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Epidemiology of Clergy Sexual Abuse in the U.S. Catholic Church

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Introduction

Dr. Jack Coyne offered background information on sexual abuse by the clergy, reasons why priests sexually abuse children, and a summary and thoughtful critique of the professional response to sexual abuse in the Catholic Church (Coyne, 2011). We would like to add to Dr. Coyne's discussion by reviewing the results of a large-scale study undertaken by the John Jay College of Criminal Justice addressing the quantitative aspects of the sexual abuse crisis in the Catholic Church, which was released in 2004 (John Jay College, 2004). In a subsequent article, we plan to review the results of their second large-scale study, which addresses the contextual aspects of the crisis.

Over the past 10 years, the clergy sexual abuse "crisis" was heralded by a series of articles that appeared in the *Boston Globe* beginning in January 2002, led by emotionally-charged headlines about "scandal and cover-up" and "predator priests" (NPR, 2002; 2007). These investigative reports focused attention not only on the actual cases of sexual abuse but also on how the Archdiocese of Boston handled several instances of sexually abusive contacts between its priests and minors ("Spotlight investigation," 2006). Most concerning was the growing perception that the perpetrators were transferred between parishes and dioceses after the suspicions of potential abuse had surfaced, and that these reassignments were done without basic safeguards in place to protect the new, unsuspecting communities of children and families that would receive and welcome the abusive priests (Newberger, 2003).

The extensive press coverage that ensued led to additional investigations, some of which are detailed on the *Boston Globe*'s Web site in "Spotlight Investigation: Abuse in the Catholic Church." This special section chronicles over 10 years of news stories about clergy sexual abuse. Additionally, other major newspapers, including the *New York Times* (Goodstein, Zirilli, & *NYT* Staff, 2003), the *Los Angeles Times* (Wattanabe, 2002), and *USA Today* ("The accusers and the accused," 2002), carried stories about the sexual abuse crisis on an almost daily basis.

Background of Sexual Abuse in the Church

Philip Jenkins, Professor of History and Religious Studies at Pennsylvania State University, provided a well-researched time line and analysis of the "scandal" that had occurred to date, notably a full 6 years prior to the "crisis" that would unfold in 2002 (Jenkins, 1996).

He chronicled the media coverage of the notorious cases that had occurred in the mid-1980s and early 1990s. According to Dr. Jenkins, a 1985 report, initially shared confidentially among Church leaders, entitled "The Problem of Sexual Molestation by Roman Catholic Clergy: Meeting the Problem in a Comprehensive and Responsible Manner," addressed the (1) need for Church leaders to avoid the appearance of secrecy and cover-ups by taking urgent action and making swift responses when allegations arose, and (2) possibility of criminal charges if leaders failed to report allegations to civil authorities. Additionally, the report discussed the potential for large settlements in civil proceedings brought by victims against the Church (Jenkins, 1996).

It has been difficult to fully analyze sexual abuse in the Church for many reasons, including the underreporting and hidden nature of sexual abuse and the lack of formal responses by the Catholic Church (Flynn, 2000). The studies conducted in the 1990s prior to the 2002 crisis are not generalizable because they included small samples of clergy members from single parishes or treatment programs. To provide a scholarly foundation for the evolving picture that is emerging from our systematic inquiry into the clergy abuse problem, Table 1 illustrates some of the early studies conducted in the field, including the samples and methodologies employed.

In response to a number of factors, including widespread media attention, the outrage of many Church members (both clerics and lay members) and many local district attorney and state-level attorney general investigations, the U.S. Catholic bishops wrote and ratified a 17-article *Charter for the Protection of Children and Young People* at their June 2002 meeting in Dallas, Texas. Often referred to as the *Dallas Charter*, this document contained the bishops' collective apology for the leadership failures that were broadly recognized and their commitment to deal with the problem and to prevent further sexual abuse from occurring in the Church. The Charter calls for the dioceses to provide aid to victims and their families, to report allegations of abuse to authorities, to discharge clergymen guilty of sexual abuse, and to provide better background checks on priests and deacons, among other

Table 1. Published Studies in the Church in the 1990s

Author(s), year	Sample	Method
Andrews, 1999	Four congregations of clergy and parishioners	Self-reports
Flynn, 1999	25 sexually abused women	Self-reports
McDevitt, 1999	Three groups of Roman Catholic priests to determine the extent of their own personal abuse	Self-reports
Mendola, 1998	277 Catholic priests and religious brothers referred for psychiatric evaluation	Retroactive study examining archival data
Pritt, 1998	115 Mormon women who reported sexual abuse	Questionnaire examining spirituality, concept of God, and optimism and pessimism.
Rosetti, 1997	1, 810 Catholics to determine the effect of abuse accusations on their faith in Church and God	Questionnaire
Rosetti, 1995	1,810 Catholics to determine the significance in victim trauma based upon age and gender	Questionnaire
McLaughlin, 1994	Pilot study with adults and children to find out the difference in effects of abuse on their spirituality	Spirituality scale and self-reports
Irons and Laaser, 1994	25 sexually abusive priests who are in treatment	Assessment scales to determine sexual and other addictions
Geotz, 1992	374 ordained pastors to find out how many had affairs	Self-report surveys

Source: Terry (2006), p. 232.

important steps to address sexual abuse in the Church (U.S. Conference of Catholic Bishops [USCCB], 2002).

The Dallas Charter contained an agreement on the part of the bishops to establish a lay committee called the National Review Board (NRB) (2004) to assist the bishops in maintaining their commitments to the Catholic faithful that were made in the Charter. The lay members of the NRB were charged with conducting several studies directed at enhancing understanding surrounding the problem of sexual abuse by clergy. In addition to academic studies, the NRB was also asked to receive and approve reports from a newly established diocesan auditing process in which each diocese was visited and data were collected related to the diocese's compliance with the activities called for in the Charter.

The first scholarly study to be commissioned by the NRB, the Nature and Scope study, provided a statistical overview of the epidemiology of the sexual abuse crisis in a report issued in February 2004 (John Jay College, 2004). Also released in February 2004 was the NRB's *Report on the Crisis in the Catholic Church in the United States*, a compilation and analysis of over 85 interviews conducted by NRB members of Church leaders as well as others who had insights to offer on the clergy sexual abuse crisis (NRB, 2004). These interviews provided a framework from which to view the sexual abuse crisis, and the NRB's report contained a nonscientific analysis of the information gleaned from the interviews. Among other things, the report called for enhanced screening and oversight of priests and deacons, increased effectiveness in responding to abuse allegations, greater accountability of bishops and Church leaders, and improved interaction with civil authorities. A later study, the Causes and Context study, was released in 2011 (John Jay College Research Team, 2011).

The Nature and Scope Study

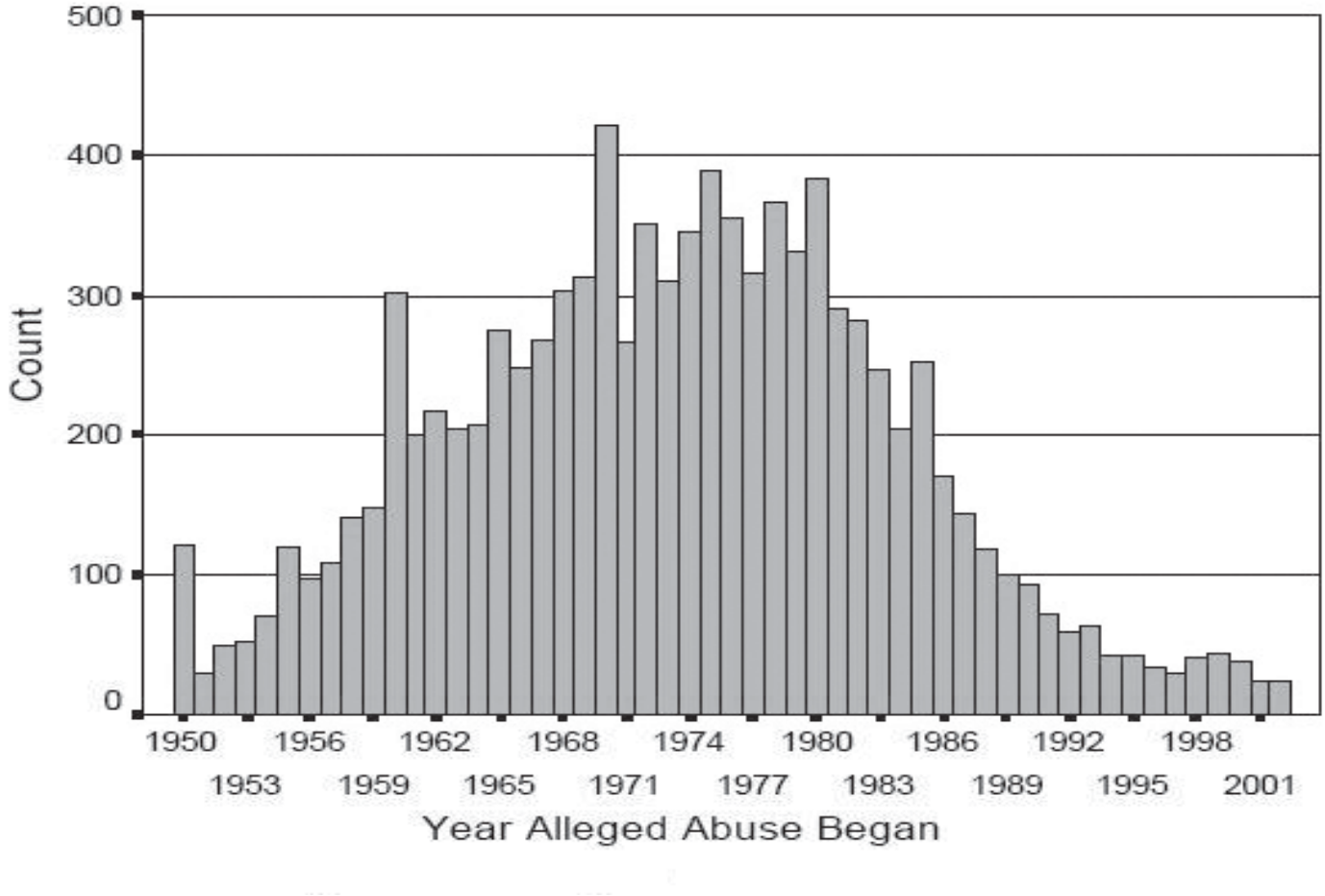
The researchers at John Jay College of Criminal Justice were commissioned to conduct a quantitative study on the nature and scope of child sexual abuse (CSA) in the Catholic Church. The researchers gathered information about every allegation of sexual abuse of a minor by priests and deacons in the United States from 1950–2002 by gathering information from existing files at all Catholic dioceses, eparchies, and religious communities. Individuals at each diocese, eparchy, and community completed

surveys with questions regarding the diocese, the priest with an allegation, and the victim who made the allegation. Identities of all priests and victims were confidential, and the researchers employed a double-blind procedure to ensure the anonymity of the subjects. Overall, 97% of all dioceses and eparchies and 63% of all religious communities (representing 84% of religious priests) responded (John Jay College, 2004).

In the 18 months that followed this report, the Church granted John Jay access to the database to conduct further analyses to address certain issues in more detail, including the following: the estimation of the overall problem of abuse in the Church, patterns of abuse, duration of abusive behavior, priests with one allegation and priests with multiple allegations, subgroups of priests with allegations of abuse, and the institutional response to the abuse problem (Terry & Smith, 2006).

The core findings help illustrate the true scope of sexual abuse among the Catholic clergy. In the period between 1950 and 2002 in the United States, we know that clergy members abused 10,667 children. The majority of these victims (81%) were male and between the ages of 11 and 14. Turning to the clergymen, 4,392 priests or deacons had credible allegations of clergy sexual abuse made against them, which represents 4% of the clergy who were active in the U.S. ministry during that period. Of this number, 149 priests had 10 or more allegations made against them. The results revealed a significant delay in reporting, with 44% of sexual abuse reports made between 2000 and 2002. Additionally, a surge of clergy sexual abuse appears to have begun in the latter years of the 1960s, reaching a peak during the 1970s and then declining steadily during the 1980s, 1990s, and early 2000s (see Figure 1).

Figure 1. Clergy Abuse Cases From 1950, by Year Abuse Began



Source: John Jay College (2004), p. 29.

In the 1970s, child sexual abuse in general was also coming to the forefront of our professional attention, owing to the groundbreaking work of feminists such as Susan Brownmiller and Florence Rush and academic investigators such as Diana Russell, Suzanne Sgroi, and Ann Burgess (Brownmiller, 1975; Burgess & Holmstrom, 1974; Rush, 1980; Russell, 1984; Sgroi, 1981). In addition, with his 1978 address and subsequent publication "Sexual abuse, another hidden pediatric problem," the world-renowned pediatrician C. Henry Kempe (1978) helped to raise the pediatric profession's awareness. Additionally, as professional knowledge about sexual abuse grew in the early 1980s, law enforcement and prosecutors began to consistently pursue allegations of child sexual abuse. A significant reporting lag masked the true extent of CSA in the Church at this time. Only 17% of abuse cases were known prior to the 1990s, and only 810 cases of abuse were known to the Church before 1985—the time of the notorious Gauthe case in Louisiana. These 810 cases represent less than 10% of what is now known to have occurred using the post-2002 data (John Jay College, 2004). There are many reasons why victims of sexual abuse do not report the abuse immediately, and this information about clergy sexual abuse is consistent with what is known about sexual abuse in the general population. Victims often do not report or delay reporting, for example, due to feelings of guilt, shame, and embarrassment; when realizing that the abuse is scandalous; and for fear that they may not be believed because the perpetrator is often viewed as a powerful and trusted person in the community (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003.) Figure 2 compares all cases known in 2002 with 1993 estimates.

The age and gender distributions of the 10,667 child victims of clergy sexual abuse are displayed in Figure 3. One can see that the majority of the child victims are males who are 12 years old or older. The first observation would be that the clergy sexual abuse problem is less a problem of the sexual abuse of prepubertal children than that of peri- and postpubertal children. This has important clinical implications since the abuse of prepubertal children is often referred to as pedophilia and has specific treatment and rehabilitation issues associated with this problem. The abuse of preteens and teens is viewed clinically as a different type of disorder called ephebophila.

The preponderance of the abused children being male is a pattern that stands in stark contrast to the overall national child sexual abuse data, which consistently identify girls as being sexually abused at a rate 3 or 4 times that of boys and which also shows the highest risk group for both girls and boys as the 7–13 years of age grouping (John Jay College, 2004). Possible explanations for the dominance of male children being abused in the Church relate to access by clergy to such male children or a primary attraction to male children and adolescents by clergy, or both. Throughout the time period of this study, priests had much more frequent contact with boys than girls and assumed positions of trust in boys' lives (Isley & Isley, 1990). It is thus possible that priests abused boys at a much higher frequency because of this unique situational access that gave them the opportunity to use the beliefs of the boys to both manipulate and silence them (Farrell & Taylor, 2000).

Table 2 contains the distribution of male victims' ages listed for both the single-victim group and for the group in which 2–20 incidents of clergy sexual abuse were known to have occurred. These numbers again show a predominance of abuse victims being pubertal, a dimension that must be considered. Some theoretical constructs have raised concerns that clergy sexual abuse perpetrators may in fact be emotionally and sexually immature males who are involved in inappropriate sexual exploration with victims whom they inappropriately see as similar in development. This in no way is meant to excuse the abuse, but it is a dimension that needs serious attention because the pattern of abuse characteristics is so different from the expected data within the society at large.

Most Recent Number of New Reports and New Cases
One of the major commitments of the Dallas Charter was that the Office of Child and Youth Protection would produce an annual report detailing the progress the Church was making in implementing the Charter. Under the oversight of the NRB, approximately annual audits are conducted to measure compliance. In addition, the Center for Applied Research in the Apostolate (CARA) conducts surveys to track new reports of sexual abuse of minors, the number considered to be credible cases, and information on the amount of money dioceses expended related to the allegations as well as the amount the dioceses have paid for safe environment efforts.

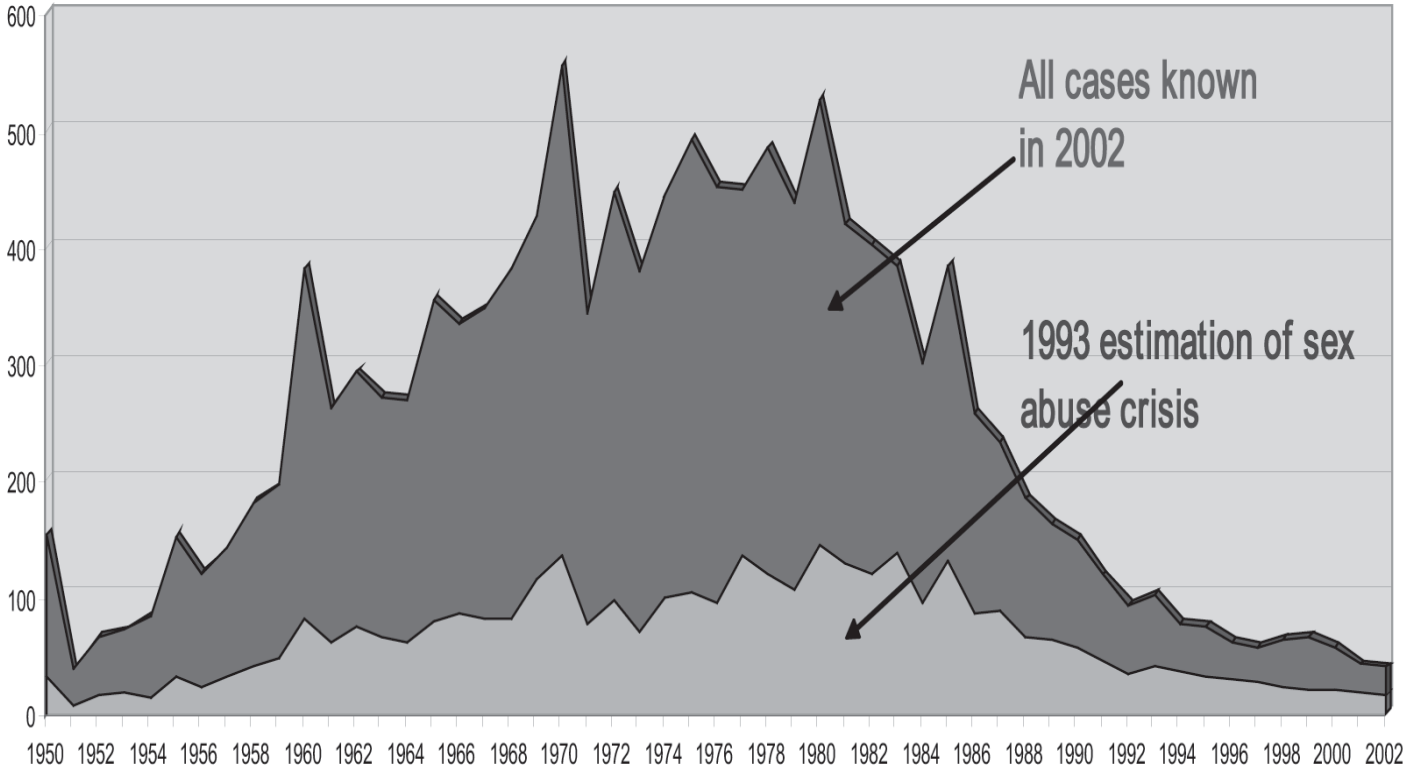
Continued on page 7

Table 2. Distribution of Male Victims by Age

	Single Victim Group		**2–20 Victim Group**	
Male Victim Age (yrs)	Number	Percentage	Number	Percentage
1–7	33	2.8	203	3.3
8–10	131	11.1	992	16.6
11–14	482	40.9	2930	48.1
15–17	532	45.2	1964	32.3
Totals	**1178**	**100**	**6089**	**100**

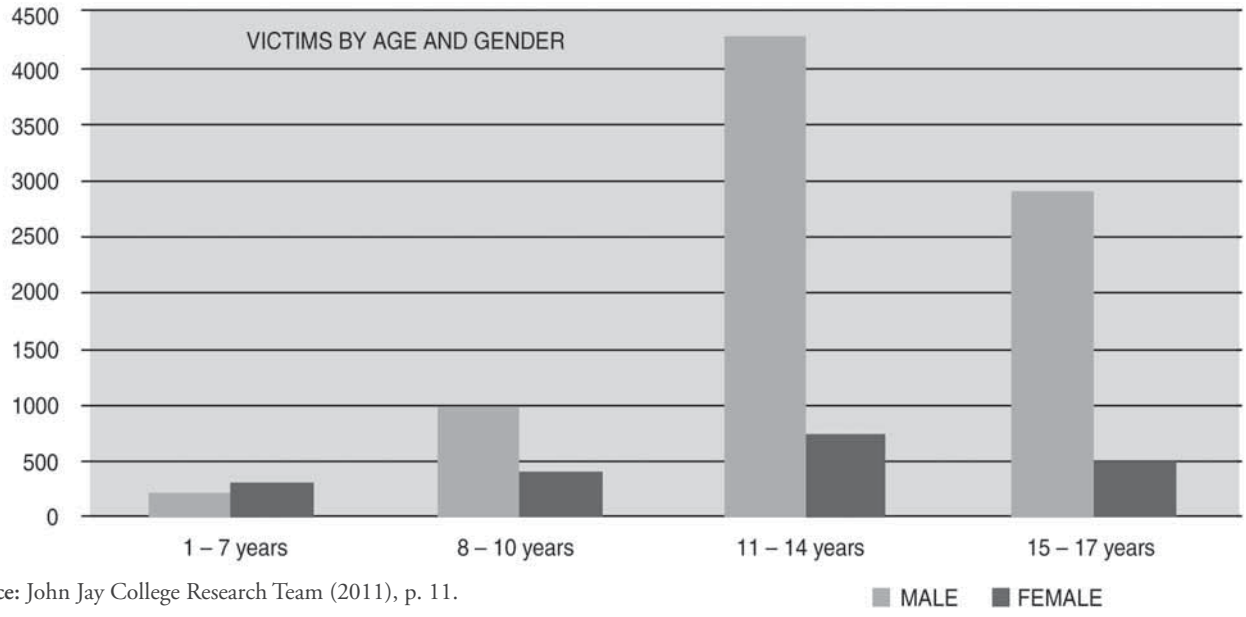
Source: John Jay College (2006), p. 27.

Figure 2. Estimation Based on 1993 Reporting Pattern, Compared to All Known Cases (2002)



Source: John Jay College (2011), p. 11.

Figure 3: Age and Gender Distribution for the Known Cases of Clergy Sexual Abuse in 2002



Source: John Jay College Research Team (2011), p. 11.

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In the most recent annual report issued in April 2012, which covers the 2011 calendar year, of the 195 dioceses, 187 participated in the audit process and 191 took part of the CARA survey (USCCB, 2012). During 2011, 21 allegations of abuse by a cleric were made by current minors and 683 adults came forward to report abuse for the first time. Of the 21 cases involving minors, 7 were considered credible by law enforcement, 3 were considered false, and the others were in various stages of investigation and response at the time the audit was released.

In all, the minors and adults made new allegations that involved 551 priests and 7 deacons. Of the accused clerics, 253 were deceased, 58 had been permanently removed from the priesthood (i.e., laicized), 184 had been removed from ministry, and 281 had been named in previous audits. Safe environment training was completed by 99% of clerics and by 96% of employees and volunteers. Over 4.8 million children had received safe environment training as well. Finally, background evaluations had been conducted on over 99% of clerics, 99% of educators, 96% of employees, and 96% of volunteers. From the CARA surveys, we know that the reporting dioceses and eparchies had total costs related to the current and previous allegations in 2011 of $108,679,706, which was approximately $15 million less than in 2010. The total costs from 2004 through 2011 were over $2.2 billion.

Conclusions From the Studies

The data may be viewed as supporting the idea that clergy sexual abuse is a unique subset of the more general societal problem of CSA, accounting in 2002 for 10,667 cases known to have occurred in the 52-year period of time between 1950 and 2002. Unfortunately, sexual abuse by clergy remains a problem since even one case is one too many and we know from the 2011 audit report that at least 7 minors made a new credible report of being abused. From a public health perspective, clergy sexual abuse is a subset of the much larger problem of CSA, which itself is part of an even larger public health issue of child maltreatment and interpersonal violence.

The institutional response of the U.S. Catholic Church leaders was on public display in 2002 and appropriately remains intense today. In addition to public apologies and commitments to take action to halt the occurrence of clergy sexual abuse, the Church's leaders adopted an approach oriented toward study and disclosure as evidenced by the Nature and Scope study. This public transparency was uncharacteristic and welcome because secrecy and poor communication surrounding the problem of clergy abuse were heretofore hallmarks of how the problem was handled (Benyei, 1998; Fegert, 2004; Plante, 1999).

From the data gathered thus far within the Catholic Church, it is possible to determine a number of unique aspects of clergy sexual abuse that will allow professionals and Church leaders to further understand how this form of sexual abuse is similar to and different from other subsets of the downward trend in cases of CSA that Finkelhor, Jones, and Shattuck (2010) described during the 1990s and 2000s. In fact, the downward trend appears to have begun earlier for clergy sexual abuse when compared with the trends in general CSA because cases began their steady decline in the 1980s. The predominance of male victims and the relatively higher proportion of adolescents are clear differences from the age and gender pattern seen in the general CSA problem.

The U.S. Catholic Church's response to the clergy abuse crisis with a population-based study is welcome but surprising and somewhat unique among child-serving and faith-based organizations. In a comprehensive literature review, Terry and Tallon (2004) looked at a number of other organizations that serve young children and that have come under scrutiny related to the potential of CSA occurring within their organizations. Looking at material related to Boy Scouts of America, the Big Brother Organization, and the Young Men's Christian Association (YMCA), each has had periods of significant media attention around the risk of CSA, and each has developed proactive training programs for staff and volunteers. However, none has participated in a comprehensive, publicly disclosed epidemiologic study that would provide comparable incidence and prevalence data (Clayton, 2002; Mattingly, 2002; Schaeffer, 1999; Shakeshaft, 2004; Wattanabe, 2002). Other churches may be in the process of planning studies on the topic of sexual misconduct, and some comprehensive data on the topic are anticipated within the next 5 years.

While the Roman Catholic Church can praised for its unprecedented agreement to set up the NRB and for commissioning the study, there are less positive features of this history—the variable implementation of the Charter across dioceses, the continuing problems with management of problem clergy in some places such as Philadelphia, the slowness to act on recommendations at the level of the Vatican, the fact that few responsible Church officials faced internal discipline for their role, and the challenge the Church has faced in regaining the confidence of survivors and many segments of the Church laity.

In a 2003 commentary, David Finkelhor discussed the "legacy" of the clergy sexual abuse crisis, and he identified a series of positives (described as helpful aspects) and negatives (described as problems) for the public and professionals interested in child maltreatment to consider (Finkelhor, 2003). One of the helpful aspects that emerged from the discovery and response to the clergy sexual abuse crisis was that the crisis had alerted parents to talk about

risk of sexual abuse with their children. Additionally, the attention the crisis received from the media, law enforcement, and the public had highlighted the need for organizations and their administrators to deal proactively with the risk of sexual abuse.

Unfortunately, we cannot ignore the negative effects that have emerged as well. For example, this crisis has reinforced stereotypes about sexual abusers as being pedophiles attracted to prepubertal children, each having multiple victims and compulsion to perpetrate further abuse. In reality, most priests were not pedophiles and did not have multiple victims. The crisis also served to reinforce the idea that homosexuals were to blame for the problem of sexual abuse, thus creating an easy scapegoat that could interfere with substantive reform. Further research will be necessary to clarify the role, if any, that homosexuality plays in this problem. Additionally, the crisis and its coverage in the media served to reinforce the belief that sexual offenders are incorrigible and unable to be treated. Very few of the priest offenders continued to perpetrate sexual abuse after they were discovered and received treatment, which was almost never discussed in the media's reporting (Finkelhor, 2003).

Next Steps

Clergy sexual abuse, like child sexual abuse in general, involves powerful adults taking advantage of a child's trust in a sexualized way. Because the powerful adult in clergy abuse is a religious leader, spiritual well-being may also be harmed in addition to emotional and physical well-being. The additional potential for spiritual injury makes clergy sexual abuse unique among CSA cases, as do the age and gender distribution differences.

The downward trend in the rate and number of recent clergy sexual abuse cases, which is consistent with the downward trend of CSA cases in general, is welcome, but a small number of cases continue to occur. More prevention work will be necessary to drive this number of new cases to as near zero per year as possible. At an organizational level, the crisis that ensued around clergy abuse points to the need for constant training of workers and officials in large organizations such as the Catholic Church and the need for transparency in how cases are handled to inspire confidence in the way administrators receive and process reports. This need for transparency would appear to be particularly important for stigmatized problems such as clergy sexual abuse. For example, the delay in reporting may in part be due to the belief that arises in secretive and shrouded processes that apparently confirm in the minds of the victims that nothing will be done even if they come forward.

The increasingly accurate epidemiologic statistics that are being collected, analyzed, and publically shared serve a number of purposes beyond simply being an academic exercise. By looking at accurate numbers that have a solid research foundation, victims, the public, and all concerned professionals and organizations can begin to see the magnitude of the problem requiring attention. This is important with regard to developing interventions, treatment services, and prevention and informs training efforts as well. In addition, having accurate measures of the problem allows for a metric to measure the issue's worsening or improvement with some degree of confidence.

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Advanced Practice Nurse Barriers to Reporting Child Maltreatment

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The abuse and neglect of children is not a new phenomenon. History is replete with accounts of heinous acts perpetrated against the innocent. Healthcare providers have also taken note of child maltreatment (CM) in writings appearing as early as AD 900. In his text *Practica Puerorum,* the Arabic physician Rhazes stated that intentional injury might be a cause of some hernias in children (Labbé, 2005). In 1860, the French physician and child welfare advocate Ambroise Tardieu published details of 32 cases of CM in an attempt to raise social awareness about the "singular insanity" of child abuse and neglect (Labbé, 2005; Roche, Fortin, Labbé, Brown, & Chadwick, 2005). Tardieu's efforts to raise social awareness were met with resistance (Al-Holou, O'Hara, Cohen-Gadol, & Maher, 2009; Jenny, 2008), and it would take more than 100 years for healthcare professionals to rediscover CM. Similarly to Tardieu, Kempe also encountered resistance and disbelief (Jenny, 2008; Kempe, Silverman, Steele, Droegemueller, & Silver, 1962; Leventhal, 2003). Kempe and associates' publication of *The Battered-Child Syndrome* in 1962 transformed CM from a social phenomenon to a recognized detriment to childhood health and well-being.

For nearly a half-century, CM has been researched extensively; entire journals are dedicated to the subject. The fight against CM has made great strides with much more needing to be accomplished. Nevertheless, the consequences and costs of CM make it imperative that providers protect of healthcare and advocate for the most vulnerable populations.

The importance of identifying and reporting cases of suspected maltreatment is due in part to the prevalence of CM. National data indicate that 1.2% of the U.S. child population, nearly 1 million children, were either abused or neglected (Centers for Disease Control and Prevention, 2008; 2012). This number has remained stable over the past decade (Sedlak et al., 2010). The U.S. Department of Health and Human Services (HHS) estimates that only one third of abused and neglected children come to the attention of Child Protective Services (CPS). It further concluded in the National Incidence Survey-4 (Sedlak et al., 2010) that CPS does not investigate all reported cases meeting the criteria established by HHS. In a national survey of children and youth, Finkelhor, Turner, Ormrod, and Hamby (2009) found the incidence of CM to be 10 times greater than the number of CM cases substantiated by CPS, and a study conducted in North and South Carolina reported an incidence of CM greater than 40 times the official number of reported cases (Theodore et al., 2005).

The consequences of CM are pervasive and long-lasting, potentially affecting survivors of CM for their entire life. These outcomes have been linked with increased incidence of mental health issues such as depression, anxiety, posttraumatic stress disorder, and suicide (Dube et al., 2003). Abused and neglected persons also suffer poorer physical wellness and score lower on both subjective and objective measures of health. Sachs-Ericsson, Blazer, Plant, and Arnow (2005) found that persons who had been physically abused as children were more than 2 times as likely to suffer from a major physical illness as their nonabused counterparts. Individuals of advanced age with a history of CM were 1.5 times more likely to have three or more serious medical diagnoses (Draper et al., 2008). Heart disease, liver disease, and obesity occur at higher rates in people who were abused or neglected in childhood (Aaron & Hughes, 2007; Dong, Dube, Felitti, Giles, & Anda, 2003; Draper et al., 2008; Sachs-Ericsson, Blazer, Plant, & Arnow, 2005). Exposure to CM predisposes victims to engaging in high-risk health behaviors such as drug, alcohol, or tobacco use; early sexual debut; prostitution; a higher number of lifetime sexual partners; and lack of condom use. There is also a link between CM and behavioral issues with victims experiencing increased rates of juvenile delinquency, violent behavior, and adult criminality. The estimated annual cost of CM ranges from $80 billion to $124 billion (Fang, Brown, Florence, & Mercy, 2012; Gelles & Perlman, 2012). Although these estimates incorporate direct and indirect costs of the maltreated individual, they do not include some of the secondary costs incurred across the lifetime of the victim.

The adverse effects of CM are cumulative (Dube et al., 2003; Flaherty, Thompson, et al., 2006; Flaherty et al., 2009). Each episode of abuse or neglect a child experiences increases the probability of suffering serious or lasting harm. It is imperative to identify and intervene at the earliest opportunity to minimize the negative effects of maltreatment. Yet there is no point in the timeline of maltreatment that intervention is fruitless. To that end, all

fifty states have established mandatory reporting laws that require CPS to be notified when a reasonable suspicion of abuse or neglect exists. Research indicates, however, that clinicians do not report all suspicious cases for CM even when the probability of maltreatment suspected by the clinician is high (Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty, Sege, et al., 2006; Flaherty et al., 2008; Flaherty & Sege, 2005; Gunn, Hickson, & Cooper, 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Schweitzer, Buckley, Harnett, & Loxton, 2006).

Several studies have examined the decision-making processes and factors that inform and influence a clinician's reporting behavior. The research has focused primarily on physicians without any inclusion of nurse practitioners or certified nurse midwives (hereafter identified as advanced practice nurses or APRNs). Certified nurse midwives provide healthcare to women of childbearing age, including girls as young as 12 years of age, and are also mandated to report suspected child abuse. As mandated reporters, APRNs have the opportunity and responsibility to identify and refer potential victims of CM. Advanced practice nurses play an increasingly large role in the delivery of healthcare (Allen & Viens, 2006; Brown, Hart, & Burman, 2009), and it is important to understand their reporting behaviors and experiences. The purpose of this study is to determine what barriers APRNs perceive in fulfilling their mandate to report suspected CM.

We reviewed the literature using MEDLINE, CINAHL, and PsychInfo databases with the search terms *child*, *abuse*, *neglect*, *maltreatment*, *reporting*, *mandatory reporting*, and *barriers*. Initially, we searched literature from 2000 to the present, which returned only 30 articles. The search was then expanded to include the years 1960 through the present to discover any insights into barriers that may have existed at the creation of mandatory reporting statues. Additionally, expanding the timeline provided an opportunity to gain an understanding of any changes in the identified barriers to reporting that have occurred across time.

Barriers to Reporting Child Maltreatment

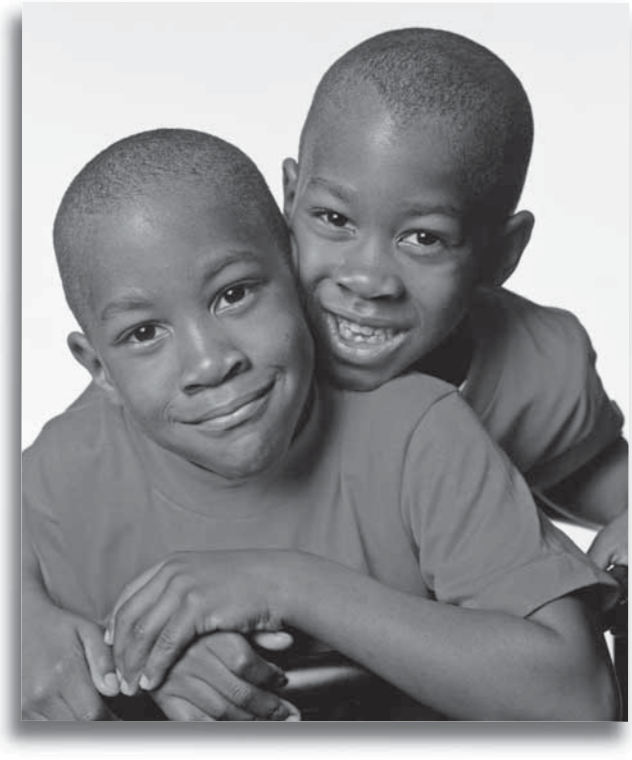
The decision not to report suspected CM appears to involve a complex decision-making process, and previous research has identified many barriers that inhibit reporting. Literature from the past several decades revealed that barriers to reporting CM as perceived by providers are consistent over time. These barriers can be divided into two categories: failure to recognize CM and anticipated consequences of reporting CM (Sege & Flaherty, 2008).

Failure to Recognize Child Maltreatment

A child who has been abused or neglected is not a common clinical presentation (Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). Some providers reported having never treated a child who had been abused (Flaherty, Sege, et al., 2006). Based on the vast undersubstantiation of CM, it is more likely that CM goes unrecognized in the clinical setting. Lack of training is a commonly reported barrier that causes clinicians to lack a sense of competence in recognizing CM (Flaherty, Sege, et al., 2006; Flaherty, Jones, & Sege, 2004; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006; Leder, Emans, Hafler, & Rappaport, 1999). Studies indicate clinicians who have received education regarding CM are more likely to report their suspicions (Flaherty et al., 2000; Fraser, Mathews, Walsh, Chen, & Dunne, 2010), yet education remains sparse. Most emergency medicine residents and family practice residents receive fewer than 7 hours of didactic education on CM (Starling, Heisler, Paulson, & Youmans, 2009). McCarthy (2008) reported the median time spent educating about CM in medical schools is 2 hours. Furthermore, the CM education that providers receive varies greatly between specialties leading to differing levels of competence and comfort among providers (Lawrence & Brannen, 2000; Starling et al., 2009). Participants in one focus group described their training regarding CM as "haphazard and infrequent" (Flaherty et al., 2004), which may be due to a lack of CM training requirements in APRN education. No state medical board requires specific CM education for licensure or license renewal (American Medical Association, 2010), and Iowa is the only state that requires APRNs who routinely treat children to receive regular training on CM identification and reporting (Medscape, 2009; State of Iowa, 2007).

Anticipated Consequences of Reporting Child Maltreatment

Some have indicated that the reality of CM is too psychologically challenging for the provider to accept (Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999). Denial that an



injury or behavior is the result of CM is not an unusual occurrence. Reports of sexual abuse have in the past been explained away as child fantasies or some other psychological dysfunction (Labbé, 2005). As participants of one study stated, "Do we really want to know this information and then [have to] deal with it?" (Leder et al., 1999).

A recurring barrier theme is the impact the CPS system has on clinicians' decision to report. Negative interactions with CPS staff and perceptions that CPS interventions are either inadequate or may potentially harm the family or child, discourage reporting (Flaherty et al., 2000; Flaherty et al., 2004; Gunn et al., 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999; Vulliamy & Sullivan, 2000). In some instances, clinicians have felt their management of CM would be adequate or superior to CPS involvement (Flaherty, Sege, et al., 2006; Jones et al., 2008).

The legal environment in which clinicians practice appears to create a barrier to reporting CM. State laws always require mandatory reporting when a reasonable suspicion of abuse or neglect is evident (Child Welfare Information Gateway, 2008). This mandate is problematic in that there is no uniform definition of what constitutes *reasonable suspicion*. Levi and Loeben (2004) have extensively explored the concept of reasonable suspicion from both legal and cognitive perspectives and concluded that the term creates ambiguity. This lack of a clearly established threshold for suspicion leads to inconsistent reporting even among child abuse experts (Flaherty, Sege, et al., 2006; Levi & Brown, 2005; Levi & Loeben, 2004; Levi, Brown, & Erb, 2006; Lindberg, Lindsell, & Shapiro, 2008).

Many healthcare providers choose not to report in order to avoid the legal system (Flaherty, Sege, et al., 2006; Vulliamy & Sullivan, 2000). Those who have provided depositions or testified are less likely to report their suspicions again (Gunn et al., 2005); furthermore, fear of litigation or having been previously sued decreases the likelihood of reporting CM (Flaherty, Sege, et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006).

As with the previous issues, the relationship between the clinician and the family also affects the decision to report. Unlike the previously mentioned barriers, the clinician–family relationship may impede or support reporting behaviors. Lack of familiarity with the child or family appears to encourage reporting (Flaherty et al., 2008), but a closer relationship with the family deters reporting (Flaherty, Sege, et al., 2006; Flaherty et al., 2004; Jones et al., 2008). In some instances, however, a close relationship with the family supports reporting. Provider knowledge of previous or current CPS involvement or awareness of risk factors for abuse in the family positively affects reporting behavior (Flaherty et al., 2004; Jones et al., 2008).

Methodology of Our Reporting Barriers Study

Purpose

We examined the perceived barriers to CM reporting experienced by nurse practitioners and nurse midwives in an intermountain state to determine if these barriers are similar to the barriers perceived by physicians.

Sample

A search for APRNs in the state's Department of Professional Licensure's (DOPL) database provided a potential sample size of 1,223 nurse practitioners and nurse midwives. Using a random number table, we selected 400 names to participate in the study. Participants met inclusion criteria if they were actively licensed in the state as a Family Nurse Practitioner (FNP), Pediatric Nurse Practitioner (PNP), or Certified Nurse Midwife (CNM) who treated children under the age of 18 years and could read and speak English. Excluded from the study were nurses licensed as a nurse anesthetist or clinical nurse specialist, or who had not provided care to a child within the past 5 years, or had not been concerned about the possibility of abuse or neglect for any child in the past 5 years.

Procedures

Institutional Review Board approval was obtained. A cover letter explained the general purpose of the study. Participants were informed that returning the survey constituted their consent to participate in the study. The survey instrument was mailed to

individual addresses obtained through the DOPL search. A participation incentive of one dollar was included in the mailing. A self-addressed stamped envelope was also included to encourage the participants to return the survey. Anonymity was maintained through the following means: the survey was entirely anonymous; the mailing list and returned surveys were kept in a locked file. At the conclusion of the study, all identifiable documentation and the surveys were destroyed.

Instrument

A 25-question survey, entitled "Child Maltreatment Survey," was adapted specifically for this study, using a previous questionnaire for determining barriers to reporting CM developed by Gunn, Hickson, and Cooper (2005). Although validation data for the original study are not published, the purpose of our study was to compare APRN and MD barriers; therefore, use of the same survey was appropriate. The survey was divided into three sections and contained question formats such as yes/no, Likert scale, and free response. Section I posed questions to determine a respondent's familiarity with reporting laws and processes and also asked about any previous experience reporting abuse or neglect. Section II used a Likert scale to elicit the perceived barriers to reporting experienced by APRNs. Section III included three clinical vignettes in which a child presented for evaluation of an injury. After reading each case presentation, the participants were asked if they would report the situation as suspicious for abuse or neglect, and if so, to whom. Additionally, participants were asked to rate their level of suspicion using a visual analog scale to assess the level of suspicion that prompts the APRN to file a report of suspected CM. Demographic information was also obtained as part of the survey and included gender, race, age, number of years in practice, practice area, practice type, and degree type.

Data Analysis

The data collected were analyzed using SPSS® version 19 (SPSS Inc., Chicago IL). Descriptive statistics were used to define the sample characteristics. Likert items, which measure level of perceived barriers, were analyzed using descriptive statistics, including means and standard deviations. Additionally, correlational statistics were conducted to determine relationships between demographic data and perceived barriers. According to the levels of data collected, descriptive variables and T-tests were run. The vignettes, which assessed the provider's level of suspicion that would prompt reporting, were analyzed using the appropriate correlational statistics. Qualitative questions were analyzed according to themes and patterns (Lincoln & Guba, 1985), and the yes/no questions were analyzed using frequencies. Trustworthiness was established by having an experienced qualitative researcher review responses to the qualitative questions and confirm findings. The researchers discussed findings until they reached consensus according to Denzin and Lincoln (2000).

Results

Out of the 400 surveys sent to APRNs in the original sample, 26 were returned as undeliverable. Of the remaining 374 possible participants, 182 (48.6%) returned surveys. Ninety-three indicated they had, in the past 5 years, either not treated a child under the age of 18 years or not treated a child under 18 whom they suspected had been abused or neglected. Of the 89 eligible respondents, 88 completed the survey. One returned the survey refusing to answer. Respondent demographics, practice setting, specialty certification, and prior CM reporting experience are listed in Table 2. The study sample is similar to the demographic trends for APRNs within the United States (Allen & Viens, 2006). The mean age of all respondents was 45.5 years (range: 26–65 years) with standard deviation of 10.3 years (range: less than 12 months–36 years) of practice experience in the nurse practitioner role. Family nurse practitioners made up nearly two thirds (64.6% n=51) of the sample while 12.7% (n=10) and 8.9% (n=7) identified themselves as pediatric nurse practitioners or certified nurse midwives, respectively. The majority of respondents identified themselves as female (88.6%) and Caucasian (98.9%).

Nearly all of those responding to the survey (85.2%) reported at least one case of possible CM, with a mean of 5.3 reports. However, most of the respondents (76.1%) filed a total of five or fewer reports, with the median number of CM reports filed being two. In response to the question "Have you ever considered

Table 1. Respondent Demographics and Reporting Experiences

Demographics	% Who Suspected Maltreatment but Did Not Report	Significance
Gender		NS
Male (10)	40	
Female (78)	29.48	
Specialty		NS
FNP (51)	19.6	
PNP (10)	30	
CNM (7)	57	
Other (11)	40	
Practice Setting		NS
Primary care (36)	25	
Hospital (26)	42	
Emergency dept (6)	16.7	
Other (20)	30	

Based on descriptive variables and T-tests.

reporting suspected child abuse or neglect, but chose not to do so?" 31% (n=27) of participants indicated that at some time they suspected a child to be a victim of CM but had declined to report their suspicions.

When comparing those providers who had not reported cases suspicious for CM with those who had always reported their suspicions, no statistically significant differences were discovered. While no differences were found between the groups of APRNs included in this study, the survey did identify some beliefs that may negatively affect reporting. At least half of all respondents expressed frustration with CPS during the reporting process and that CPS provided no follow-up with the reporter. Although a significant number of respondents expressed negativity toward CPS, most agreed that CPS involvement is necessary to provide adequate assistance to resolve the CM issue. Other potential barriers were the beliefs that reporting suspected CM may harm the child and may negatively impact the family. Interestingly, while nearly half (45.3%) of respondents agreed or strongly agreed that reporting may result in harming the child victim, three fourths (75.6%) disagreed with the statement "Reporting suspicions of child abuse or neglect does not improve the outcome for the child victim."

The APRNs who declined to report suspected CM were asked to list the factors that influenced their decision. The most common reason for not reporting was lack of evidence that CM had occurred. From the remaining responses, lack of certainty that CM had occurred and lack of physical evidence were overwhelmingly cited as the reason for not reporting. Out of the total responses provided, only two stated that additional patient history or the physical exam lead the APRN to exclude CM as a reasonable diagnosis. Table 3 lists themes of the responses for declining to report.

All survey participants were asked to list reasons why a healthcare provider might decide not to report possible CM. Ten distinct themes emerged during the analysis of these perceived barriers: (1) Fear of being wrong about the diagnosis of CM; (2) Fear reporting may harm the provider personally, professionally, or legally; (3) Lack of time; (4) Provider lack of confidence in CPS; (5) Not wanting to become involved in reporting; (6) Lack of knowledge about CM or the reporting process; (7) Fear report would harm the victim; (8) Fear report would harm the family; (9) Relationship with the family; and (10) Assumed someone else would report.

Table 2. Themes for Nonreporting Behavior

Reasons for declining to report (actual) – 24 responses

Reason	n=	%
Not enough evidence or unsure abuse occurred	17	70.8
Lack of knowledge about abuse or reporting	2	8.3
Assumed someone else would report	2	8.3
Influenced not to report by others	1	4.2
Concerned report would harm the victim	1	4.2
Lack of confidence in the child protection system	1	4.2

Why would others be reluctant to report (hypothetical) – 170 responses

Reason	n=	%
Afraid of being wrong about CM diagnosis	51	30
Fear report may harm the provider personally, professionally or legally	40	23.5
Lack of time	25	14.7
Lack of confidence in the child protection system	13	7.6
Do not want to become involved in the reporting–legal process	10	5.9
Lack of knowledge about abuse or reporting	9	5.3
Fear report would harm the victim	7	4.1
Fear report would harm the family	6	3.5
Relationship with the family	5	2.9
Assumed someone else will report	4	2.4

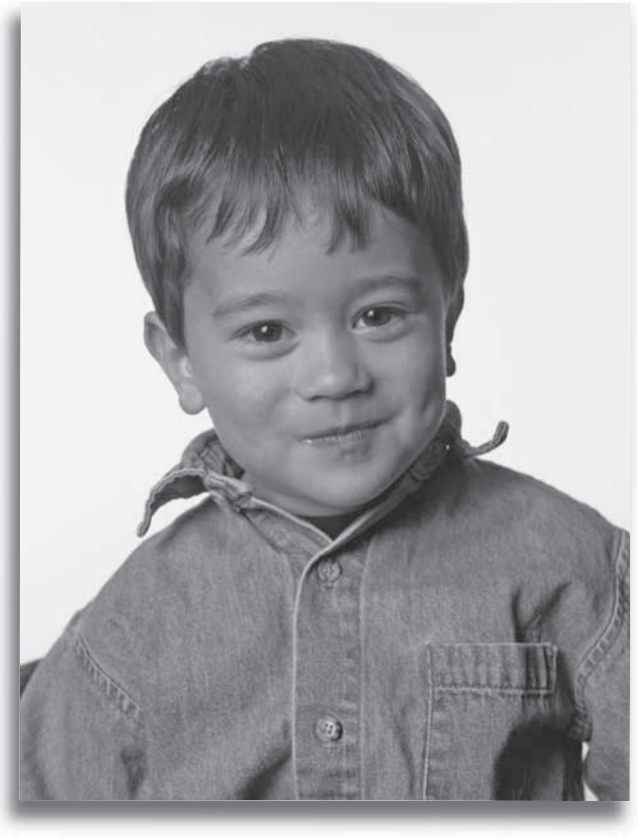
Discussion

This study demonstrates that the perceived barriers reported by APRNs are similar to those previously reported by physicians, with 31% of APRNs and 28% of MDs not reporting a case of suspected child maltreatment (Gunn et al., 2005). The primary obstacle to reporting identified by the participants was uncertainty that CM had occurred. This manifested as clinicians citing a lack of evidence or expressing fear of CM being an incorrect diagnosis. These misgivings and resultant inaction may be the result of inadequate CM training or little exposure to CM in the clinical setting (Flaherty et al., 2004; McCarthy, 2008; Starling, et al., 2009). Lack of training about CM or feelings of being unqualified to render a definitive opinion about whether or not CM occurred is a barrier that is recurrent in the literature about reporting behavior (Flaherty et al., 2004; Gunn et al., 2005; Lane & Dubowitz, 2009; Lazenblatt & Freeman, 2006; Leder et al., 1999). Participants of this study indicated that clinicians infrequently see CM. These results are congruent with other studies that indicate CM is an uncommon presentation or CM is dramatically underrecognized in the clinical setting (Flaherty, Sege, et al., 2006; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). This paucity of experience reinforces the feelings of inadequacy by professionals in the identification of CM.

Implications for Practice. Findings from this study indicate that a significant barrier to reporting CM is lack of competency in recognizing CM. Educating providers about CM has been shown to increase rates of reporting (Flaherty et al., 2000; Fraser et al., 2010). In light of this, states should consider implementing mandatory CM education as part of the licensure renewal process in order to increase awareness of CM and, consequently, reporting. However, it has been demonstrated that experience with CPS via the reporting process negatively impacts reporting behavior (Flaherty et al, 2000; Flaherty et al., 2004; Gunn et al., 2005). Merely educating the clinician may not be enough to sustain lasting and meaningful behavior change. What may be necessary is to change the reporting process altogether. One option could be for the clinician to refer the child to an abuse expert. Lane and Dubowitz (2009) in their study of pediatricians found strong support for the use of referrals to CM specialists. A referral allows for the child victim to be screened by a healthcare provider with CM expertise who can determine the need for CPS involvement, thus mitigating some of the perceived barriers by removing the APRN from the reporting process. Furthermore, such a process provides an opportunity for the expert to provide the referring clinician's validation or education regarding the appropriateness of one's suspicions, increasing the clinician's sense of competency. Another option is to increase the number of clinical sites that provide social services interventions via an onsite licensed clinical social worker (LCSW). This provides an opportunity to develop a collegial relationship with individuals who, by virtue of their education and training, may have had more positive and effective interactions with CPS staff.

Limitations. Although the return rate for the survey was good (48.6%), the low incidence of recognized CM in the clinical setting resulted in a usable sample size (23.5% of all possible participants) that may have not been large enough to adequately determine if any actual differences are present between APRNs who always report CM and those who have declined reporting. This means that the results are not representative of APRNs. Mailing a reminder card 2 to 3 weeks after the initial mailing of the survey was not done but may have helped to increase the return rate and, subsequently, the number of usable surveys.

Recommendations for Further Research. It is important to accurately determine the reporting barriers APRNs experience in order to implement effective interventions to overcome them. Research comparing reporting rates between states that have mandatory CM training and those that do not may be of value in determining the effectiveness of such training. Next, focus groups to determine why APRNs require such a high degree of certainty prior to intervening in cases of suspected CM have the potential to be of great benefit. Finally, research is needed to determine what processes must be changed or implemented to increase the collaboration between clinicians and CPS workers. Such research should focus on determining healthcare providers' knowledge of the CPS system and its mandate, as well as understanding the qualifications of CPS staff members, their case loads, and how they proceed with a report of suspected CM. Focus groups of



CPS staff members would facilitate understanding their perceived barriers about working with healthcare providers.

Conclusion

This study demonstrates that the nonreporting rates among APRNs are similar to physician rates of nonreporting and that the perceived barriers are similar (Gunn et al., 2005; Lane & Dubowitz, 2009; Schweitzer et al., 2006). Lack of evidence or certainty CM occurred was the most common reason given for failing to report. Also, CPS may exert an important influence regarding the clinician's decision to report.

Ironically, mandatory reporting laws are written to empower the clinician to refer suspected victims of CM to investigators, specifically CPS. Unfortunately, negative interactions between CPS and healthcare providers, lack of follow-up, and the perception that CPS interventions are inadequate or harmful may be directly responsible for a provider's need for a greater level of certainty prior to intervening than with other clinical presentations (Jones et al., 2008; Leder et al., 1999). Referring to CM experts within the healthcare field may be one option for overcoming this barrier, but unless current laws are changed, it would not remove the legal responsibility of reporting to CPS nor would it guarantee that the family would follow up with the referral.

Ultimately, APRNs must remain open to the possibility that any child they treat may be the victim of CM and should appropriately include CM in their differential diagnosis. Acknowledging the possibility of CM promotes caution and awareness when gathering history and performing the physical assessment and may help to overcome the failure to recognize CM in the clinical setting. The next critical step is reporting to the appropriate agency. Although the CPS system is far from perfect, it is what currently exists to intervene in cases of abuse and neglect, and merely avoiding its use will not improve it. In summary, increased interaction between clinicians and CPS workers has the potential to aid in the identification of and the improvement in the reporting–response process.

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Current Trends in Forensic Interviewing and Medical Evaluations: A Review of the Children's Advocacy Center Model

Kori Stephens, BA, Kim Martinez, PNP, MPH, and Jane Braun, MA

Child maltreatment in the United States remains a serious threat affecting millions of children and families each year. According to *Child Maltreatment 2010*, a report published by the U.S. Department of Health and Human Services (HHS), Child Protective Service (CPS) agencies received over 3.3 million referrals, involving the alleged maltreatment of about 5.9 million children across the United States. Over 25% of the cases reported were those of physical or sexual abuse (HHS, 2011).

Children's Advocacy Centers (CACs) were first developed in the 1980s and play an increasingly significant role in the response to child sexual abuse and other forms of child maltreatment in the United States. In 2011, CACs served 269,000 children, a number that has doubled in the past decade. With multidisciplinary collaboration at the heart of the CAC movement's ideology, these centers are able to bring together professionals such as law enforcement agencies (LE), CPS centers, prosecution offices, mental health therapists, and medical associations to provide a holistic response to a child's disclosure of abuse. Recent research indicates that CAC investigations typically result in positive outcomes. This type of investigation is preferred by most nonoffending caregivers (Cross et al., 2008; Faller & Palusci, 2007).

There are currently 750 accredited Children's Advocacy Centers and 200 developing centers and multidisciplinary teams nationwide. These subscribe to various membership levels (affiliate, associate, and accredited) within the National Children's Alliance (NCA), a program appropriated by the Victims of Child Abuse Act in 1992 and charged with administering over $9 million in funds to CACs. Under NCA's leadership, the movement of CACs has grown from 30 to more than 950 centers and identified multidisciplinary teams focused on child abuse intervention. The Alliance oversees a rigorous accreditation process for CACs that is informed by evidence-based models of care and treatment. There are ten standards CACs must achieve to become accredited: (1) multidisciplinary team (MDT), (2) cultural competency and diversity, (3) forensic interviews, (4) victim support and advocacy, (5) medical evaluation, (6) mental health, (7) case review, (8) case tracking, (9) organizational capacity, and (10) child-focused setting (NCA, nd).

The 1992 Victims of Child Abuse Act also created an infrastructure of four Regional Children's Advocacy Centers (RCAC) located in the Northeast, Midwest, West, and South to provide training and technical assistance to MDT professionals and CACs. The RCACs provide a variety of training opportunities to move centers towards NCA accreditation and work with communities interested in developing a multidisciplinary response to child abuse. The National Children's Alliance recognizes that "no single model for an ideal multidisciplinary program exists because each community's approach must reflect its unique characteristics" (Walsh, Jones, & Cross, 2003). Although communities vary in ways to create a CAC, the child maltreatment community recognizes specific standards with regard to forensic interviewing, forensic medical evaluations, multidisciplinary teams, and trauma-focused therapy (Cross et al., 2008).

Methodology

To gather data about trends in the CAC movement, the Midwest Regional Children's Advocacy Center (MRCAC) distributed a survey using Qualtrics, an online survey tool. The survey was created to inform the training and technical assistance efforts of the RCACs and evaluate how well CACs are meeting the required professional qualifications for forensic interviews and medical evaluations outlined by the NCA Accreditation Standards. The survey was e-mailed to the primary contact at 747 CACs. The National Children's Alliance (NCA) provided the primary contact e-mail addresses for their member Children's Advocacy Centers. Each contact was assigned a unique link to the survey tied to its agency's operations. The survey consisted of 106 questions about forensic interview practices and medical services as well as key position salaries and job descriptions. In all, 470 CACs (63%) responded.

Survey Sample

The regional and geographic distribution of survey participants is representative of the CAC population (see Table 1). When compared with Project Access, implemented by NCA, the sample for this survey is very similar. Project Access found that CACs were 45% rural, 10% suburban, and 45% urban. Regionally, they were 27% Midwest, 14% Northeast, 37% South, and 22% West.

The information for Project Access was reported based on zip code analysis using census definitions rather than the self-report format implemented with the survey.

The survey sample is also representative of the various CAC structures reported in Project Access: 56% independent nonprofits, 17% hospital-based, 16% government-based, and 17% as a program of a larger umbrella nonprofit. Overall, more accredited centers completed the survey (78% of respondents) than associate centers (20% of respondents). This is also similar to Project Access's distribution: 64% accredited and 15% associate.

It is important to note that 44% of respondents serve roughly 200–499 children per year and 42% operate with an annual budget of from $100,000 to $250,000. The majority (57%) of participating CACs reported having 1–4 paid employees (23% having only 1–2 paid employees). This is significant because many of these employees hold multiple roles in CACs.

Results

The survey results suggest three findings: (1) Both forensic interviewers and medical examiners are receiving increased training in more than one modality to better service their diverse clientele, (2) there has been a significant increase in peer-review participation from 2009 to 2011, and (3) and the prevalence of children receiving a medical evaluation has steadily increased (see Table 2).

Forensic Interviews

Forensic interviews have been defined as "a professional interview designed to assess or evaluate the truth about a suspicion of child maltreatment" (Cross, Jones, Walsh, Simone, & Kolko, 2007). Furthermore, the NCA Standards for Accreditation require that "Forensic Interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, and coordinated to avoid duplicative interviewing" (National Children's Alliance, nd). Recent research has identified several characteristics that lead to more accurate and complete disclosures from the child. These characteristics include rapport building during the interview, use of open-ended questions, and age-appropriate vocabulary and language (Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007; Cross et al., 2007; Wood & Garvin, 2000).

These characteristics are core components of the many different forensic interview trainings and modalities, including CornerHouse and the National Children's Advocacy Center (NCAC). The NCA Standards for Accreditation consider documentation of 40 hours of a "competency-based child abuse forensic interview training that includes child development" essential to conducting a forensic interview at a CAC.

The results of this survey suggest that CACs have moved toward employing specialized forensic interviewers rather than relying on LE and CPS professionals. In 2011, 77% of CACs reported the

Table 1. Survey Sample Demographics

VARIABLE	COUNT	PERCENTAGE
Geographic Location		
Rural	211	51%
Urban	75	18%
Suburban	82	19%
Other	54	12%
Regional Representation		
Midwest	137	29%
Northeast	69	14%
South	187	39%
West	85	18%
CAC Structure		
Nonprofit 501c3	256	62%
Hospital Based	38	9%
Government Based	58	15%
Umbrella 501c3	66	13%
Other	5	1%
Population Size		
Less than 25,000	22	6%
25,000 to 49,000	44	12%
50,000 to 99,000	82	22%
100,000 to 499,000	156	42%
500,000 to 999,000	45	12%
More than 1 Million	26	7%
Number of Children Served Annually		
Fewer than 99	30	8%
100 to 199	90	23%
200 to 499	170	44%
500 to 799	36	9%
800 to 1199	34	9%
1200 to 1999	14	4%
More than 2,000	10	3%
Annual Budget		
$99,000 or less	35	9%
$100,000 to $250,000	159	42%
$251,000 to $499,000	106	28%
$500,000 to $750,000	30	8%
$751,000 to $1,000,000	16	14%
More than $1,000,000	37	10%

Table 2. Key Findings From the Multisite Children's Advocacy Center Survey

Variable	Key Findings
FORENSIC INTERVIEWING	
Professionals Conducting Forensic Interviews	The majority of CACs (77%) reported that they employed a specialized forensic interviewer to conduct forensic interviews at their CAC. Many CACs reported using other professionals, such as from law enforcement or child protection, in addition to a CAC-employed forensic interviewer. CAC-employed forensic interviewers have increased 25.8% since 2009.
Forensic Interview Training	CornerHouse (56%) and the National Children's Advocacy Center (54%) forensic interview trainings continue to be the most popular trainings. The survey also indicated that forensic interviewers are often trained in more than one modality.
Forensic Interview Peer Review	CACs participating in forensic interview peer review (94%) increased by 12% from 2009 to 2011. The majority of CACs conduct peer review on a monthly or quarterly basis.
Number of Interviews per Interviewer per Day	About 50% of CACs reported one to two interviews conducted per interview per day. In contrast, 46% reported three to four interviews conducted per interviewer per day.
Number of Interviews per Interviewer per Week	There was no apparent trend in the number of interviews conducted per interviewer per week, which greatly depends on the location of the CAC and population served. For example, some urban centers reported that interviewers conduct over 10 interviews per week, and some rural centers reported conducting only one to two interviews per week. Additionally, 73% of respondents provide after-hours forensic interview coverage.
Recording of Forensic Interviews	CACs recording forensic interviewers increased from 90% in 2009 to 94% in 2011, for which the majority (81%) use a DVD to record.
MEDICAL SERVICES	
Professionals Conducting Medical Evaluations	SANE nurses are the primary medical providers for CACs (65%) with physicians following close behind at 62%. This is a flip from the 2009 data that reports physicians at 81% and SANE nurses at 42%. (Note that participants were able to select all professionals that conduct medical evaluations at their CAC, therefore the total will be greater than 100%.)
Training of Medical Professionals	The majority (54%) of CAC medical providers have received pediatric SANE training, 47% have attended Medical Training Academy, and 37% are Board-certified pediatricians. Medical providers can be trained in more than one capacity. For those who reported using SANE nurses to conduct medical evaluations, 40% are receiving supervision from a professional who has not received specialized child abuse medical evaluation training.
Availability of Medical Evaluations	Nearly every CAC surveyed (96%) provides the opportunity for a medical evaluation to all CAC clients.
Completed Medical Evaluations	Approximately 36% of children are actually receiving a medical evaluation (SD 26.49). This varies greatly on the size, location, and structure of the CAC. Hospital-based CACs, 63.69% (SD 28.96); 501c3 nonprofit CACs, 34.18% (SD 24.95); government-based CACs, 31.08% (SD 23.65); and umbrella 501c3 CACs, 30.60% (SD 20.73).
Medical Peer Review	Participation in medical peer review has increased from 71% in 2009 to 82% in 2011. Modes for conducting peer review include statewide (28%), regional (28%), technology facilitated (14%), institution wide (9%), and other (19%).
Medical Evaluation Documentation	The majority of participants reported the use of a digital camera (56%) or a colposcope with still camera (66%) by their primary medical provider to document exam findings. Note that multiple methods of documentation may be used.

use of a CAC-employed forensic interviewer, a 25.8% increase from 2009. This increase is likely due to recent federal, state, and local funding cuts that have led to a reduction of Law Enforcement and Child Protective Services workforce. As a result, CACs have been compelled to hire additional staff to fulfill the forensic interview role. The RCACs have also provided scholarships to novice forensic interviewers to gain more skills by attending a nationally recognized training.

The NCA Standards for Accreditation also highlight peer review and quality improvement activities as an important measure to be undertaken by CACs to ensure best practice. Studies have discussed the importance of specialized training in combination with regular peer review and monitoring (Wood, 2000; Lamb et al., 2007; Cross et al., 2007). Survey results indicate that peer review has become integrated into the culture of CACs, with 94% participating in forensic interview peer review. It is well to note that forensic interview peer review is not possible without the use of recording equipment, whether it be audio, video, or both. The survey results for recorded interviews (94% of respondents) correspond with the number of CACs participating in peer review. The results also found that 22% of respondents are mandated to record forensic interviews, demonstrating that other investigative partners value peer review as a quality improvement activity.

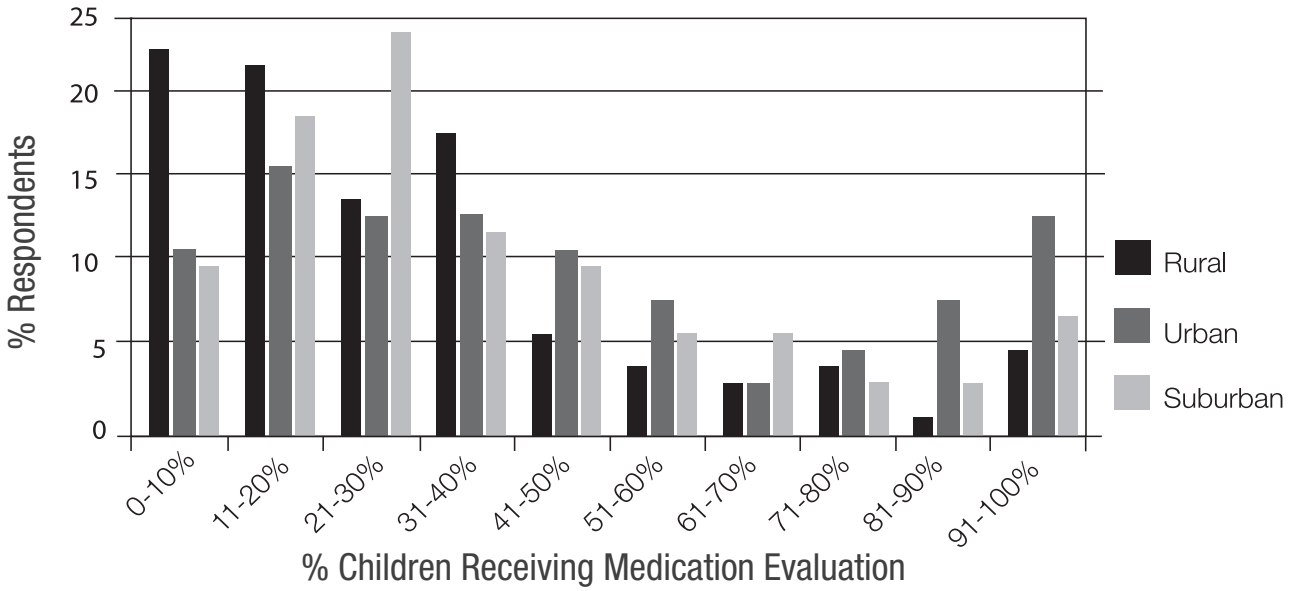
Medical Evaluations

The rise of forensic medical evaluations is acknowledged in the child maltreatment field and has been an avenue for new research and system improvement. Medical examinations have become a valuable part of an investigation as they improve the likelihood of timely medical care to a child victim and can provide information to support legal decisions (Adams et al., 2007). The NCA Standards of Accreditation recognize that a "medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate history is essential in making the medical diagnosis and determining appropriate treatment of child abuse" (p. 18). The NCA Standards of Accreditation also highlight that photo documentation of medical evaluations is the standard of care and allows for peer review and quality improvement practices (National Children's Alliance, nd).

The American Board of Medical Specialties (ABMS) approved the child abuse pediatrics specialty in 2006, and the American Board of Pediatrics (ABP) issued the first certification examinations in November 2009. Nationwide, there are only 264 pediatricians certified by the American Board of Pediatrics in the field of child abuse pediatrics, amounting to an approximate ratio of one Board-certified child abuse pediatrician for every 313,000 children (*Workforce Data 2011–2012,* 2012*)*, or one child abuse pediatrician for every 2,633 founded cases of child abuse (HHS, 2011). Seven states have no Board-certified child abuse pediatricians, and 16 additional states have fewer than three CAPs, indicating that access to experts in the field is limited for a significant proportion of the country.

In 2011, 62% of CACs reported physicians (MDs) as the primary medical providers, a 19% decrease from 2009. CACs using Board-certified child abuse pediatricians have increased from 63 in 2009 to 137 in 2011. Sexual assault nurse examiners (SANEs) have taken the lead as the primary medical providers for CACs, increasing from 42% in 2009 to 65% in 2011. The survey indicated that 28% of respondents utilized certified nurse practitioners (CNP) to complete medical evaluations. While the survey did not ask specifically about pediatric nurse practitioners (PNP), these professionals have played an important role in the CAC movement and serve as a valuable resource for child abuse medical evaluations. It is important to note that for this particular question, respondents were able to check all professions that provide medical evaluations for their CAC; therefore, CACs could be

Figure 1. Children Receiving Medication Evaluation



using a combination of professionals to provide services. For example, physicians must supervise CACs that utilize pediatric SANEs as primary medical providers; thus, the CACs would indicate utilizing both a physician and SANEs. This may explain why the number of physicians has remained flat while SANEs have increased in number.

In addition to the professional shift, we also see that pediatric SANE training (54%) is the most common training for 2011 providers, although Medical Training Academy (47%) is close behind. Participation in medical peer review increased 11% from 2009 to 2011, another direct result of the 2010 Revised Medical Standard for Accreditation. The majority of participants reported that primary medical providers use a digital camera (56%) or a colposcope with still camera (66%) to document exam findings. Additional peer review modalities have surfaced from 2009 to 2011, with statewide and regional peer review leading the way. Technology-facilitated peer review, including NCA n.e.t. Medical Peer Review and Telehealth Institute for Child Maltreatment (THICM), have continued to be successful tools for peer review in both the medical and forensic interview fields. All THICM cases are peer reviewed by a panel of nationally recognized Board-certified child abuse pediatricians (CAP). Recent research suggests that CAPs have "greater knowledge and competence in interpreting medical and laboratory findings in children with Child Sexual Abuse" when compared with pediatric SANEs and advanced practice nurses (APN) in the field (Adams et al., 2012, p. 383).

Nearly every CAC surveyed (96%) provides the opportunity for a medical evaluation to all of its clients. This is a great advancement in the field and is a direct result of the revised Medical Standard in the 2010 NCA Standards for Accreditation (NCA, nd). Approximately 36% of children are actually receiving a medical evaluation (SD 26.49). This average is skewed with outliers from urban centers and hospital-based CACs (see Figure 1).

Figure 1 indicates that hospital-based centers are indeed having an impact on the national average of percentage of children receiving medical evaluations. Hospital-based CACs provide medical exams on average to 63.69% (SD 28.96) of their clients, much greater than nonhospital-based CACs (501c3 independent nonprofits, 34.18% [SD 24.95], government based, 31.08% [SD 23.65], and 501c3 umbrella, 30.60% [SD 20.73]).

Conclusions

Data gathered from this survey demonstrate progress toward meeting best practices in the field of child maltreatment and progress toward meeting the NCA Standards for Accreditation. A significant increase in peer review participation for both forensic interview specialists as well as medical providers demonstrates continuous quality improvement in the field. Peer review provides not only an opportunity for professional growth but also an opportunity to discuss and review best practices in action, a necessary process to ensure that we are providing the best quality care for children seen at CACs.

Although progress has been made in providing medical evaluations to CAC clients, a substantial number of children still are not receiving this service. With increased training and technical assistance in this area, the average number of children receiving medical exams is expected to increase over the next few years.

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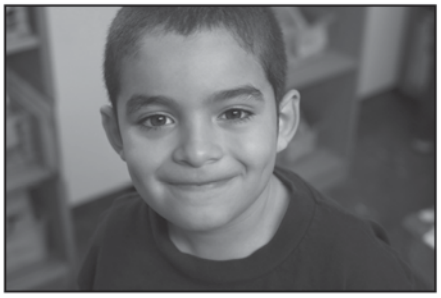

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JOURNAL HIGHLIGHTS

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Addressing Early Childhood Adversity

Support for intervening early in the lives of vulnerable children has come increasingly from our knowledge of brain development, genetics, and the toxic effects of early stress and maltreatment. Advances in a wide range of biological, behavioral, and social sciences are expanding our understanding of how early child maltreatment, environmental influences, and genetic predispositions affect lifelong physical and mental health. This has increased our interest in reducing these risks for all children and in early identification of children and families who would benefit from special programs such as early childhood education and home-visitation programs. Brownell et al. designed a screening process for newborns to predict family risk for out-of-home placement. This article reports on whether all families with newborns were screened, the screening tool's predictive validity for identifying risk of out-of-home placement as a proxy for maltreatment, and which items were most predictive. Using all infants born in Manitoba, Canada, from 2000 to 2002, the authors linked four population-based data sets (newborn screening data on biological, psychological, and social risks, population registry data on demographics, hospital discharge data on newborn birth records, and data on children entering out-of-home care) through age 4 years. They noted that 18.4% were not screened and 3.0% were placed in out-of-home care at least once during the study period. Infants screening "at risk" were 15 times more likely to enter out-of-home care than were those screening "not at risk." Sensitivity and specificity of the screen were 77.6% and 83.3%, respectively. The screening tool demonstrated moderate predictive validity for identifying children at risk for entering care in the first years of life. However, screening efforts to identify vulnerable families missed a substantial portion of families needing support.

Home visitation is increasingly recognized for its potential to foster early child development and competent parenting as well as to reduce risk for child abuse and neglect and other poor outcomes for vulnerable families. Azzi-Lessing provides a discussion of several aspects of home-visitation programs that warrant further development and evaluation, including the powerful role of context in determining program outcomes as well as the impact of other factors, such as service dosage, levels of family engagement, and characteristics of home visitors. The importance of more accurately understanding and measuring risk and engaging family members beyond the mother–child dyad is also discussed. Recommendations are made for making improvements in all of these areas in order to strengthen home-visitation programs and produce better outcomes for the children and families they serve. Aspects of the Nurse Family Partnership and Early Head Start, two widely replicated and rigorously evaluated programs, are highlighted to demonstrate how the issues discussed here are likely to affect service delivery and program outcomes. There are multiple challenges inherent in replicating and evaluating home-visitation programs, and programs that are truly responsive to the needs of a wide array of families with young children are examined.

In a policy statement and supporting technical report, the American Academy of Pediatrics (AAP) presents an integrated "ecobiodevelopmental" framework to assist in translating dramatic advances in developmental science into improved health across the life span. Pediatricians are now being armed with new information about the adverse effects of toxic stress such as maltreatment on brain development as well as a deeper understanding of the early life origins of many adult diseases. Pediatric providers should now complement the early identification of developmental concerns with a greater focus on those interventions and community investments that reduce external threats to healthy brain growth. The AAP endorses a leadership role for the entire pediatric community—one that mobilizes the scientific expertise of both basic and clinical researchers, the family-centered care of the pediatric medical home, and the public influence of AAP and its state chapters. As an organization, the AAP is committed to leveraging science to inform the development of innovative strategies to reduce the precipitants of toxic stress in young children and to mitigate their negative effects on the course of development and health across the life span.

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Biologic Changes Associated with Trauma

Although current evidence is replete with data that support linkages between exposure to violence or abuse and the subsequent development of medical illnesses, the exact underlying mechanisms of these relationships are poorly understood. Physiologic changes occurring in violence- or abuse-exposed individuals point to potentially common biological pathways connecting traumatic exposures with medical outcomes. Keeshin, Cronholm, and Strong (2012) reviewed the long-term physiologic changes in abuse and violence-exposed populations and their associated medical illnesses. They examined the current data that support the presence of specific neurobiochemical changes associated with exposure to violence and abuse, the biological pathways that have the potential to lead to the development of future illness, and the common physiologic mechanisms that may moderate the severity, phenomenology, or clinical course of medical illnesses in individuals with histories of exposure to violence or abuse. They concluded that additional work is needed to advance our emerging understanding of the biological mechanisms connecting exposure to violence and abuse with negative health outcomes.

One mechanism that has been postulated is posttraumatic stress. Posttraumatic stress disorder (PTSD) is associated with increased risk for age-related diseases and early mortality, and an accelerated rate of biological aging could contribute to this increased risk. Telomeres on human chromosomes shorten as we get older, and their length has been associated with premature aging and disease. O'Donovan et al. (2011) assessed leukocyte telomere length as an emerging marker of biological age in men and women with and without PTSD and examined childhood trauma as a risk factor for both PTSD and short leukocyte telomere length. Participants included 43 adults with chronic PTSD and 47 control subjects (none with multiple categories of childhood trauma). Structured clinical interviews were conducted to assess PTSD and other psychiatric disorders and childhood trauma exposure, and leukocyte telomere length LTL was measured with a quantitative polymerase chain reaction method. Participants with PTSD had shorter age-adjusted leukocyte telomere length than did control subjects and exposure to childhood trauma was also associated with short leukocyte telomere length. Childhood trauma seemed to account for the PTSD group difference. The authors concluded that childhood trauma is associated with short leukocyte telomere length in individuals with PTSD and that chronic exposure to the psychobiological sequelae of childhood trauma could increase risk for PTSD and short leukocyte telomere length, suggesting the lasting psychological impact of exposure to trauma in childhood might be accompanied by equally enduring changes at the molecular level.

Shaley et al. (2012) examined telomere erosion in relation to children's exposure to violence, which also has known long-term consequences for well-being and is a major public health and social welfare problem. In the first prospective-longitudinal study with repeated telomere measurements in children while they experienced stress, they tested the hypothesis that childhood violence exposure would accelerate telomere erosion from age 5 to age 10 years. Violence was assessed as exposure to maternal domestic violence, frequent bullying victimization, and physical maltreatment by an adult. Participants were 236 children recruited from the Environmental-Risk Longitudinal Twin Study, a nationally representative 1994–1995 birth cohort. Each child's mean relative telomere length was measured simultaneously in baseline and follow-up DNA samples. Compared with their counterparts, the children who experienced two or more kinds of violence exposure showed significantly more telomere erosion between baseline and follow-up measurements, even after adjusting for gender, socioeconomic status, and body mass index. They concluded that this finding provides support for a mechanism linking cumulative childhood stress to telomere maintenance at a young age with potential impact for life-long health.

In an additional study, low-socioeconomic status (SES) was studied to assess whether there was any association with accelerated biological aging because prior findings relating SES with telomere length have been inconsistent. Steptoe et al. (2011) tested the hypotheses that shorter telomere length and telomerase activity would be related more to education than to current indicators of socioeconomic circumstances. Healthy men and women ages 53–76 years from the Whitehall II epidemiological cohort provided blood samples from which telomere length was assessed in more than 400 individuals. Educational attainment was classified into four levels, while household income and grade of employment were measured as indicators of current socioeconomic circumstances. Age, gender, blood pressure, glycosylated hemoglobin, high-density lipoprotein cholesterol, smoking, body mass index, and physical activity were included as covariates. They found that lower educational attainment was associated with shorter telomere length after controlling statistically for biological and behavioral covariates. Neither household income nor employment grade was related to telomere length. The association between telomere length and education remained significant after adjusting for current socioeconomic circumstances. In men, highest levels of telomerase activity were found in the lowest education group. They concluded that low SES defined in terms of education but not current socioeconomic circumstances is associated with shortened telomeres. Education may promote problem-solving skills leading to reduced biological stress responsivity with favorable consequences for biological aging.

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Trends in Child Maltreatment Epidemiology

Several recent trends have been noted in the epidemiology of child maltreatment and the potential effects of the national economic recession on injuries and reports of child abuse and neglect. To assess trends in children's exposure to abuse, violence, and crime victimizations, Finkelhor et al. (2010) analyzed two cross-sectional national telephone surveys using identical questions in 2003 and 2008 to measure the experiences of children aged 2 to 17 years (2,030 children in 2003 and 4,046 children in 2008). Using responses to the *Juvenile Victimization Questionnaire*, they found that physical assaults, sexual assaults, and peer and sibling victimizations, including physical bullying, were reported significantly less often in 2008 than in 2003. There were also significant declines in psychological and emotional abuse by caregivers, exposure to community violence, and the crime of theft. Physical abuse and neglect by caregivers did not decline, and witnessing the abuse of a sibling increased. They concluded that these declines parallel evidence from other sources, including police data, child welfare data, and the National Crime Victimization Survey, and suggested that there were reductions in various types of childhood victimization in recent years.

Berger et al. (2011) evaluated the rate of abusive head trauma (AHT) in three regions of the United States before and during the economic recession to assess whether there was a relationship between the rate of AHT and county-level unemployment rates. They collected clinical data for AHT cases diagnosed in children younger than 5 years from January 1, 2004, until June 30, 2009, by hospital-based child protection teams within three geographic regions. They defined the recession as December 1, 2007, through June 30, 2009. Quarterly unemployment rates were collected for every county in which an AHT case occurred. They found that during the 5 1⁄2-year study period, a total of 422 children were diagnosed with AHT in a 74-county region, and the overall rate of AHT increased from 8.9 in 100,000 before to 14.7 in 100,000 during the recession. There was no difference in the clinical characteristics of subjects in the prerecession versus recession periods and no relationship between the rate of AHT and county-level unemployment rates. They concluded that the rate of AHT increased significantly during the recession and that this finding was consistent with our understanding of the effect of stress on violence. Given the high morbidity and mortality rates for children with AHT, they also concluded that prevention efforts might need to be increased significantly during times of economic hardship.

Leventhal, Martin, and Gaither (2012) used the 2006 Kids' Inpatient Database to estimate the incidence of hospitalizations due to serious physical abuse among children <18 years of age. Abuse was defined by using *International Classification of Diseases, Ninth Revision, Clinical Modification* codes for injuries (800–959) and for physical abuse (995.50, 995.54, 995.55, or 995.59), selected assault codes (E960–966, 968), or child battering (E967). They examined demographic characteristics, mean costs, and length of stay in three groups of hospitalized children: abusive injuries, nonabusive injuries, and all other reasons for hospitalization. Incidence was calculated using the weighted number of cases of physical abuse and the number of children at risk based on 2006 intercensal data.

They found that the weighted number of cases due to abuse was 4,569 and the incidence was 6.2 per 100,000 children <18 years of age. The incidence was highest in children <1 year of age (58.2 per 100,000) and even higher in infants covered by Medicaid (133.1 per 100,000). Overall, there were 300 children who died in the hospital due to physical abuse. They concluded that data from the 2006 Kids' Inpatient Database on hospitalizations due to serious physical abuse can be used to track trends over time and the effects of prevention programs on serious physical abuse.

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Maltreatment and Unintentional Child Deaths

Vital statistics, medical examiner and police reports, and CPS reports often inaccurately underascertain maltreatment mortality, especially when there is an absence of physical findings directly related to an abusive act. Several investigators have begun to note

a potential relationship between child maltreatment and later accidental injury and have also highlighted the difficulty in differentiating neglect from unintentional or accidental deaths. Parks et al. (2011) examined unintentional injury deaths among children with and without a history of child maltreatment. Using data from reviews of 1,192 unintentional injury deaths occurring among children in Texas during 2005–2007, they examined differences in child demographic characteristics, injury mechanism, and supervisor status at time of death between children with and without maltreatment history by using descriptive statistics. Separate analyses compared characteristics of asphyxia, drowning, and poisoning deaths. They found that in 10% of the unintentional injury deaths reviewed, the child had a history of maltreatment. The prevalence of a history of maltreatment was highest among blacks and lowest among whites. Prevalence was also high among infants and low among older youth ages 10–14 years. Among deaths where there was no maltreatment history, 54% were due to motor vehicle-related incidents, whereas among deaths of children with maltreatment history, 51% were caused by drowning, asphyxia, and poisoning. Supervisors of child who died with a history of maltreatment were significantly more likely to have been alcohol impaired (6.9% vs. 1.6%) or asleep (12.1% vs. 6.6%) at the time of the death. Differences between cases with and without maltreatment history were also observed in infant sleep surface in suffocation deaths, location and barrier type in drowning deaths, and substance type in poisoning deaths. They concluded that the mechanisms and circumstances surrounding unintentional injury deaths among children with a history of maltreatment differ from those without a history of maltreatment. They noted that this underscores the need for appropriate interventions to prevent injuries in families with a history of maltreatment.

Putnam-Hornstein (2011) reported a population-based study of early childhood injury mortality following a nonfatal allegation of maltreatment. She used a unique data set constructed by establishing child-level linkages between vital birth records, administrative child protective services records, and vital death records. These linked data reflected over 4.3 million children born in California between 1999 and 2006 and provided a longitudinal record of maltreatment allegations and death. Children reported for nonfatal maltreatment subsequently faced a heightened risk of unintentional and intentional injury mortality during the first 5 years of life (after adjusting for risk factors at birth). Children with a prior allegation of maltreatment were noted as dying from intentional injuries at a rate that was 5.9 times greater than unreported children and twice the rate as from unintentional injuries. She also noted that a prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of 5 years.

Schnitzer, Covington, and Kruse (2011) reported that most unintentional injury deaths among young children result from inadequate supervision or failure by caregivers to protect the child from potential hazards. They note that while determining whether inadequate supervision or failure to protect could be classified as child neglect, a component of child death review (CDR) in most states, establishing that an unintentional injury death was neglect-related can be challenging because differing definitions, lack of standards regarding supervision, and changing norms make consensus difficult. In this study, CDR team members were surveyed and asked to classify 20 vignettes presented in 10 pairs that described the circumstances of unintentional injury deaths among children. Vignette pairs differed by an attribute that might affect classification, such as poverty or intent. Categories for classifying vignettes were that the caregiver was not responsible/not neglect related, that there was some caregiver responsibility/somewhat neglect related, or that the caregiver was responsible/case definitely neglect related. CDR team members (287) from five states completed surveys, and respondents assigned the child's caregiver at least some responsibility for the death in 18 vignettes (90%). A majority of respondents classified the caregiver as definitely responsible for the child's death in 8 vignettes (40%). This study found that the attributes that influence CDR team members' decisions are supervision, intent, failure to use safety devices, and a pattern of previous neglectful behavior. The authors suggest these findings offer insight for incorporating injury prevention into CDR more effectively.

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WASHINGTON UPDATE

John Sciamanna

Federal Budget Fight

The first half of the year has focused on the budget debate with the likelihood it will not be addressed fully until the December holidays. The President's budget request for fiscal year (FY) 2013 (which starts October 1, 2012) spends $3.8 trillion with a projected $901 billion deficit, decreasing from the projected $1.3 trillion for this year. The budget allocates spending at levels set by last year's debt ceiling agreement (Public Law 112-25). The $3.8 trillion includes $830 billion for Social Security, $672 billion in defense spending (including $88 billion for the war), $530 billion for Medicare, $282 billion for Medicaid, $248 billion in interest payments, $140 billion for Veterans Affairs, and $568 billion for the remaining discretionary (annually appropriated) programs.

Last year's debt agreement included cuts already enacted but also directed Congress to find an additional $1.2 trillion in additional deficit reduction. If Congress cannot reach that goal, across-the-board cuts (referred to as a sequestration) will be imposed on January 2, 2013, to both defense spending and domestic spending. Medicaid, Medicare (outside of some provider cuts), foster care, adoption assistance, and several other vital programs are exempted from such cuts, which would be implemented on January 2. Projected cuts for Health and Human Services (HHS) could be as high as 10% according to some calculations. That would mean the remaining child welfare services, the Child Abuse Prevention and Treatment Act (CAPTA), discretionary child care funding, Head Start, and several other programs would be hit with dramatic cuts.

The President's budget included a new $5 million that would provide competitive grants to address child sex trafficking. These grants would be targeted to coordinate with child welfare agencies and law enforcement, the development of services for child victims, and training for child welfare agencies in identifying and dealing with youth in care who have become trafficking victims. The President's budget also included a carryover from last year's budget: a $252 million proposal to reform child welfare systems. The Administration has not provided legislative details on how these funds would be used.

The House of Representatives has taken its own approach with top priority being to avoid cuts to the Defense Department. In April, the House voted to completely eliminate the Social Services Block Grant (SSBG). The action was a part of a reconciliation

bill, which is a result of the House budget resolution (H. Con. Res. 112) adopted earlier this spring. Six committees adopted cuts to mandatory programs to obtain 10 years worth of savings. In addition to SSBG cuts, reduced spending covers a number of domestic areas, including the children's tax credit, Affordable Care Act (health insurance law), nutrition programs, and the federal workforce.

States use the SSBG to supplement a range of child welfare and child protection services. In fact, SSBG funding used for Child Protective Services (CPS) has consistently been around $300 million a year, far exceeding the $27 million allocated through the CAPTA. States also supplement their child abuse prevention, adoption, and foster care services with this fund. According to past surveys of child welfare spending, SSBG represents 12% of all federal funds spent annually. States can use SSBG for 29 different services to all vulnerable populations, but child welfare is one of the largest categories. In FY 2009, states spent approximately $980 million of SSBG money on child welfare services. Some of the money allocated comes from the Temporary Assistance for Needy Families (TANF) block grant, and in such cases, SSBG allows more direct support for child welfare. In 2009, 41 states used SSBG dollars to fund their child protective service agencies, 30 states used funding for prevention and intervention services, 22 states used funds to assist in adoptions, and 36 states supplemented foster care systems with the funding. There are additional funds used to assist youth and to address some residential care services. SSBG also is the main funder of adult protective services; it supplements senior meals and a number of services for people with disabilities.

More than ninety organizations have signed a letter opposing the elimination of SBBG. The letter states, "SSBG is a major funder for state and local child abuse prevention services, child protective services (CPS) and it supplements services for adoptions and for services to infants, children and youth in foster care." Groups that have signed the letter were solicited through the National Child Abuse Coalition and the National Foster Care Coalition (http://www.nationalfostercare.org/uploads/8/7/9/7/8797896/ssbg_sign_on_letter.pdf).

During the 1996 welfare reform debate that resulted in the creation of TANF, SSBG was temporarily reduced to $2.3 billion from its level of $2.8 billion. It was to be restored at $2.8 billion after 5 years. The federal budget did reach surplus in the late 1990s, but despite that, SSBG was never restored. Congress again reduced SSBG, this time permanently to $1.7 billion, as a way to offset the cost of the 1998 transportation reauthorization in lieu of an increase in the gas tax. One of the champions for restoration of SSBG to $2.8 billion in the 2003 House bill (HR 1858) was Congressman David Camp (R-MI), the current Chair of the Ways and Means Committee. While the current proposal is unlikely to pass the Senate before the election, the proposal is now on the table as a revenue option during November negotiations.

Administration Issues Waiver Guidance and Memo on Child Well-Being

Starting with an April 17 Information Memorandum (IM) on Child Well-Being (ACYF-CB-IM-12-04) and finishing with a May 14 IM on new waiver authority to flexibly spend foster care funds, the Administration for Children and Families (ACF) has begun to push states in the direction of greater emphasis on improving the well-being of children and families who come into contact with the child welfare system. The IM on child well-being argues that emphasis on child well-being based on evidence and research-based approaches will not only address safety and permanence (the focus over the past decade) but will also assist maltreated children and children and youth in care.

The IM states, "While it's important to consider overall well-being of children who have experienced abuse and neglect, a focus on social and emotional well-being can significantly improve outcomes for these children while they are receiving child welfare services and after their cases have closed" (ACYF-CB-IM-12-04, p. 1). The IM indicates that ACF will design its approach around the policy outlined in the memo. The guidance to states suggests that addressing safety and permanence is not enough and promotes programs and policies that consider four areas: cognitive functioning, physical health and development, behavioral and emotional functioning, and social functioning. The IM lays out several examples of evidence- and research-based treatments and approaches in the four areas. The memorandum proposes that child welfare systems need to "scale-up" effective practices while "de-scaling" practices that are considered ineffective. It argues that it is not enough for programs to simply supplement ineffective practices by adding more effective practices, but there needs to be both scaling-up and de-scaling at the same time.

The IM on state waiver authority (ACYF-CB-IM-12-05) provides guidance on how states can apply for a waiver of federal funding restrictions on the use of Title IV-E foster care funds. The waiver authority was created in 1994 and renewed last year with passage of the Child and Family Services and Innovations Act (PL 112-34). The waiver allows states to spend foster care funds more flexibly if they can do it in a "cost neutral" way and conduct ongoing research to track results. Up to ten states a year can receive a waiver in years 2012 through 2014. The waiver authority is implemented to promote state efforts that will further strategies to focus on child and family well-being. The guidance also suggests broad outlines for defining cost neutrality with states having an opportunity to develop a model that can be negotiated with HHS. The waiver requires an interested state to implement at least two new child welfare policy changes from a list incorpo-

rated into the waiver law. Most of the suggested policy changes are based on initiatives (such as extending care to age 21 or implementing a subsidized guardianship program) that were enacted as part of the 2008 Fostering Connection to Success Act (PL 110-351). States have until July 9 to submit their applications. The successful waiver applications would go into effect at the start of the next fiscal year, October 1. (To obtain a copy of the waiver online, see: http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1205.pdf)

Senate Roundtable Focuses on Child Well-Being in Child Welfare

On Friday, April 27, 2012, Senator Ron Wyden (D-OR) led a roundtable discussion of leaders from the child welfare community on ways to address and measure efforts to improve child well-being. The offices of Senator Max Baucus (D-MT) and Senator Orrin Hatch (R-UT) also participated. Wyden highlighted that Congress had passed a good bill with last year's reauthorization of the two Title IV-B programs, the Child and Family Services Improvement and Innovation Act, but he then talked about the need to take the next steps in the reform of the nation's child welfare system. More than fifty advocacy groups, Administration officials, and program and research experts heard from the Chair of the Finance Committee, Senator Max Baucus, who reflected on the Senate's recent passage of the Violence Against Women Act and how that act, created 2 decades ago, had a significant impact on the issue of domestic violence. He indicated we should have a similar effort to address and focus attention on the challenges in child welfare.

Much discussion focused on brain development both for infants and toddlers and for adolescents. There was discussion around implementing good practice at the state and local levels, how youth fare in the current system, and how much of the focus that has previously been on safety and permanency now needs to extend to well-being. The group heard from young people who had been in foster care and their observations on what needs to be addressed. The Acting Assistant Secretary for the Administration on Children and Families, George Sheldon, summed up the 2-hour session by observing how child welfare can't be viewed in isolation. We must also look across systems and areas of need. He listed such issues as mental health, substance abuse, and domestic violence as playing a role in many child welfare cases. He further talked about the need to address the impact of trauma in different contexts: within the family, when being removed from the family, and because of multiple placements. There was a brief discussion on the next steps for the group, and Senator Baucus' office indicated great interest within the Finance Committee to enact a comprehensive reform. While it wasn't clear when an opportunity might arise as far as committee and congressional dynamics, the committee members wanted to be prepared to act.

Violence Against Women Act (VOWA) Headed to Senate–House Negotiation

The House of Representatives approved HR 4970, a bill to reauthorize the Violence Against Women Act (VOWA) on Wednesday, May 16. The bill by Congresswoman Sandy Adams (R-FL) was approved by a largely partisan vote of 222 to 205. The focus of the House debate continued along the same lines as the previous week's Committee debate. There are three issues of difference: one provision allows tribal authorities to prosecute non-Indian men who abuse Indian women. Critics contend the provision would extend too much power to tribal governments and is not constitutional. Proponents point to the narrowness of the legal language and declare that the higher rates of violence, including rape on tribal reservations, demand stronger protection not currently in the law. The Senate language (S 1925) provides limited authority to address the high rates of domestic violence in tribal areas.

A second issue of difference between the two bills is that the Senate bill increases the total number of visas that are issued to undocumented immigrant women who are victims of domestic violence, increasing from 10,000 to 15,000 per year. House critics contend this provision could be abused and open up too many visas and supersede current immigration limitations. The Senate language would increase annual visas to 15,000, conditioned on addressing the backlog of visas not issued due to the bureaucratic delay in the implementation of the 2000 reforms.

Finally, the Senate version clarifies language that formally extends the law to cover domestic violence when it involves issues of gender identity and sexual orientation. Critics of the Senate bill see this provision as an expansion. Supporters note that people from this community already receive services in some areas of the country, and the new language will make clear that lesbian, gay, bisexual, transsexual, and questioning (LGBTQ) populations can be served under the law. VOWA includes a number of programs that address child abuse services. Other programs of note include the Court Appointed Special Advocates (CASA) grants, Rural Domestic Violence and Child Abuse Enforcement grants, Battered Women's Shelters grants (HHS), and Rape Prevention Education. There are also several smaller grants to address campus-based violence, advocacy for youth victims, and combating dating violence.

New Study Puts Annual Child Abuse Costs at $80 Billion

On Thursday, May 10, Prevent Child Abuse America (PCA) released an updated study of annual cost of child abuse and set the total price tag at $80 billion. The study, which was conducted by Dr. Richard Gelles (University of Pennsylvania) and Dr. Staci Perlman (Kutztown University), divided annual cost between

direct costs at $33 billion, which took into account expenses such as law enforcement, hospitalization, and mental health services, and $47 billion for indirect long-term costs, such as special education services for the victim, juvenile and adult criminal justice costs, and lost work productively. (The report is available at: http://www.preventchildabuse.org/downloads/PCAA_Cost_Report_2012_Gelles_Perlman_final.pdf)

In releasing the report, Jim Hmurovich said, "The fact is we still have a lot of work to do to ensure the healthy development of all children. Evidence-based programming such as home visiting, and sexual abuse and shaken baby syndrome prevention, show that abuse and neglect can be prevented, but it takes all of us to make children a priority to accomplish this. We need to prioritize children not only in our policies and budgets, but [also] in our everyday actions" (http://preventchildabuseamerica.blogspot.com/2012/05/cost-study-calls-for-continued-focus-on.html). This most recent study by PCA calculates the costs for all current and previous-year victims on an annual basis. Other studies have calculated costs based on an examination of current-year victims projected forward.

Report Grades States on Reporting Child Abuse and Neglect Deaths

On Tuesday, April 17, the Children's Advocacy Institute at the University of San Diego Law School and First Star released *State Secrecy and Child Deaths in the U.S.,* the second in a series of reports that assesses state disclosure laws regarding child deaths. Twenty states were rated as receiving a *C+* rating or lower with four receiving *D*'s or lower. The report, which bases its assessments on five areas dealing with disclosure of child deaths—whether there is a state policy for disclosure, whether the process is codified, ease of access, openness of proceeding, and scope of information made public—concluded that 11 states had made improvements since the original report was issued in 2008. The report and briefing were used to promote the Protect Our Kids Act, sponsored in the Senate (S 1984) by Senator John Kerry (D-MA) and Senator Susan Collins (R-ME) and in the House (HR 3653) by Congressman Lloyd Doggett (D-TX) and Congressman Joe Crowley (D-NY). The bills would create a national commission to focus on child deaths and make recommendations on a course of action.

A statement by Senator Kerry said, "It is more difficult to address a problem if we don't know the extent of it, and this report confirms that many states have either papered over the problem or failed to dedicate the resources needed to address it." The Senator re-stated his call for Congress to pass the legislation. In 2010, the National Child Abuse and Neglect Data Systems (NCANDS) reported 1,537 child deaths. This figure includes deaths reported through CPS but does not necessarily include deaths that may be reported through law enforcement and hospitals and other possible sources. (To read the report by the Children's Advocacy Institute online, see http://www.caichildlaw.org/Misc/StateSecrecy2ndEd.pdf)

New Report Ranks Half the States Falling Short on Child Legal Representation

On Thursday, May 10, First Star and the Children's Advocacy Institute released a report titled *A Child's Right to Counsel*. This report is third in a series of report cards on how each state performs in providing effective legal representation to maltreated children. Three states were ranked superior and received *A+* ratings: Connecticut, Massachusetts, and Oklahoma. Another dozen were recognized as *A* states: Iowa, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Mexico, New York, Ohio, Texas, Vermont, and West Virginia. The report based its rankings on six factors: whether or not the state mandates the appointment of an attorney for a child, if the state defines the duration of such representation, if the representation is client-directed, if there is special training for such attorneys, if the law gives the child the legal status of a party, and whether rules regarding immunity from liability and confidentiality apply to attorneys representing children in these cases. The release of the report was presented along with a panel presentation that included the comments of three young people who had been in foster care as well as representatives from the American Bar Association. Congressman David Camp (R-MI), Chairman of the House Ways and Means Committee, stepped away from the House debate on Reconciliation legislation to lend his support to the report and the issue. He said it was unfortunate that children who are abused and neglected through no fault of their own and are abandoned by the states when they are denied such legal representation. He said he would do more to make sure that states have the tools they need to help implement reforms. He referred to last year's reauthorization of Promoting Safe and Stable Families, which included the reauthorization of the court improvement program. (To obtain a copy of the report, see: www.firststar.org)

About the Author
John Sciamanna is Executive Director of the National Children's Coalition and was Director of Policy and Government Affairs for the American Humane Association (AHA), overseeing AHA's legislative agenda in Washington, D.C., and working specifically with the Administration, Congress, and other national groups. For close to 2 decades, he has been working on children's issues and, in the last decade, has more specifically focused on child welfare issues. Before joining AHA, he worked in the U.S. Senate as a Legislative Assistant, with the American Public Human Services Association (APHSA) as a Senior Policy Associate, and most recently as Codirector of Government Affairs for the Child Welfare League of America. Contact: johnscia@yahoo.com

APSAC News

APSAC Celebrates 25th Anniversary During Annual Colloquium in Chicago

More than 500 professionals attended the 20th Annual APSAC Colloquium, sponsored by the American Professional Society on the Abuse of Children, which was held June 27–30, 2012, in Chicago, Illinois. A strong program, coupled with the multidisciplinary support of professionals who serve children and families affected by child maltreatment and violence, attributed to the success of the Colloquium, during which APSAC also celebrated its 25th Anniversary as an association.

APSAC's Colloquium offered nearly 100 institutes and workshops that addressed all aspects of child maltreatment—prevention, assessment, intervention, and treatment regarding victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. Several special programs attracted strong attendance from law enforcement personnel, as well as international delegates from Russia. Cultural considerations were also addressed.

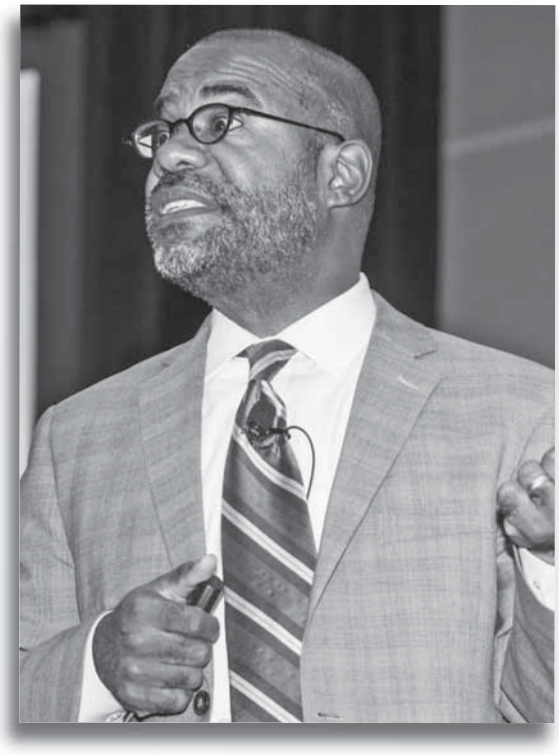
The Colloquium is a major source of education and research for professionals in the field of child maltreatment, including mental health, medicine and nursing, law, law enforcement, education, prevention, research, child protective services, advocacy, and related fields. The educational goal of APSAC's gathering is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education.

The 21st APSAC Annual Colloquium will take place in Las Vegas, Nevada, June 25–28, 2013.

APSAC Board Elects New Directors and Officers

APSAC's Board of Directors met June 25–26 in Chicago, Illinois, in conjunction with the Colloquium. During the meeting, new Board members were seated, and 2012 Officers were elected.

The following officers were elected to serve: President Viola Vaughan-Eden, PhD, LCSW, Child and Family Resources, Newport News, Virginia; Vice President Tricia Gardner, JD, Associate Professor, Center on Child Abuse & Neglect, Oklahoma City, Oklahoma; Treasurer Vincent J. Palusci, MD, MS, Loeb Child Abuse Center, New York, New York; Secretary William Marshall, BS, Detective, Spokane Police Department, Spokane, Washington; Board Member at Large to the Executive Committee Frank Vandervort, JD, Clinical Assistant Professor at Law, Child Advocacy Law Clinic, University of Michigan Law School, Ann Arbor, Michigan; and Immediate Past President Ronald C. Hughes, PhD, MScSA, Director, Institute for Human Services, Columbus, Ohio.



Bryan Samuels of the US Department of Health and Human Services delivered the Opening Plenary Session presentation on "Current and Future Issues in Child Protection".

The following Board members were elected to 3-year terms: Julie Kenniston, LSW (second term), Director of Training and Education, Butler County Children Services, Mason, Ohio; David L. Corwin, MD, Psychiatrist, University of Utah—Pediatrics, Sandy, Utah; Toni Cardenas, LCSW, JJI Borough Director, New City, New Jersey; Brenda Mirabal Rodriguez, MD, UPR School of Medicine, San Juan, Puerto Rico; and Marilyn J. Stocker, PhD, Leadership Development, Chicago, Illinois.

Additional APSAC Board members are currently completing their terms: Elissa J. Brown, PhD, St. John's University, Partners Program/Psychology, Jamaica, New York; Bill S. Forcade, JD, Attorney at Law, Chicago, Illinois; Monica Fitzgerald, PhD, Assistant Professor, Medical University of Colorado—Denver, Kempe Center for the Prevention of Child Abuse & Neglect, Denver, Colorado; Lori Frasier, MD, Professor of Pediatrics, University of Utah School of Medicine, Salt Lake City, Utah; and Michael V. Johnson, BSCJ, Director, Detective (ret), Boy Scouts of America, Irving, Texas.

APSAC Recognizes Contributions at Annual Colloquium

APSAC recognized outstanding service and commitment within the field of child maltreatment during its Annual Colloquium this past June in Chicago. Following is a list of awards presented and the recipients:

Participants in the Second Russian-American Child Welfare Forum, held in conjunction with the APSAC Colloquium, look on during one of the many presentations. The Forum was sponsored and organized by the National Foundation for the Prevention of Cruelty to Children (NFPCC) in Moscow, the American Professional Association on the Abuse of Children (APSAC), and the North American Resource Center for Child Welfare / Institute for Human Services, in Columbus, Ohio.

Special Recognition Award–(for outstanding contributions and service to the organization)

Peter Banks, Det, Director, Training & Outreach (Retired), National Center for Missing and Exploited Children

Thomas Birch, JD, Legislative Counsel (Retired), National Child Abuse Coalition

James Campbell, PhD, Associate Dean, Program and Partnership Development, University of Wisconsin, Madison

Luke Dembosky, JD, Resident Legal Advisor, U.S. Department of Justice, Embassy of the United States, Moscow

Judith Rycus, PhD, Program Director, Director of International Child Welfare Training and Programming, Institute for Human Services

Additionally, the Colloquium honored two former presidents of the organization with *President Emeritus for Life* status:

Jon R. Conte, PhD, School of Social Work, University of Washington

Ronald C. Hughes, PhD, MScSA, Institute for Human Services, Ohio

APSAC Offers Three Advanced Training Institutes in January

APSAC Advanced Training Institutes are being held in conjunction with the 27th Annual San Diego International Conference on Child and Family Maltreatment on Sunday, January 27, 2013. The Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars offer hands-on, skills-based training grounded in the latest empirical research. Participants are invited to take part by asking questions and providing examples from their own experience. The 2013 Institutes include the following:

APSAC Pre-Conference Institute #1: Advanced Issues in Child Sexual Abuse Medical Evaluations
Sunday, January 27, 8 am–5 pm,
lunch break on your own (8 hours)
Lori D. Frasier, MD, and Suzanne Starling, MD

APSAC Pre-Conference Institute #2: Cognitive Processing: Advanced Clinical Strategies for CBT Trauma Therapist
Sunday, January 27, 8 am–4 pm,
lunch break on your own (7 hours)
Monica Fitzgerald, PhD, and Kimberly Shipman, PhD

APSAC Pre-Conference Institute #3: Maximizing Corroborative Information in Child Abuse and Witnessing Violence Cases
Sunday, January 27, 8 am–4 pm,
lunch break on your own (7 hours)
Julie Kenniston, LSW, MSW, and Chris Kolcharno

Details and registration are available on the APSAC Web site under the Events tab, Event List.

Call for Abstracts

APSAC is now accepting abstracts for its 2013 Colloquium, June 25–28, Las Vegas, Nevada. Details on responding to the Call for Abstracts are available on the association's Web site, www.apsac.org.

Conference Calendar

September 9–12, 2012
17th International Conference on Violence, Abuse, and Trauma
Institute on Violence, Abuse, and Trauma
San Diego, CA
858.527.1860
ivatconf@alliant.edu
www.ivatcenters.org/Conferences.html

September 9–12, 2012
19th ISPCAN International Congress on Child Abuse and Neglect
International Society for the Prevention of Child Abuse and Neglect
Istanbul, Turkey
303.864.5220
info@ispcan2012.org
www.ispcan.org

September 9–12, 2012
Arkansas Conference on Child Abuse and Neglect
University of Arkansas at Little Rock; Arkansas Commission on Child Abuse, Rape, and Domestic Violence; Arkansas Children's Hospital
Hot Springs, AR
501.296.1920
loryan@midsouth.ualr.edu
www.midsouth.ualr.edu/

September 29–October 1, 2012
12th International Conference on Shaken Baby Syndrome/Abusive Head Trauma
National Center on Shaken Baby Syndrome
Boston/Cambridge, MA
801.447.9360
mail@dontshake.org
www.dontshake.org

October 18–20, 2012
7th Biennial Adoption Conference "Best Interests of the Child?" Race, Religion, and Rescue in Adoption
Adoption Initiative/St. John's University
New York, NY
adoptioninitiative@gmail.com
www.adoptioninitiative.org

October 22–23, 2012
31st Annual Michigan Statewide Conference on Child Abuse and Neglect: Prevention, Assessment, and Treatment
University of Michigan Medical School
Plymouth, MI
734.763.1400
OCME@umich.edu
www.cme.med.umich.edu/childconference/default.html

November 14–16, 2012
Conference on Differential Response in Child Welfare
Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
Henderson, NV
303.630.9429
amyh@americanhumane.org
www.differentialresponseqic.org/conference

December 4–7, 2012
CornerHouse Advanced Forensic Interview Training
CornerHouse
Minneapolis, MN
612.813.8310
cornerhousemn.org
www.cornerhousemn.org

January 26–27, 2013
APSAC Advanced Training Institutes
American Professional Society on the Abuse of Children
San Diego, CA
807.402.7722
apsac@apsac.org
www.apsac.org

January 28–31, 2013
27th Annual San Diego International Conference on Child and Family Maltreatment
Chadwick Center for Children and Families
San Diego, CA
858.966.4972
SDConference@rchsd.org
www.sandiegoconference.org/

March 18–22, 2013
29th National Symposium on Child Abuse
National Children's Advocacy Center
Huntsville, AL
256.327.3863
mgrundy@nationalcac.org
www.nationalcac.org/national-conferences/symposium.html

April 14–17, 2013
National Conference
Child Welfare League of America (CWLA)
Washington, DC
202.688.4200
www.cwla.org/conferences/conferences.htm

April 15–19, 2013
APSAC's Child Forensic Interview Clinic
American Professional Society on the Abuse of Children
Norfolk, VA
877.402.7722
apsac@apsac.org
www.apsac.org

June 25–28, 2013
21st APSAC Annual Colloquium
American Professional Society on the Abuse of Children
Las Vegas, NV
877.402.7722
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