mentally ill parents who have greatly increased risk for physically abusing or killing their children (McCurdy & Daro, 1994).

Community Strategies A large body of theory and empirical research suggests

that intervention at the neighborhood level is likely to prevent child maltreatment within families. This represents a "fourth wave" in prevention activities, with emphasis on altering communities on par with those aimed at the individual parenting level (Daro & Dodge, 2009). The two components of intervention that appear to be most promising are social capital development and community coordination of individualized services. Social disorganization theory suggests that child abuse can be reduced by building social capital within communities—by creating an environment of mutual reciprocity in which residents are collectively engaged in supporting each other and in protecting children. Research regarding the capacity and quality of service delivery systems in communities with high rates of maltreatment underscores the importance of strengthening a community's service infrastructure by expanding capacity, improving coordination, and streamlining service delivery (Daro & Dodge, 2009). Community strategies to prevent child abuse and promote child protection have focused on creating supportive residential communities whose residents share a belief in collective responsibility to protect children from harm, and on expanding the range of services and instrumental supports directly available to parents. Both elements—individual responsibility and a strong formal service infrastructure—are important. The challenge, however, is to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment.

Daro and Dodge (2009) have also noted that, in the short run, the case for community prevention is promising on both theoretical and empirical grounds. Community prevention efforts are well grounded in a strong theory of change and, in some cases, have strong outcomes. At least some of the models have reduced reported rates of child abuse and injury to young children, altered parent-child interactions at the community level, and reduced parental stress and improved parental efficacy. When focusing on community building, the models can mobilize volunteers and engage diverse sectors within the community such as first responders, the faith community, local businesses, and civic groups in preventing child abuse. This mobilization can exert synergistic impact on other desired community outcomes, such as economic development and better health care.

Societal Policies Factors in society that can contribute to child maltreatment include the social, economic, health and education policies that lead to poor living standards, socioeconomic instability, or hardship as well as social or cultural norms that promote or glorify violence, demand rigid gender roles, or diminish the status of the child with regard to the parent (WHO, 2006). On the global scale, the United Nations Convention on the Rights of the Child offers a framework as a legal instrument for integrating the principles of children's rights with professional ethics and for the policy changes needed to enhance public health responses to prevent maltreatment (Reading et al., 2009). Each of these rights has specific implications for practice, advocacy, and research that can assist in defining, measuring, legislating, monitoring, and preventing child maltreatment. Achieving appropriate investments in community child abuse prevention programs will require a research and policy agenda that recognizes the importance of linking learning with practice. It is not enough for scholars and program evaluators to learn how maltreatment develops and what interventions are effective, and for practitioners, separately, to implement innovative interventions in their work. Instead, initiatives must be implemented and assessed in a manner that maximizes both the ability of researchers to determine the effort's efficacy and the ability of program managers and policy makers to draw on these data to shape their practice and policy decisions, which can affect society as well as families and communities (WHO, 2006; Daro & Dodge, 2009).

Elements of Effective Approaches

The Prenatal and Perinatal Periods Ray Helfer (1987) noted the "window of opportunity" that is present in the perinatal period to enhance parent-child interactions and prevent physical abuse. This period, which he defined as from one year before birth to 18–24 months of life, was determined to be a critical time to teach new parents skills of interaction with their newborns. Several program models have shown promise based upon key periods within this time frame, including prepregnancy planning, early conception, late pregnancy, prelabor and labor, immediately following delivery, and at home with the child. Opportunities for prevention in the early months of life include teaching parents and caregivers to cope with infant crying and how to provide a safe sleep environment for their infant. A recent meta-analysis of several early childhood interventions concluded that the evidence for their preventing child maltreatment in the first year of life is weak, but longer-term studies may show reductions in child maltreatment similar to other programs such as home visiting, when longer follow-up can be achieved (Reynolds, Mathieson, & Topitzes, 2009).

Public Health Approach The public health model follows a common pattern of intervention and evaluation when addressing a variety of conditions. The problem is defined, risk and protective factors are identified, prevention strategies are developed and tested, and if successful, they are widely adopted (CDC, 2009). A key operating assumption in such efforts is that change initiated in one sector will also have measurable spillover effects into other sectors and that the individuals who receive information or direct assistance will change in ways that begin to alter normative behavioral assumptions across the population. This gradual and evolutionary view of change is reflected in many public health initiatives that, over time, have produced dramatic improvement in such areas as smoking cessation, reduction in drunk driving, increased use of seat belts, and increased conservation efforts. CDC and the Maternal Child Health Bureau, for example, have

strengthened the public health role and funding for child maltreatment and violence prevention (Children's Safety Network, 2007; CDC, 2007). A caution is that the public health model of reducing adverse outcomes through normative change may not be directly applicable to the problem of child maltreatment. In contrast to the "stop smoking," "don't drink and drive," and "use seat-belts" campaigns, child abuse prevention often lacks specific behavioral directions that the general public can embrace and feel empowered to impose on others in their community. Exceptions may exist for specific forms of maltreatment, such as shaken baby syndrome, but much maltreatment is neglect, which is less amenable to identification and public health intervention (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008). In these situations, the public health approach can still affect child maltreatment by applying what we know about various types of abuse to create more effective social action for prevention.

Evidence-Based Programs
Although evaluating child maltreatment prevention programs has been discussed for some time (Helfer, 1982), it is only recently that the practice field has begun to develop the necessary capacity to understand and use evidence in decision making. National organizations—such as the U.S. Centers for Disease Control and Prevention, Prevent Child Abuse America, Parents Anonymous, and the National Alliance of Children's Trust and Prevention Funds—have begun to assess and disseminate information about the effectiveness of programs (Prevent Child Abuse America, 2008). The World Health Organization (2006) has also assembled a guide to assist policy makers and program planners in using and developing evidence-based programs. The CDC has promoted evidence in the creation and implementation of family programs, for example, which integrate evidence and evaluation into the program model. Programs should ideally monitor their impact, create and enhance new approaches to prevention based on those results, apply and adapt effective practices, and build community readiness for additional activities (CDC, 2008).

Targeting Specific Types of Child Maltreatment Several parent education programs have been evaluated for their association with decreases in physical abuse and neglect. Family Connections, a multifaceted, home visiting community-based child neglect prevention program, showed "cost effective" improvements in risk and protective factors and behavioral outcomes (DePanfilis, Dubowitz, & Kunz, 2008). To address a specific form of physical abuse, Mark Dias and colleagues devised a hospital-based parent education program implemented immediately after birth that has been shown to decrease the incidence of shaken baby syndrome (Dias, Smith, deGuehery, Mazur, Li, & Shaffer, 2005). After a similar program delivered to over 15,000 new parents in West Michigan, the number of SBS cases admitted to the hospital dropped from 7 per year to 5.3, a 24% reduction (Palusci, Zeemering, Bliss, Combs, & Stoiko, 2006).

Barr and colleagues (2009) have devised a program of parent education in late pregnancy, delivery, and early infancy phases to change maternal knowledge and behaviors relevant to infant shaking (Barr et al., 2009). Using a randomized controlled trial, they were able to demonstrate how "The Period of Purple Crying" was able to increase maternal knowledge scores, knowledge about the dangers of shaking, and sharing that information with other caretakers. No significant differences were noted in maternal behavioral responses to crying.

Two risk factors, poverty and substance abuse, have been singled out as particularly important in terms of the strength of their association with physical abuse and neglect (Ondersma & Chase, 2003). Ondersma and Chase review the pathways in which substance abuse potentiates the effects of poverty and increases the risk of neglect, and they suggest a number of ways professionals can reduce substance abuse and maltreatment. Increased recognition and integration of substance abuse treatment in child welfare is a first step. A motivationally based public health approach for potentially at-risk parents would be proactive, brief, and repetitive and would incorporate substance abuse prevention messages into routine public health approaches spread over the parenting years. There is growing evidence that such programs, when implemented in multiple settings without stigmatizing parents, can appreciably reduce substance abuse and its associated maltreatment (Ondersma & Chase, 2003).

The biggest questions of how best to prevent sexual abuse, how to reduce rates over time, and eventually, eliminate sexual abuse remain unanswered. There are numerous signs that prior efforts

have been useful, but new methods need to be further explored and researched. In tests that show learning and skill acquisition for children and adults as a result of policy change, education, or media campaigns, study after study shows benefits of past prevention efforts (Davis & Gidycz, 2000; Rispens, Aleman, & Goudena, 1997). However, until recently, no study actually showed that participation in a prevention program resulted in reduced rates of sexual abuse for participants, with only anecdotal reports on successes and actions taken to stay safe as evidence (Plummer, 2001). A recent study, however, showed that college women (n=825) who had participated in a child sexual abuse prevention program as children were significantly less likely to experience subsequent sexual abuse than those who had not had such a program (Gibson & Leitenberg, 2000). Additionally, although some argue that sexual abuse has not decreased as a result of sexual abuse prevention efforts (Bolen, 2003), actual rates of sexual abuse do seem to be decreasing, and one proposed explanation is that sexual abuse prevention efforts may be at least part of the reason (Finkelhor & Jones, 2004). Finkelhor (2007) has concluded that these decreased rates and other available evidence support providing high-quality sexual abuse prevention education programs because children are able to acquire the concepts, the programs promote disclosure, there are lower rates of victimization, and children have less self-blame after attending these programs. There is additional evidence that movements to build adult and community responsibility for child sexual abuse prevention, such as the "STOP It Now" program, are also an important component.

Despite the prevalence and demonstrated long-term effects of psychological maltreatment, there is little evidence detailing specific programs and practices designed specifically for its primary prevention. Several interventions for prevention of physical abuse and neglect do promote attachment and enhanced parent-child interactions, which by their very nature should decrease psychological maltreatment. However, given the varying definitions of psychological maltreatment from study to study and our difficulty in its accurate identification and reporting, it will be inherently problematic to show its reduction after prevention activities.

Integrating Prevention Into Professional Practice

Professionals have several potential roles in violence prevention, including advocating for resources for effective programs, screening, recognizing and referring at-risk families for services, and promoting nurturing parenting and child-raising styles (AAP, 1999). Johnson (1998), Dubowitz (2002), and Plummer and Palusci (in press) have suggested several opportunities for professionals to take a leadership role in preventing child maltreatment:

Parent Education Professionals need to give parents effective strategies for discipline and nurturing by providing materials, consultation and referral. They should promote issues of Internet safety, supervision, selecting safe babysitters, and choosing quality day care programs. Posters in waiting rooms, take-home brochures, and lists of Web addresses should be readily available for referrals for parents' use. Additional resources on child abuse prevention programs that exist in and around the community and referrals of parents to area agencies for additional information or assistance are also vital prevention interventions.

Community Awareness Professionals need to offer to provide radio or TV public service announcements to build awareness of child abuse as a societal and public health issue and an issue related to physical and mental health. Health care professionals have the credibility to promote awareness of the links between childhood trauma and future health problems.

Bystander Involvement In personal or professional capacities, professionals need to be become involved when they are concerned about a child's safety and to seek supervision or consultation when necessary. Despite great demands on their time, professionals must be willing to make referrals to Child Protective Services based on reasonable suspicion rather than waiting until they are certain to report child maltreatment.

Early Behavior Problem Identification Caregivers often consult with authorities about behavior problems with their children, who may be exhibiting reactive symptoms of being abused or of stress after trauma exposure. Behavioral problems are often nonspecific, but professionals can guide parents to seek additional assistance, while guarding against parental overreaction to self-exploration or developmentally-appropriate behavior.

Policy and Organizational Prevention Efforts Professionals should be willing to make changes in policy, hiring, supervision, and training in their own office or organization to put proven risk-reduction procedures in place. This can include establishing clinical practice guidelines to address these issues in the office and clinic.

Improved Clinical Care and Education Professionals need to recognize risk factors for violence when providing clinic care and be able to identify, treat, and refer violence-related problems at all stages of child development. There are several tools available, such as from the American Academy of Pediatrics (AAP, 2005). Professionals need to identify, for example, issues with mental illness, substance abuse, stress, inappropriate supervision, family violence and exposure to media violence, access to firearms, gang involvement and signs of poor self-esteem, school failure, and depression (AAP, 2005). Professionals need to support early bonding and attachment, educate parents on normal age-appropriate behaviors for children of all ages, and educate parents

about parenting skills, limit setting, and protective factors to be nurtured in children to help prevent a variety of injuries. Consistent discipline practices and body safety techniques should be emphasized.

Treatment and Referral Professionals need to know what they can handle through office counseling and when they need to refer families for help. They must also be cognizant of the resources available in their community to address these risks. This will require knowledge of the child welfare, emergency shelter, and substance abuse treatment systems and how to make referrals to appropriate therapists and mental health professionals.

Advocacy Professionals should use their given status in the community to advocate for the needs of individual families and for the broader needs of children in society. This includes working on public policy which can be best achieved by working with organizations that address the needs of children in different arenas. Professionals can endorse and support quality, comprehensive child-focused education and can serve on advisory boards for a local child abuse prevention agency or home visiting program, thereby assisting in networking alliances between prevention programs and the treatment field (AAP, 2009). Professionals can also be role models and leaders in their communities by offering support for family and neighbors who might need encouragement, help, or referrals and being advocates to assure that their communities have resources and services for parents.

Keeping Up to Date With the Field Professionals can be more effective advocates if they are knowledgeable about the current prevention field and evidence-based strategies for prevention. In the CPS practice field, professionals can identify prevention opportunities within the population of families and children who come to their system, but who are unsubstantiated or do not require that the children be taken into protective custody. Professionals in the "more traditional" fields of practice can help prevention professionals and volunteers by recognizing the importance of their prevention work, participating in multidisciplinary training, and helping to bridge the gap between research and practice.

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Journal Highlights

By Patti Beekman, BA, Stacey Saunders, MSW, Pam Quigley, MSW, and Laura Hughes, BA

This issue's Journal Highlights *summarizes the highest scoring articles for the 2010 Pro Humanitate Literary Awards in child welfare. Together they represent a snapshot of some of the exceptional work produced by child welfare researchers, academicians, and practitioners during the past year. The five highest scoring articles selected to receive the award are (1) Littell, (2) Bourke and Hernandez, (3) Jonson-Reid, Drake, and Kohl, (4) Drake, Moo Lee, and Jonson-Reid, and (5) Neustein and Lesher.*

The Quality of Published Reviews of Evidence-Based Practice

In this article, Dr. Julia Littell sought to assess the quality and rigor of compiled reviews of research studies, focusing on synthesis, analysis, and dissemination of primary research findings and conclusions, as summarized and reported in research reviews.

Using data from two studies in which she reviewed and analyzed both primary research conducted on multisystemic therapy (MST) and summary reviews of this research, she concluded that research reviews often used to determine which practices qualify as "evidence-based" may themselves be subject to bias.

In her first study, Littell identified and evaluated 37 research reviews. She noted that only a small portion (9) of the reviews was quantitative in nature, and most were in narrative form. She also found differences based on the reviewer's relationship to the research and suggested that independent reviewers were more likely to use explicit inclusion and exclusion criteria and systematic search methods, were less likely to include unpublished studies, and included fewer research reports and studies than did reviewers who were affiliated with MST.

Littell also found that standards of evidence and the way these standards were appraised also varied across reviews. Differences between randomized controlled trials and nonrandomized trials were not always considered by reviewers when reporting effects. Only four reviews assessed attrition in the original study, and only seven used some type of rating system to evaluate study quality. Synthesis of study results varied as well. In most cases, reviewers used tables of findings to synthesize data; however, reviewers frequently excluded null or negative results.

In the second study, Littell examined the 1987 Bunk, Henggeler, and Whelan trial of the effects of MST in cases of child maltreatment, and then she evaluated the 13 research reviews that reported the findings of this study. Of these reviews, only three included both positive and negative results or positive, negative, and neutral results. Littell identified several incongruities between the results of the original studies and the way authors had reported the results in their reviews.

Littell concludes with implications of these findings for social science, such as a need to provide advanced training for the next generation of scholars in systematically conducting reviews of research. Recommendations also included strengthening the peer review process to counter various types of selection bias; applying the CONSORT statement to provide clear guidelines for the reporting of meta-analyses and other types of research reviews; and endorsing use of prospective registers of trials to avoid publication bias and outcome selection bias. Littell also concludes that social science needs more scientifically sound syntheses of empirical studies to provide a valid evidence base for direct practice.

Littell, J. (2008). Evidence-based or biased? The quality of published reviews of evidence-based practice. *Children and Youth Services Review, 30*(11), 1299–1317.

Hands-on Child Victimization by Child Pornography Offenders

This article, by Dr. Michael Bourke and Dr. Andres Hernandez, reports findings of a study conducted by the authors that compared two groups of child pornography offenders participating in a voluntary treatment program at a medium-security federal prison. One group included men whose known sexual offense history at the time of sentencing involved Internet pornography but did not include "hands-on" child sexual abuse. The other group consisted of men who had participated in both Internet pornography and hands-on sexual offending against at least one child victim. The study sought to determine if the first group of offenders, thought to be only collectors of child pornography, in fact posed little risk of hands-on sexual offenses, or if they actually were hands-on offenders whose criminal sexual behavior involving children had gone undetected.

The study findings demonstrated that the Internet-only offenders were significantly more likely than not to have committed "hands-on" sexual abuse of a child. Further, offenders in both groups who abused children were likely to have offended against multiple victims, and the incidence of "crossover" victimizing across gender and age categories was high.

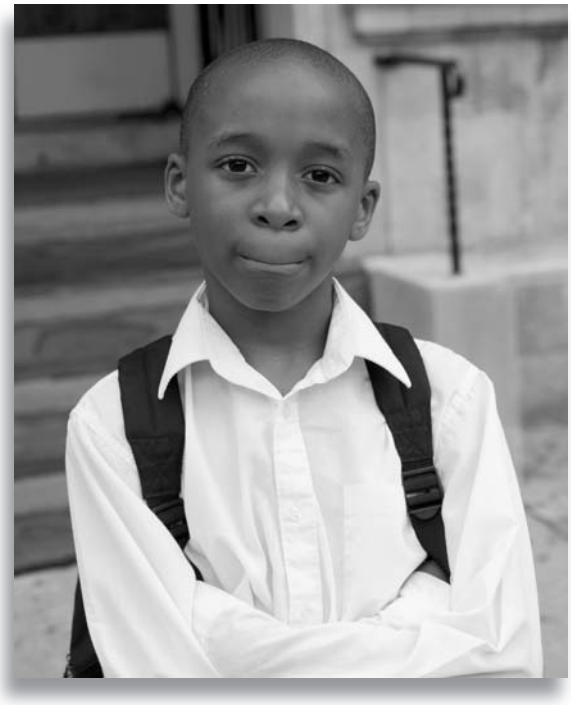
Previous research had confirmed the co-morbidity of sexual criminality among child pornographers. One of the authors (AEH) had initially raised this issue in November 2000 in a poster session, the "Butner Study," at the 19th annual conference of the Association for the Treatment of Sexual Abusers (ATSA). This study had also compared offenders in treatment and identified a substantial number who first claimed they merely collected child abuse images, only to later admit acts of previously undetected child sexual abuse. The current study utilized a larger sample, employed more rigorous research methodology, and explored the issue of "crossover" abuse in more depth.

The authors believe the offenders in the current study did disclose their offenses while in treatment, even after years of deception, because they felt it was safe to tell the truth without fear of prosecution. The authors also contend that few, if any, of the offenders would have admitted the true extent of their sexual offense histories if they had not been participating in an intensive treatment program. This underscores the importance of prison-based sex offender treatment programs to enhance the accuracy of risk appraisals and to improve the management of offenders in the community.

The fact that many study offenders reported previously undetected hands-on sexual crimes raises the question of whether the Internet has created a new type of sex offender, or if it provides additional outlets for sexually deviant individuals. The authors suggest that many Internet child pornography offenders are undetected child molesters, and that their use of child pornography is indicative of their paraphilic orientation. The study findings suggest that online criminal investigations targeting child pornographers can have the added benefit of identifying and apprehending concomitant child molesters. If hands-on contact offenders were not involved in criminal sexual activity online, their more serious crimes might not otherwise come to the attention of law enforcement.

In conclusion, the authors state that while this study is exploratory, it highlights the complex and reciprocal interaction between viewing child pornography online and contact sexual crimes. They also caution that although their preliminary findings indicate that the majority of so-called online child pornographers are, in fact, undetected child abusers, it is presumptuous to conclude that the Internet is a causal factor in contact sexual criminality. More research is needed to define this relationship.

Bourke, M. L., & Hernandez, A. E. (2009). The 'Butner Study' redux: A report of the incidence of hands-on child victimization by child pornography offenders. *Journal of Family Violence. 24*(3), 183–191.



Overrepresentation of the Poor Due to Bias or Need?

Although research confirms that maltreatment occurs across social classes, poor children are more likely to have contact with the child welfare system than are non-poor children. However, the child protection field has been unclear whether poor children are actually more likely to suffer maltreatment, or if bias related to the social and economic class of clients exists at one or more levels of the child protection system. The authors—Drs. Melissa Jonson-Reid, Brett Drake, and Patricia Kohl—define *bias* as reliance on social and economic class membership to determine the likelihood of child protective service involvement rather than an objective identification of risk or a need for services.

To assess for the presence of class bias, the authors compared child welfare system involvement (defined as maltreatment reports, investigations, out-of-home placements, and/or recurrences) with involvement rates from other service systems, such as income maintenance, hospitals, juvenile court, public health, or mental health. The study findings suggested that the presence of increased risk among poor children, rather than high levels of systemic class bias, drives the overrepresentation of poor children in the child welfare system.

The authors consider this to be the first study to explain how class bias might manifest in child welfare involvement, and to further test these relationships using criteria that are not sensitive to class bias. The study draws data from a larger longitudinal study based in a Midwestern metropolitan area and follows children from 1993 through mid-year 2006.

The authors compared child welfare outcomes (e.g., initial reports, placement, recurrence) and nonsystem negative outcomes (e.g., injuries, mental problems, substance abuse) for three groups that included (1) poor children reported to child welfare, (2) non-poor children reported to child welfare, and (3) poor children who were not reported to child welfare. The data uniformly presented against the existence of large degrees of class bias. Poor children reported to child welfare appeared to be at substantially more risk of nonsystem negative outcomes when compared with either non-poor children who were reported or poor children who were not reported. These findings were also consistent with theory and research suggesting that poor children are appropriately overrepresented in the child welfare system because of the stress of poverty and its associated ecologic conditions, which typically place families at greater risk of abusive and neglecting behaviors.

The authors do caution that regardless of study findings, the field must still address biased decision making if and when it occurs. They also contend that while others recommend that we focus attention on addressing poverty directly, the child welfare system cannot afford to abandon its current work with at-risk children and families while searching for a long-term resolution to poverty. Further, professionals must not confuse the need to prevent poverty with the prevention of negative behaviors, including child abuse and neglect and other outcomes that are exacerbated by poverty.

Jonson-Reid, M., Drake, B., & Kohl, P. (2009). Is the overrepresentation of the poor in child welfare due to bias or need? *Children and Youth Services Review, 31*(3), 422–427.

Race and Child Maltreatment Reporting: Are Blacks Overrepresented?

Child welfare professionals have widely presumed that discrimination and bias are largely responsible for racial disproportionality in child maltreatment reporting. In this study, Drs. Brett Drake, Sang Moo Lee, and Melissa Jonson-Reid tried to determine whether racial disproportionality exists in child maltreatment reporting and to identify differences in child maltreatment reporting rates for white and black families.

The authors used U.S. Census data and child protection reports from Missouri's child abuse and neglect database from January 1, 1999, through December 31, 2001. To minimize potential investigator bias, they studied both substantiated and unsubstantiated referrals. The final data set included approximately 90,000 white children and 33,500 black children.

The study determined that blacks in Missouri were disproportionately reported to the child welfare system when compared with whites, at a ratio of about 2:1. However, when poverty was held constant, racial disproportionality in reporting rates was not evident. In addition, the findings indicated that poverty was associated with higher child maltreatment reporting regardless of race.

The authors identified six possible theories that could account for racial disproportionality: poverty, aggregation bias, visibility bias, straightforward racism, being "out of place," and differential sensitivity to poverty. They reported that black families were heavily aggregated in poorer communities and would access resources and services to alleviate the effects of poverty, thereby becoming more visible to potential reporters and drawing higher rates of reports (aggregation bias). However, counter to their hypothesis, the researchers also noted that mandated reporters were less likely to report individuals living in poverty, regardless of race. As an example of differential sensitivity, the study indicated that whites in high-poverty areas had slightly higher reporting rates than blacks in high-poverty areas; and in very low-poverty areas, blacks had higher reporting rates than whites. Data supported the suspected outcome that report rates would be higher for either race when in the minority ("out of place") as compared with times when they were in the majority, but this is held more for whites and for blacks only in less poor areas.

The study results confirmed the relationship of poverty and child maltreatment but did not show evidence of general racial bias in child maltreatment reporting. The authors concluded that their findings were consistent with earlier data. They also discussed how the heavier representation of blacks in poorer neighborhoods may increase their likelihood of being reported for child maltreatment. They cautioned against looking at racial disproportionality in reporting rates at "face value" when making policy changes to the process of reporting child maltreatment. Finally, the authors acknowledged that this study did not consider racial differences among reports accepted for investigation versus reports that were not, and they recommended that future research examine this issue.

Drake, B., Moo Lee, S., & Jonson-Reid, M. (2009). Race and child maltreatment reporting: Are blacks overrepresented? *Children and Youth Services Review, 31*(3), 309–316.

Rabbinic Sexual Abuse in the Orthodox Jewish Community

This article by Dr. Amy Neustein and attorney Michael Lesher explores how a rabbinic court intervened in a Brooklyn case involving charges of child sexual abuse perpetrated by a rabbi within an orthodox Jewish community. The authors provide insight into how religious and cultural concerns that guide rabbinic court activities could interfere with the effectiveness of the secular criminal justice system.

In 1997, a 9-year-old boy with a serious hearing deficiency required special tutoring in order to be mainstreamed into the *yeshiva*, or religious school. After a year and a half of intensive tutoring, the boy's performance became stagnant. In late 1998, the parents fired the rabbi tutor. Months later, the boy began to disclose abusive acts by the rabbi during tutoring sessions (pulling on his genitals and hitting his ear with the hearing aid). He also said the rabbi threatened him if he told anyone about the abuse.

In January 2000, secular authorities arrested the rabbi and charged him with child abuse. A rabbinic court, composed of five influential rabbis from orthodox communities in New York City, assembled to conduct an investigation of the charges against the accused perpetrator. An assembly speaker, also an orthodox Jew, became involved to ensure the district attorney would listen to the court rabbis.

The rabbinic court, or *beth din,* has great influence in orthodox communities, just as this traditional institution held unchallenged authority in centuries past. Orthodox community members are under a cultural imperative to forego secular courts and take all disputes first to the *beth din* for resolution. In this case, the victim's family did go to law enforcement first; but the rabbinic court also approached the district attorney, not to cooperate with prosecution but to stop the investigation of a credibly accused child sexual abuser. Traditional beliefs justify intervention by the *beth din* to prevent potential threats due to involvement in secular courts; or to address the fears that a rabbi convicted of sexual abuse would be attacked in prison, or that the rabbi's family would be shamed, or that relatives would be unable to find suitable marriage partners; and a fear, historically grounded, that scandal of this nature could reinforce anti-Semitism. In the case study, the rabbinic court used political influence to convince the district attorney to drop charges against the alleged perpetrator. Thus, the rabbi avoided criminal investigation and was not held accountable.

During the authors' preparation of the article, a prominent rabbi reported that no problem of child sexual abuse by rabbis existed, and that the orthodox Jewish community would never face scandal as did the Catholic church because the rabbinate does not include homosexuals. Still, the authors propose educational and legal reforms to prevent further vulnerability of Jewish children to rabbinic sexual abuse. For example, education could alert the community to lifelong consequences of abuse and also empower victims to reveal violations. Law enforcement could neutralize the influence of rabbinic courts in criminal cases, just as they do if gangs or members of organized crime attempt to intimidate witnesses or interfere with court processes. The authors qualify that *beth din* methods are not criminal; however, within their communities, *beth din* actions can be intimidating and can undermine justice.

Neustein, A., & Lesher, M. (2008). A single-case study of rabbinic sexual abuse in the orthodox Jewish community. *Journal of Child Sexual Abuse, 17*(3–4), 270–287.

The Quest for Evidence-Based Practice

This article reprints an address delivered by Dr. Bruce Thyer at an international conference sponsored by the Center for Social Services Studies at the University of Belefield, Germany, In this address, Thyer briefly catalogs the history of science in the social work movement and offers recommendations to enhance the link between science and social work. He contends that the foundation of the social work profession can no longer be caring for persons in need but rather evidence about results, effects, and outcomes. He references Auguste Compte's belief that human affairs are, in fact, amenable to successful investigation using tools of inquiry found in the physical sciences, mathematics, and biology, and he asserts that social work should be subject to these same types of inquiry. Thyer also outlines the history of positivism in the evolution of the social work profession and its influence on the establishment in 1994 of the Society for

Social Work and Research. He suggests that these advances represent both the quest toward evidence-based practice and an opportunity to ground the social work field on a scientific foundation.

Thyer recommends that social work embrace the philosophical assumptions and scientific methods associated with the larger evidence-based practice movement. He contends that social work practitioners need to stop criticizing these methods and principles as inherently incompatible with social work values and objectives. He acknowledges that social work lags behind other professional disciplines because of endless professional wrangling over inherently unresolvable philosophical issues, and recommends replacing this debate with a commitment to high-quality social work research and to prioritizing funding for this purpose.

Thyer recommends that the profession reduce its focus on a theory-driven research agenda and instead should evaluate processes and outcomes. He suggests that the profession become much more proactive in collaborating with organizations such as the Cochrane and Campbell Collaborations because much needed data from systematic reviews in social work and social welfare are notably lacking. He recommends adoption of ethical standards that support a client's right to effective treatment, as well as adoption of an evidence-based approach to social work education. He also contends that the profession should stop seeking knowledge that is specific to the social work discipline, since social problems and their interventions are not discipline-specific. Attempts to carve out unique social work-specific knowledge should be replaced by interdisciplinary approaches to problem solving. He concludes by suggesting that through the combination of evidence-based practice with caring attitudes and liberal views, the social work field will become "truly professional."

Thyer, B. A. (2008). The quest for evidence-based practice? We are all positivists! *Research on Social Work Practice, 18*(4), 339–345.

Clergy Sexual Abuse in the Context of the Catholic Religious Tradition

In this article, Rev. Joseph J. Guido uses a case example of a man named Danny, whose priest sexually abused him on three separate occasions when he was an adolescent. By describing these experiences, the author illustrates how sexual abuse of children and adolescents by Roman Catholic priests is not only a physical violation but potentially also a spiritual one. He contends that the associated infringement on a fundamental sacred trust can leave survivors feeling alone, unable to believe, and in Danny's words, "spiritual orphans." The author argues that the intersection of the status of priests in the church combined with a "sacramental" culture makes this crisis unique to Catholicism.

Guido discusses the importance of understanding both Catholic culture and the role of priests to fully understand the idiosyncrasy of this violation. The author suggests that in a sacramental culture, spiritual rituals have deep symbolic meaning to parishioners. To illustrate the importance of sacraments in the Catholic religion, Guido sites the work of Hoge, whose research showed that 80% of Catholics across three generations identified sacraments as the most important component of their self-identification as Catholic. Through the sacrament of Holy Orders, priests become vessels through which parishioners can experience their faith and receive their sacraments, and priests' alignment with Christ creates role confusion for child victims and often leaves victims questioning the role of God in abusive acts.

The author suggests that in order to heal, survivors often need to confront the underlying religious meaning to them personally of the abuse, by examining both their own religious beliefs and the personal implications of having been abused by such a sacred figure. To help clients in this situation, therapists need to address not only the alleviation of symptoms caused by the trauma but a client's spiritual needs as well. In some cases, therapists should refer survivors to knowledgeable and compassionate church representatives for spiritual help. In other situations, clients may choose not to return to the Catholic faith and may change denominations, or they may choose not to believe at all.

Guido, J. J. (2008). A unique betrayal: Clergy sexual abuse in the context of the Catholic religious tradition. *Journal of Child Sexual Abuse, 17*(3–4), 255–269.

Maltreated Children's Emotional Availability With Kin and Non-kin Foster Mothers

Federal policy mandates the placement of children with kin (i.e., relative) foster parents whenever possible to ensure continuity of family relationships and to reduce placement trauma experienced by children placed outside the family unit. However, there has been limited research conducted to compare the efficacy of kin versus non-kin foster placements. The present study sought to identify placement options for maltreated children that would provide them with the greatest likelihood of developing strong relationships with their caregivers.

Dr. Michael J. Lawler based this research on sociobiological theory, which implies the existence of a biologically-based investment in kin foster mother–maltreated child dyads, which would be stronger than bonds between non-kin foster mothers and the children in their care. The current study examined how biological relatedness of kin foster care contributed to the quality of maltreated child–foster parent relationships, as defined by dyadic emotional availability between young maltreated children (2–8 years old) with behavioral problems and their kin or non-kin foster mothers.

The study assessed 106 randomly selected maltreated children, ages 2–8, and their foster mothers. The research controlled for the children's age, foster mother's age, foster mother's level of education, and placement duration. To measure the emotional availability of the foster parents and the child, the author used the *Emotional Availability Scales*, including categories of *maternal sensitive structuring, maternal non-hostility, maternal non-intrusiveness,* and *child emotional availability.* Researchers also scored an age-appropriate play response using Parent-Child Interaction Therapy (PCIT).

Study findings did not support the hypothesis of a sociobiologically-based relationship advantage for kinship foster placements. Lawler suggests that non-kin foster parents may demonstrate altruistic motivation and behaviors when deciding to become caregivers to maltreated children. Lawler cautions, however, that demographic and characteristic differences exist between the two caregiving groups.

This study has added to limited existing data on sociobiology and substitute caregivers. However, due to the lack of verifiable difference in emotional availability between the kin foster parent and maltreated child relationship and the non-kin foster parent and maltreated child relationship, Lawler recommends that practitioners complete thorough assessment when conducting any out-of-home placement. He also suggests that future research include longitudinal study of a broader sample of maltreated children and their kin or non-kin caregivers, which would also take into consideration the variations in professional support provided to non-kin, agency approved families, and kinship families.

Lawler, M. J. (2008). Maltreated children's emotional availability with kin and non-kin foster mothers: A sociobiological perspective. *Children and Youth Services Review, 30*(10), 1131–1143.

Missing Children: Representing Young People Away From Placement

A 2002 article in the Detroit *Free Press*, "State Loses Track of 302 Abused and Neglected Kids," precipitated this chapter in *Childhood, Youth, and Social Work in Transformation* (Nybell, Shook, & Finn, 2009). These youth became Michigan's "missing children" and the publicity generated years of advocacy on behalf of child welfare in Michigan.

In this chapter, Dr. Lynn M. Nybell suggests that by categorizing youth who leave placement as "missing children," the media inappropriately labeled the youth by simplifying and generalizing their stories. The author met with youth and recognized common themes. They reported feeling a "pull" from their families, a "push" from their living facility, and a need to feel "normal." Some felt they could not make their concerns heard at the placement facility. Others cited abuse, bullying, and threats by other residents or staff. Rules and regulations put in place by the facilities made it difficult for young people to attend after-school programs or activities that could help normalize their experiences.

Michigan was not alone in its previously benign response to youth who were AWOL (away without legal permission) from placement. In 1996, 20% of 17-year-olds in foster care in California had exited the foster care system by running away. "Just leaving" became one of the principal ways for youth to terminate their placements. Soon after the *Free Press* article, Michigan posted names of photographs of "missing children" on its government Web site. As a result, the state found some children living with relatives to avoid placement. In response to the court order for the secure detention of these "missing children," the Youth Law Center warned of action against the court system and the Family Independence Agency, the agency initially cited by the *Free Press* for "losing" these children.

The initial *Free Press* article generated a transformation of Michigan's foster care system. The paper's publication of 27 ensuing news articles through the end of 2002 ensured that the newly-created Wayne County Task Force would continue to address concerns and would advocate for children in foster care in Michigan. The task force developed intervention strategies that included therapeutic foster care and alternative residential settings. After initiating these strategies in 2006, the courts placed only 10 AWOL children in detention centers, compared with 140 in 2003.

Nybell offers two critical points in this chapter. First, she urges further advocacy efforts on behalf of youth in foster care, specifically when they enter secure detention centers as punishment for leaving placement. She also challenges the foster care system to identify and reconsider what factors and situations impel children to leave placement, and she lobbies for the "missing children" theme to continue to underscore the need for advocacy. In conclusion, Nybell challenges the foster care system to balance a degree of freedom for children placed in substitute care with needed direction to navigate through the foster care system and into life after placement.

Nybell, L. M. (2009). Missing children: Representing young people away from placement. In L. M. Nybell, J. J. Shook, & J. L. Finn (Eds.), *Childhood, youth, and social work in transformation: Implications for policy and practice.* New York: Columbia University Press.

What's New and Who's Doing It?

By Lori D. Frasier, MD

The American Board of Pediatrics (ABP) offered the first subboard examination for certification of specialists in Child Abuse Pediatrics on November 16, 2009. More than 200 pediatricians qualified to sit for this examination. This is an important step in the evolution of medical care for abused and neglected children. First proposed to the ABP in 1999, Child Abuse Pediatrics was approved in 2006 as the newest subspecialty in pediatrics. The American Academy of Pediatrics, the American Medical Association, and the Association of Medical School Pediatric Program Directors supported the application to the ABP.

The development of the subboard recognizes that pediatricians, through practice and training, had developed skills and expertise in medical assessment of all areas of child abuse and neglect, as well as an understanding of legal, ethical, epidemiologic, and community-based issues. The approval of the application by the ABP demonstrated that there was a sufficient body of literature, numerous postresidency training programs, and most important, a need for such specialists to warrant creating a subspecialty.

The standards for qualifying to sit for this examination are high, with practice and training pathways defined to allow practicing child abuse pediatricians to sit for the first three examinations in 2009, 2011, and 2013. After 2013, only those board-certified pediatricians who also complete a three-year fellowship in an accredited child abuse pediatrics program will be eligible to apply for the examination. Six years of postmedical school training will therefore be required for a pediatrician to become certified in child abuse pediatrics.

The Accreditation Council for Graduate Medical Education (ACGME) recently published curriculum requirements for accredited fellowships. Those fellowships will be under the scrutiny of the Residency Review Committee (RRC), and must meet the same standards as any specialty of pediatrics. Subboard certification in Child Abuse Pediatrics does not detract from the responsibility of general pediatricians, other specialties in medicine, or nursing in providing care to abused and neglected children. These new specialists will be trained not only in clinical areas but also research methodology. They will develop the educational and clinical infrastructure at medical schools, tertiary medical centers, and Children's Hospitals. Academic Pediatric departments will be encouraged to include board-certified child abuse pediatricians on their faculties.

This new subspecialty was built on the foundation of the many physicians who, over the past five decades chose to provide medical care to maltreated children. This new specialty is a tribute to their hard work and persistence. Their legacy will be a new generation of physicians whose research, clinical skills, and community advocacy will improve the lives of children and their families.

Update On January 26, 2010, the American Board of Pediatrics announced the first cohort of nearly 200 physicians who are now Board Certified in Child Abuse Pediatrics. The next subboard examination will be given in November 2011 to pediatricians who meet the ABP requirements (Practice/Training or both pathways).

For information on qualifying requirements, forms, and deadlines for the subboard examination, please refer to the Web site of the ABP at www.abp.org. Curriculum requirements are available at www.acgme.org.

About the Author
Lori Frasier, MD, is Associate Professor of Pediatrics at the University of Utah School of Medicine and Medical Director of the Medical Assessment Team at Primary Children's Medical Center, Center for Safe and Healthy Families. Dr. Frasier is Chair of the executive committee of the Section on Child Abuse and Neglect for the American Academy of Pediatrics. She is also a member of the APSAC Board.

Washington Update

Thomas L. Birch, JD, National Child Abuse Coalition

Health Care Bill Faces Uncertain Future

Until the Democrats lost their essential 60th seat in the Senate with the election of Republican Scott Brown to fill the vacancy left by the death of Sen. Edward M. Kennedy, health care reform legislation was on an "expedited timetable" as House and Senate Democrats were working to reconcile the differences between the bills passed by each chamber at the end of last year. The timetable for the legislation has been scrapped and the path forward for a health care bill remains uncertain. Particular provisions around health care for children that had been included in the two versions of the bills already passed face an unpredictable future.

Home Visitation The home visitation initiative appeared to be safe in the final health care legislative package, but there is no clear indication what form it might take now, even though House and Senate staff had neared agreement on the final provisions for a home visiting program. The House proposed mandatory funding of $750 million in Title IV child welfare funds over a period of 5 years for a new program of home visitation services, plus a provision allowing states to apply Medicaid funds to pay for home visitation to eligible families. The Senate would guarantee $1.5 billion in mandatory spending over 5 years for home visitation through the Title V Maternal and Child Health Block Grant. The outcome could hang on an urge to hold down costs, which could spell the difference.

SCHIP More uncertain is the outcome for continued funding of the State Children's Health Insurance Program (SCHIP). The health reform bill passed by the House would eliminate SCHIP in 2013, moving the almost 650,000 children currently enrolled in the program into a proposed federal government-run private plan with fewer benefits and cost-sharing protections. The Senate bill, with provisions put forward by Sen. Jay Rockefeller (D-WV) and approved during the Finance Committee's deliberations on the health reform bill, keeps SCHIP authorized until 2019 but with no additional funding after 2013.

Without the funding beyond 2013, children enrolled in SCHIP would be forced into the insurance plans on the Senate bill's newly proposed state insurance exchanges. This is essentially the same outcome proposed by the House, in which the national exchange would presume to cover these children. Rockefeller's amendment would also extend SCHIP coverage to families earning up to 300% of the poverty level.

Rockefeller had objected to moving children covered by SCHIP into a proposed new government-regulated insurance exchange, fearing that benefits would be reduced. In explaining his amendment, Rockefeller claimed that his proposal would save $25 billion because children would otherwise have needed subsidies to buy insurance in the exchange.

A shift to the exchange for these children from low-income families could mean higher out-of-pocket costs, which could discourage families from buying insurance to cover their children at all. A study commissioned by First Focus (see http://www.firstfocus.net/pages/3635) found that depending on family income, children enrolled in SCHIP are exposed to only 0%–2% of medical expenses. Comparable exchange plans in the House and Senate bills would expose children to 5%–35% of costs, greatly increasing their financial burden and leaving low-income children worse off as a result of reform.

During Senate floor debates on health care, Senator Bob Casey (D-PA) introduced an amendment to the Senate bill that would have continued funding for SCHIP through 2019. The Casey amendment would require states to maintain current eligibility through 2013 and then raise the eligibility floor to 250% of poverty nationwide in 2014. The amendment was never brought for a vote, nor was it included in the legislative package on health care reform developed by Majority Leader Harry Reid (D-NV) and passed by the Senate. Casey and Rockefeller pledged to press the argument for SCHIP in the ongoing discussion over terms of a final bill.

The initiative to create a new federal program of funds for home visitation services gathered momentum with President Obama's fiscal year 2010 budget proposal in May, which asked Congress to approve legislation creating a program of mandated funding for grants to states for home visitation services to low-income families. At a White House briefing in May, the President's domestic policy staff suggested that the legislation to authorize the home visitation funding could be folded into a health care reform bill, because of the prevention focus of home visiting services.

Congress Completes FY10 HHS Funding Bill, Cuts Home Visit $$

With just one week left before federal funding was set to run out for the rest of the new 2010 fiscal year, the House and the Senate in December passed an omnibus appropriations bill combining six unfinished appropriations measures, including funding for the Department of Health and Human Services (HHS). In a surprise to advocates and to HHS officials, the legislation eliminates $13.5 million for home visitation grants supported since 2008 through the Child Abuse Prevention and Treatment Act (CAPTA) discretionary grants program.

Home Visitation Separate appropriations bills for FY10 approved in the House and Senate last July included continued funding for the CAPTA home visitation grants. In fact, the House would have raised the home visiting funds to $15 million, while the Senate would have held the funding at the 2009 level of $13.5 million. Instead, the funding was eliminated in the final bill. The House-Senate conference committee's statement accompanying the 2010 omnibus funding bill explains: "The conferees anticipate that mandatory funding will be provided for this activity in fiscal year 2010 as proposed by the Administration." In other words, the appropriators expect that the home visitation provisions first proposed by President Obama in his budget message last February and pending final resolution and enactment in the health care reform legislation still being shaped by Congress—no sure thing—will pick up the funds eliminated in the CAPTA program.

When the House passed its version of the Labor-HHS-Education appropriations bill in July, the House Appropriations Committee's report, in response to President Obama's budget proposal for mandated funding to states for home visitation programs, expressed strong support for home visitation and the intention to continue to fund the CAPTA grants for home visitation, "pending *enactment*" [emphasis added] of the President's initiative.

With the CAPTA funding, 17 programs received awards for evidence-based home visitation, offering up to $500,000 per year for 5 years, plus a grant for cross-site evaluation. The grantees are in the second year of the program. Grants awarded the first year provided funding for planning. Years 2–5 are meant for implementation. Discussions are ongoing at HHS and in Congress to determine what course to take with the grantees.

The only other HHS children and families services program cut––and eliminated—besides the CAPTA home visitation funding was the Compassion Capital Fund, a signature program initiated by the Bush administration aimed at supporting faith-based social services. The Obama administration requested the elimination of the $47.7 million Compassion Capital Fund, and Congress went along. The Senate Appropriations Committee report explained that the program "lacks accountability and adequate performance measures."

Children and Families Services Programs As expected, 2010 funds for most child welfare programs are frozen at the 2009

levels. In addition to level funding in the omnibus funding bill for the CAPTA basic state grants and community-based prevention grants, funding stays at the 2009 levels for the Title XX Social Services Block Grant, Title IV-B(1) child welfare services, child welfare training, Title IV-B(2) Promoting Safe and Stable Families grants, the Child Care and Development Block Grants, independent living grants for older youth leaving foster care, Community Services Block Grants, and the Adoption Opportunities and Abandoned Infants programs.

A few HHS Children's Bureau programs were tagged for funding increases in the 2010 fiscal year. Head Start's budget would grow by 17%, as proposed in the Obama budget. The growth would allow, as House and Senate committee reports attested, for Head Start to serve approximately 978,000 children in fiscal year 2010, maintaining the increase by 69,000 children served due to funding injected into the program by the stimulus package enacted earlier this year. (Not all programs maintained the 2009 stimulus funding in the base amount set for 2010.)

The National Center for Injury Prevention and Control (NCIPC) in the Centers for Disease Prevention and Control (CDC) is marked for additional funding with a $3.3 million increase to $148.615 million, the level requested in the President's budget. The Senate bill's report specifically referred to the child maltreatment activities supported by NCIPC, noting the serious impact of adverse childhood experiences on lifelong physical and mental health, and encouraging the CDC to consider developing a network of researchers and research institutions.

The largest percentage growth—a 250% increase—goes to kinship guardianship funding, authorized in the Fostering Connections to Success and Increasing Adoptions Act of 2008. Funded at $14 million in 2009, the program expands to $49 million in 2010, as proposed in the President's budget. The funds support children who might otherwise be placed in foster care but instead are being raised by their grandparents and other relatives because their parents cannot care for them.

In another new initiative, the 2010 money bill provides $20 million in first-time spending requested by the Obama administration to fund innovative strategies that improve outcomes for children in long-term foster care. The new funding is intended to provide incentives to states to implement evidence-based approaches to increase permanent placements for children in foster care.

Abstinence Education/Teen Pregnancy Prevention As proposed in the Obama administration's 2010 budget, the final HHS spending bill eliminates the $100 million program of abstinence education and in its place creates a new teenage pregnancy prevention program—also proposed by the administration—funded at $110 million and administered by a new HHS Office of Adolescent Health. The conference agreement allocates $75 million for programs "proven effective through rigorous evaluation" and offers support to "a wide range of evidence-based programs."

Up to $25 million would go for research and demonstration grants to test additional models and develop innovative strategies for preventing teenage pregnancy. Remaining funds would go for training and technical assistance, with $4.5 million designated to carry out evaluations, including longitudinal evaluations of teenage pregnancy prevention approaches.

GAO Reports On Rigorous Program Evaluations

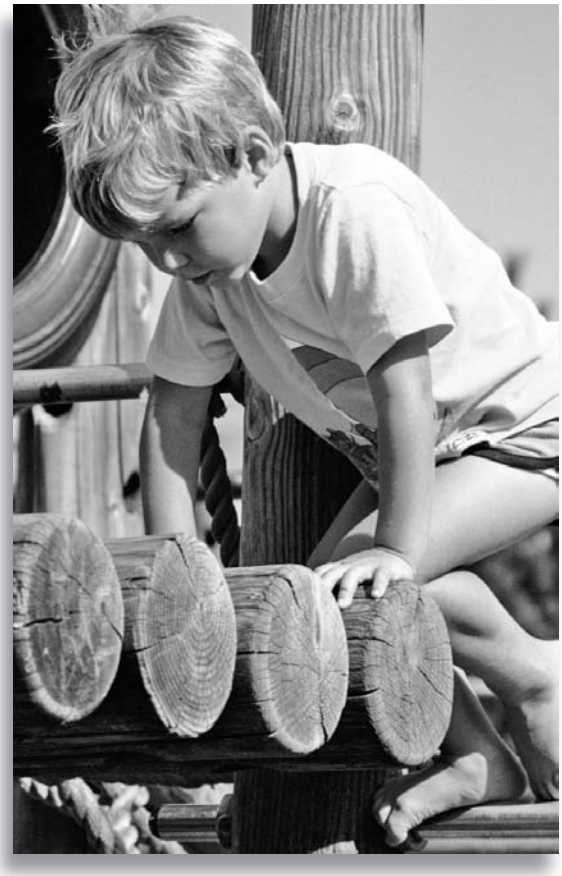
On the heels of work undertaken in the past year by the private, nonprofit Coalition for Evidence-Based Policy in its "Top Tier Evidence" initiative to help federal programs identify interventions that meet a standard for which randomized experiments show sustained benefits, the Government Accountability Office (GAO) was asked to examine the validity of that process and alternative methods for rigorous assessment of program effectiveness. GAO also looked at the types of interventions best suited for assessment with randomized experiments.

GAO concluded that requiring evidence from randomized studies as the only proof of a program's effectiveness "will likely exclude many potentially effective and worthwhile practices" and that the decision to adopt a particular intervention "involves other considerations in addition to effectiveness, such as cost and suitability to the local community."

The reliance on evidence gathered solely from randomized control trials (RCT) has recently been much debated by policymakers, politicians, and practitioners, notably around decisions on funding various models of home visitation services. When the Obama administration first proposed funds in its 2010 budget for home visiting, it would have restricted support to those programs proven to meet the RCT standard—the same identified by the Coalition for Evidence-Based Policy. The legislation on home visiting support as it has developed in subsequent proposals from the White House and through legislation in Congress would recognize the validity of supporting a broader range of home visiting interventions.

The report, titled *Program Evaluation: A Variety of Rigorous Methods Can Help Identify Effective Interventions* (GAO-10-30, Nov. 23, 2009), was prepared by the GAO Center for Evaluation Methods and Issues (see http://www.gao.gov/Products/GAO-10-30).

While GAO found that the evidence-based coalition's criteria for assessing quality "conform to general social science research standards…other features of its overall process differ from common practice for drawing conclusions about intervention effectiveness." The GAO report cites the coalition's process for failing to be "transparent about how it determines whether an intervention meets the top tier criteria…. The Top Tier initiative's choice of broad topics (such as early childhood interventions), emphasis on long-term effects, and use of narrow evidence criteria combine to provide limited information on what is effective in achieving specific outcomes."



GAO suggests that "rigorous alternatives" to randomized experiments, which GAO says can often be difficult and sometimes impossible to carry out, are considered appropriate for other situations: quasi-experimental comparison group studies, statistical analyses of observational data, and in-depth case studies. The GAO report explains that credibility relies on how well the studies' designs rule out competing causal explanations, and that collecting additional data and targeting comparisons can help rule out other explanations.

Variable State Response To Substance-Exposed Infants

An analysis of state policies regarding prenatal exposure to alcohol and other drugs shows that states vary considerably in responding to concern over the negative effects on developing infants. The National Center on Substance Abuse and Child Welfare (NCSAW), through a review of policies and practices in all 50 states and the District of Columbia and in interviews in 10 states, concluded that states must develop interagency collaborations to address the problem of substance exposed infants through a comprehensive framework of services to children and families.

The report, titled *Substance-Exposed Infants: State Responses to the Problem*, issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), found that no service delivery system in any state requires prenatal screening for substance use, and although Medicaid covers the cost of 37% of all births in the United States, there is no Medicaid requirement for prenatal screenings for substance use. No state has current prevalence data on substance use during pregnancy.

Although some states have public education campaigns on the harm done by using alcohol, tobacco, and illegal drugs during pregnancy, the national rates of use during the first trimester, according to the report, suggest that the message is not getting through, especially to younger women. The NCSAW researchers found very few hospitals using universal screening; most conduct testing based usually on subjective criteria.

Although amendments to CAPTA in 2003 required that newborns determined to be exposed prenatally to illegal drugs must be referred to child protective services (CPS), the survey found that hospitals do not usually provide CPS—or other state agencies—with data on the total number of infants tested at birth, the results of tests, or referrals to CPS. In an attempt to comply with CAPTA, the survey suggested that some states have recently enacted legislation requiring that a CPS referral be made when drug exposure is detected. However, practice does not always conform to official policy.

What's more, the report found that state responses to the CAPTA requirement that substance-affected infants receive a developmental assessment under the Individuals with Disabilities Education Act (IDEA) are "still evolving." As a result, it is difficult to assess the status of immediate postnatal services required by the CAPTA amendments. Of 10 states studied in depth, only two showed strong links between IDEA referrals and CPS agencies.

The report suggests that states could use Medicaid regulations and resources to influence hospitals to adopt prenatal screening policies, including using Medicaid to finance mental and behavioral health assessments, therapies, and services. Better collection of data is warranted to understand the level of prevalence and define the priorities for intervention.

APSAC News

Plan Now to Attend APSAC's Colloquium in New Orleans

APSAC will host its 18th Annual Colloquium from June 23–26, 2010, at the Sheraton New Orleans in New Orleans, Louisiana. The week will feature Advanced Training Institutes, the Cultural Institute, and nearly 100 seminars. In addition, the Colloquium offers ample networking opportunities, poster presentations, exhibits, and an awards ceremony.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education. Upon completion of this activity, participants should be able to:

- Apply state-of-the-art treatment methods when working with abused and neglected children.
- Identify the most up-to-date information concerning working with abused and neglected children.
- Prepare and report quality testimony in court cases, both as experts and as witnesses.
- Identify physical abuse, sexual abuse, and neglect in children.
- Apply model examination and treatment techniques for abused and neglected children.

Seminars are designed primarily for professionals in mental health, medicine, nursing, law, law enforcement, social work, education, child protective services, research, advocacy, and allied fields. All aspects of child maltreatment will be addressed, including prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. Cultural considerations will also be addressed.

To help attendees select their seminars, the Colloquium is divided into convenient tracks: Administration, Cultural Diversity, Child Protection, Interdisciplinary, Interviewing, Law, Mental Health, Medicine and Nursing, Prevention, and Research.

The 18th Annual Colloquium is cosponsored by APSAC and The Institute for Continuing Education. Continuing education credit is offered for a variety of disciplines and is awarded on a session-by-session basis with full attendance required at the sessions selected. Representatives from The Institute will be on site to accept applications for continuing education credit and to assist conference attendees. A separate processing fee is required.

Complete details and registration information are available on the APSAC Web site at www.apsac.org. The site also features a downloadable and printable PDF version of the conference brochure.

APSAC Board Meets in San Diego; New Directors and Officers Elected

APSAC's Board of Directors met January 26 in San Diego, California. Part of the agenda was to recognize the seating of new Board members and the election of officers.

Board members elected to 3-year terms are as follows:
Elissa J. Brown, PhD, St. John's University, Partners Program/Psychology, Jamaica, New York;
Lori Frasier, MD, Professor of Pediatrics, University of Utah/Primary Children's Medical Center, Salt Lake City, Utah;
Tricia Gardner, JD, Assistant Professor, Center on Child Abuse & Neglect, Oklahoma City, Oklahoma; and
William Marshall, Detective, Spokane Police Department, Spokane, Washington.

Officers elected to serve are as follows:
President – **Ronald C. Hughes, PhD, MScSA,** Director, Institute for Human Services, Columbus, Ohio;
Vice President – **Viola Vaughan-Eden, PhD, LCSW**, Child and Family Resources, Newport News, Virginia;
Treasurer – **Vincent J. Palusci, MD, MS**, Loeb Child Abuse Center, New York, New York;
Secretary– **Tricia Gardner, JD,** Assistant Professor, Center on Child Abuse & Neglect, Oklahoma City, Oklahoma;
Board Member to the Executive Committee –**Arne Graff, MD**, Medical Director, Child and Adolescent Maltreatment Services, MeritCare Health Systems, Fargo, North Dakota; and
Immediate Past President – **Michael L. Haney, PhD**, Director for Prevention and Intervention, Florida Department of Health, Children's Medical Services, Talahassee, Florida.

A complete list of APSAC Board members is available on the APSAC Web site at www.apsac.org.

Publication Editors Announced by APSAC Board

At its meeting in San Diego, the APSAC Board of Directors unanimously approved the appointment of new editors for the *APSAC Advisor* and the new *APSAC Alert*:
Judith S. Rycus, PhD, MSW, Institute for Human Services and the North American Resource Center for Child Welfare, has been named Editor in Chief of the *APSAC Advisor*. She moves into this position after serving 5 years as Associate Editor.
Jon Conte, PhD, University of Washington, will serve as Editor of the soon to be released *APSAC Alert*.

APSAC Produces Three Successful Institutes in San Diego; Attendance Soars

A total of 181 individuals—*an increase of 71% over 2009*—participated in APSAC Advanced Training Institutes January 24–25 in San Diego, California. The programs were part of the Annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center.

APSAC programs in San Diego included the following:

- Advanced Forensic Interviewing Techniques for Children: The Cognitive Interview and Beyond – Julie Kenniston, LSW, Chris Ragsdale, MSW, Lynda Davies-Faroni, BA, and Michael Haney, PhD
- Advanced Sexual Abuse Evaluation for Medical Providers – Lori D. Frasier, MD, and Suzanne Starling, MD
- Medical Issues in Child Maltreatment for the Nonmedical Team Member – Rich Kaplan, MD

In addition to offering three educational programs, APSAC also exhibited at the conference. The results were very good, with several new members joining on-site and many individuals renewing their memberships.

Forensic Interview Training Clinic Scheduled in Seattle

Consistent with its mission, APSAC is again offering its Forensic Interview Training Clinic July 12–16 in Seattle. The training is focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviewing alleged victims of child abuse has received intense scrutiny in recent years and increasingly requires specialized training and expertise.

This comprehensive clinic offers a unique opportunity to participate in an intensive 40-hour training experience and to have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing and features a balanced review of several models.

Training topics include the following:

- How investigative interviews differ from therapeutic interviews.
- Overview of various interview models and introduction to forensic interview methods and techniques.
- Child development considerations and linguistic issues.
- Cultural considerations in interviewing.
- Techniques for interviewing adolescents, reluctant children, and children with disabilities.
- Being an effective witness.

To attend the 2010 Seattle clinic, visit the APSAC Web site at www.apsac.org for details and registration.

APSAC Now Accepting Award Nominations for 2009 Achievement

Do you know a colleague who deserves recognition? Have you seen some really outstanding work that should be rewarded? If so, then you may want to consider submitting a nomination or two for APSAC Awards.

Award categories include the following: Service, Professional, Research Career Achievement, Front Line Professional, Media Coverage, Research Article, Doctoral Dissertation, and Cultural Competency in Child Maltreatment Prevention and Intervention. Complete details, the nomination form, and a list of past recipients are available on the APSAC Web site at www.apsac.org.

New this year—the nomination form is a convenient Microsoft Word document that you can download, complete on your computer, save and e-mail to APSAC, along with other required information.

The deadline for submission is **April 14, 2010**.

Job Opportunities and Free Resume Posting Available Online

The APSAC Career Center, powered by JobTarget, was constructed to help connect our members and associates with new employment opportunities. Visit the Career Center on the APSAC Web site (www.apsac.org) to begin your job search or employee recruitment process. Job seekers will also have access to tools designed to help them be successful. The Career Center is open to APSAC members and the public. Members receive significant discounts when posting job openings. Resume posting is free.

Conference Calendar

April 10–13, 2010
National Organization of Forensic Social Work Annual Conference
Atlanta, GA
860.613.0254
pbrady@nofsw.org
http://www.nofsw.org/html/annual_conference.html

April 11–14, 2010
28th NICWA" Protecting Our Children" Conference on Child Abuse and Neglect
National Indian Child Welfare Association (NICWA)
Portland, OR
503.222.4044
laurie@nicwa.org
http://www.nicwa.org/conference/

April 15–16, 2010
Fostering Connections National Summit: Charting a Better Future for Youth
American Bar Association/Center on Children and the Law
New York, NY
312.988.5000
http://www.abanet.org/youthatrisk/national%20summit%20invite%20flyer.pdf

April 16–19, 2010
29th National CASA Conference, "Spring Into Action"
Court Appointed Special Advocates
Atlanta, GA
800.628.3233
sandy@nationalcasa.org
http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.5405963/k.A2FE/Annual_Conference.htm

May 10–11, 2010
18th Children's Justice Conference
Department of Social and Health Services, Children's Administration and the Children's Justice Task Force
Seattle, WA
360.902.7966
jamt300@dshs.wa.gov
http://www.dshscjc.com

May 12–14, 2010
17th National Foster Care Conference
Daniel Memorial Institute
Clearwater Beach, FL
904.296.1055
swaugerman@danielkids.org
http://www.danielkids.org/sites/web/content.cfm?id=275

May 17–20, 2010
Project Making Medicine Training
Clinical Training in Treatment of Child Physical and Sexual Abuse
Indian Country Child Trauma Center
Oklahoma City, OK
405.271.8858
http://www.icctc.org

June 23–24, 2010
Substance Exposed Newborns: Collaborative Approaches to a Complex Issue
National Abandoned Infants Assistance Resource Center/University of California, Berkeley
Alexandria, VA
510.643.7018
jzrussell@berkeley.edu
http://aia.berkeley.edu/training/SEN2010

June 23–26, 2010
18th APSAC National Colloquium
American Professional Society on the Abuse of Children (APSAC)
New Orleans, LA
877.402.7722
apsac@apsac.org
http://www.apsac.org

July 12–16, 2010
APSAC's Child Forensic Interview Clinic
American Professional Society on the Abuse of Children (APSAC)
Seattle, WA
877.402.7722
apsac@apsac.org
http://www.apsac.org

September 12–14, 2010
11th International Conference on Shaken Baby Syndrome/ Abusive Head Trauma
Atlanta, GA
888.273.0071
dvazquez@dontshake.org
http://www.dontshake.org

September 26–29, 2010
18th ISPCAN International Congress on Child Abuse and Neglect
Honolulu, HI
303.864.5220
congress2010@ispcan.org
http://www.ispcan.org/congress2010/

October 20–22, 2010
2009 Alliance for Children and Families National Conference
Milwaukee, WI
414.359.1040
hhanson@alliance1.org
http://www.alliance1.org

October 20–23, 2010
National Juvenile and Family Law Conference
National Association of Counsel for Children
Austin, TX
303.864.5359
advocate@naccchildlaw.org
http://www.naccchildlaw.org/?page=National_Conference

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