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Trends in Children's Hospital-Based Child Abuse Medical Services: 2012 Survey Findings

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Children's Hospital Association (formerly the National Association of Children's Hospitals and Related Institutions) is committed to strengthening the child abuse response from children's hospitals. This commitment is anchored in the belief that children's hospitals—as visible and trusted community advocates for children's health care—are transformational agents in the identification, treatment, and prevention of child abuse and neglect. They are home to more than 80% of the nation's 264 certified child abuse pediatricians.

Children's Hospital Association, an institutional membership organization of 225 hospitals, includes approximately 95% of children's hospitals in the United States. Its members can be grouped into one of four hospital types: (1) children's hospitals within hospitals, (2) freestanding children's hospitals, (3) pediatric programs, and (4) specialty hospitals. These member categories are based on clinical services provided, recognition as a primary teaching site, and governance structure.

The 2012 child abuse trend survey summarized in this article received a response rate of 61% (145 of 237). Nearly all children's hospitals provide services to maltreated children, but the depth and scope of these services vary. The Association conducts a triennial survey of child abuse services to quantify the role of children's hospitals in child maltreatment and serve as a practical benchmarking resource for child protection teams and hospitals. The 2012 survey is the third such collection of data over the last seven years and reflects such information as protection team expenses and revenue, staffing practices, and types of functions and activities.

Hospital-Based Child Protection Teams

The Association developed voluntary guidelines as a self-assessment tool for child protection teams (Children's Hospital Association, 2011). These guidelines offer a three-tiered structure for the development and improvement of child abuse programs while allowing for program flexibility (Table 1). The tiers define *teams* as basic, advanced, or centers of excellence and give recommendations for each level. Ultimately, these suggestions could improve the quality and consistency of medical care to children suspected of being maltreated. In 2012, hospitals were surveyed based on the definitions used in the 2011 guidelines.

Child Abuse Medical Services Survey

The 2012 survey asked teams about a variety of characteristics of their programs, including types of programs, staff, services offered, caseloads, expenses, and resources. The survey was sent to all 225 members of the Association in early 2012. Over half (79 of 145) of survey respondents were physicians, and the majority of those, certified child abuse pediatricians at children's hospitals. The balance of respondents consisted of other types of child protection team members. The 2011 guidelines recommend all acute care children's hospitals respond to child maltreatment at least at the basic level, and 131 of 136 acute care children's hospitals (96%) followed this recommendation. Of all 145 responding hospitals, 27% described their response to child maltreatment as basic, 38% as advanced, and 27% as a center of excellence (Figure 1). Eight percent of respondents offered no services in response to child abuse, meaning they referred all suspected cases of child maltreatment to another health care institution in the community. This percentage fell to 3% if specialty hospitals (generally rehabilitation, burn, and orthopedics hospitals) were excluded.

The guidelines recommend that all child protection teams at the advanced and center of excellence levels should be medically directed, in most cases, by a certified child abuse pediatrician. Overall, such certified pediatricians led 75% (98 of 130) of child protection teams at children's hospitals. They led 90% (35 of 39) of centers of excellence, 85% (46 of 54) of advanced teams, and 46% (17 of 37) of basic programs.

Caseload

The caseload number at children's hospitals is rising. Average caseload increased 9% (from 858 to 934 cases) as reported by the same 68 respondents in both 2008 and 2012 (Figure 2). The increase is 16% for a smaller group of 34 respondents who reported caseload for all three surveys (2005, 2008, and 2012).

Table 1. The Three Levels of Child Protection Teams

Basic

In general, at the **basic** level

- The three functions essential to a child protection response are: medical leadership, administrative coordination, and social work services. Each essential function need not be performed by a separate, dedicated staff person.
- Staffing may be limited but includes, at minimum, a physician who provides medical leadership and administrative coordination, and social work services provided by staff trained in the field of child abuse.
- Representatives of community agencies routinely participate in child protection meetings.
- If mental health professionals are not assigned to child protection, they should be available from other hospital departments or via referral.

Advanced

In general, at the **advanced** level, in addition to meeting all recommendations for the basic level, the child protection team

- Is led by a full-time medical director who is board certified in child abuse pediatrics (with few exceptions).
- Generally has additional staff.
- Is an administrative unit of the children's hospital with centralized management and administrative functions.
- Meets regularly to present and review child abuse cases.
- Coordinates, as appropriate, with community agencies involved in child protection.
- Is more likely to serve a broader catchment area, receiving referrals from outlying communities.
- May offer an accredited fellowship.

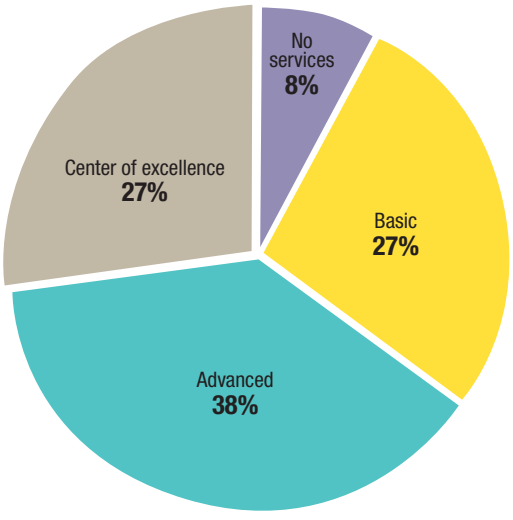
Center of Excellence

Centers of excellence are distinguished by additional educational and research capabilities. In general, in addition to meeting all recommendations for the basic and advanced levels, a center of excellence

- Features larger child protection teams whose members include additional professionals in the hospital, such as psychologists.
- Offers advanced diagnostic and treatment services that often require consultation with hospital medical and surgical subspecialists.
- Is likely to offer an accredited fellowship.
- May sponsor multicenter trials.
- Is a regional and national leader in child maltreatment and related family violence intervention and prevention.

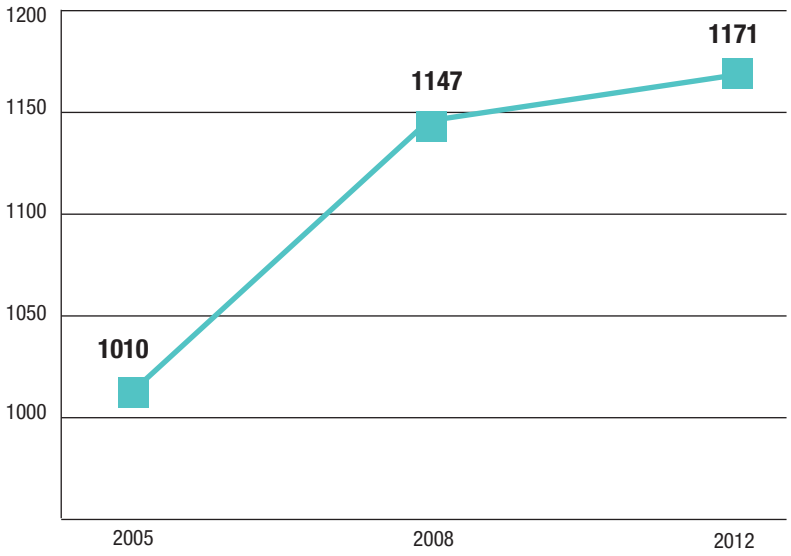
Source: *Defining the Children's Hospital Role in Child Maltreatment, Second Edition* (Children's Hospital Association, 2011), p. 3. All illustrations reprinted with permission.

Figure 1. Child Abuse Program Type (n=145)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 1.

Figure 2. Average Caseload for 2005, 2008, and 2012 (n=34)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 19.

In addition to trend data that show a caseload increase, over two thirds of 2012 survey respondents reported a perception of caseload increase since 2008. They attributed this increase to more referrals from the following: hospital staff (73%), other hospitals and providers (74%), and child protective services, law enforcement, and/or other agencies (68%). This reported increase in child protection team referrals differed from the last 5 years of National Child Abuse and Neglect Data System (NCANDS) information that showed only slight fluctuations in the number and rate of reports to state child protective services agencies (U.S. Department of Health and Human Services, 2012). The perceived increase in referrals could be interpreted as better recognition of the specialized expertise provided by teams and improved coordination with hospital and community partners.

Some respondents believed community awareness and reporting (48%) and the rate of maltreatment (46%) had contributed to more cases, although these were not leading factors in caseload increase. However, the perceived increase in the rate of maltreatment as a factor is contrary to two sources of federal data that showed a decline in substantiated abuse (U.S. Department of Health and Human Services, 2012; Sedlak et al., 2010).

Staffing

Defining the Children's Hospital Role in Child Maltreatment, Second Edition (Children's Hospital Association, 2011) describes the three functions essential to a child protection response: medical leadership, administrative coordination, and social work services. The dedicated *full-time equivalent* (FTE) of medical directors stayed essentially the same at 0.85 in 2008 and 0.84 in 2012 (Table 2). Administrative director FTE and medical social worker FTE each declined: 0.39 FTE and 0.66 FTE respectively. Total FTE on the team remained relatively flat as reported by 61 respondents: 11.49 FTE in 2008 and 11.44 FTE in 2012. There appeared to be no growth and possibly a decline in total FTE of core functions dedicated to child protection teams.

Increases of 0.50 FTE or less were reported for the following positions: nursing/medical assistants, registered nurses, nurse practitioners/physician assistants, forensic interviewers, physicians, and intake coordinators/case managers. There was almost no change in FTE for child abuse fellows and child family advocates. Decreases in FTE were all less than 1.0 for social work therapists, medical social workers, administrative support, coordinators/managers, and psychologists.

Table 2. Change in FTE in 2008 and 2012

Core functions	**FTE 2008**	**FTE 2012**	**Change in FTE**
Medical director (n=50)	.85	.84	(.01)
Administrative director (n=22)	1.19	.80	(.39)
Social worker – medical (n=29)	2.30	1.64	(.66)
Additional functions	**FTE 2008**	**FTE 2012**	**Change in FTE**
Nursing/medical assistant (n=13)	.91	1.41	+.50
Registered nurse (n=17)	2.03	2.47	+.44
Nurse practitioner/physician assistant (n=29)	1.37	1.70	+.33
Physician (n=37)	1.30	1.51	+.21
Forensic interviewer (n=14)	2.72	2.92	+.20
Intake coordinator/case manager (n=12)	1.59	1.70	+.11
Child/family advocate (n=12)	1.23	1.18	(.05)
Fellow (n=11)	1.45	1.39	(.06)
Psychologist (n=14)	1.48	1.35	(.13)
Coordinator/manager (n=18)	1.61	1.48	(.13)
Administrative support (n=43)	1.97	1.83	(.14)
Social work therapist (n=12)	4.79	3.95	(.84)

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 19.

Expenses and Revenue

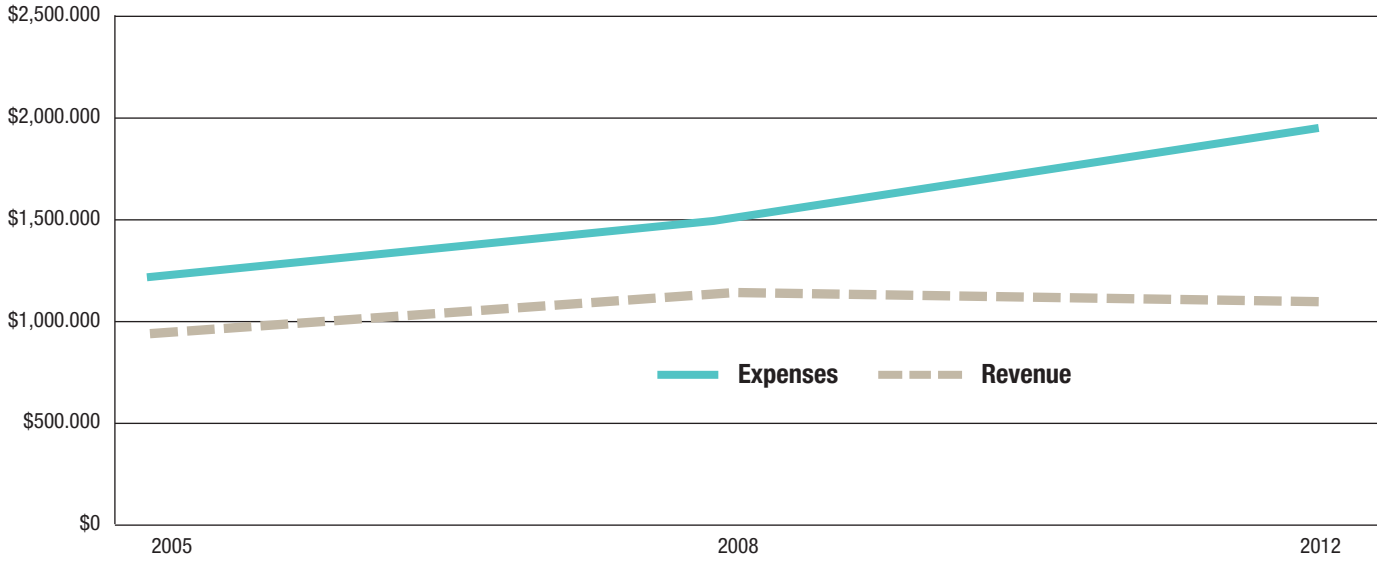
Consistent with the national rise in health care costs, direct operating expenses increased 10% since 2008 to an average $1,384,519, according to 36 respondents. At the same time, revenue shrunk 10% since 2008 to an average of $1,089,457, according to 25 respondents (Figure 3).

A group of 17 respondents reported expenses and revenue for all three surveys in 2005, 2008, and 2012. Their figures show a 60% increase in expenses and a 17% increase in revenue. With expenses going up and revenue not keeping pace, the difference will continue to widen.

Hospital Support of Direct Expenses

Prior surveys demonstrated that child protection teams are not financially self-sustaining: They do not bring in enough money to cover their costs

Figure 3. Expenses and Revenue in 2005, 2008, and 2012 (n=17)



Source: Unpublished 2012 Children's Hospital Association survey data.

and the hospital absorbs the shortfall. The 2012 survey used a new approach to quantify this gap. It asked respondents how much of the direct expenses the hospital covered for fiscal year 2011 and found that the hospital covered 47% of an average of $1,113,703 in direct expenses (i.e., $523,440 of direct expenses) for 59 respondents. For indirect expenses, the hospital covered over half (58%) of an average of $211,088 in indirect expenses (i.e., $122,431 of indirect expenses) for the same 59 respondents. There was variability among the 59 hospitals for reporting how much the hospital covered; nine hospitals reported that the hospital fully covered their expenses and five hospitals reported that the hospital covered none of their expenses. Figure 4 shows the distribution by hospital for these numbers.

Other Sources of Support for Expenses

The survey asked whether other organizations covered any child protection team expenses in addition to the hospital. Another organization covered some of the direct or indirect expenses for 62% of respondents (73 of 118). Of the 70 respondents who provided more detail, more than 20% reported various contracts, grants, and university support. Almost 15% cited a children's advocacy center as covering some portion of expenses.

Revenue

Child protection teams reported average revenue of $722,174 in 2012 (n=55) (Table 3). The majority of respondents (84%) depended on three or more sources of revenue. Medicaid, private payer, and reimbursement for services (including contracted services) provided to local, county, or state agencies or university/school were the most frequently cited revenue sources (n=104).

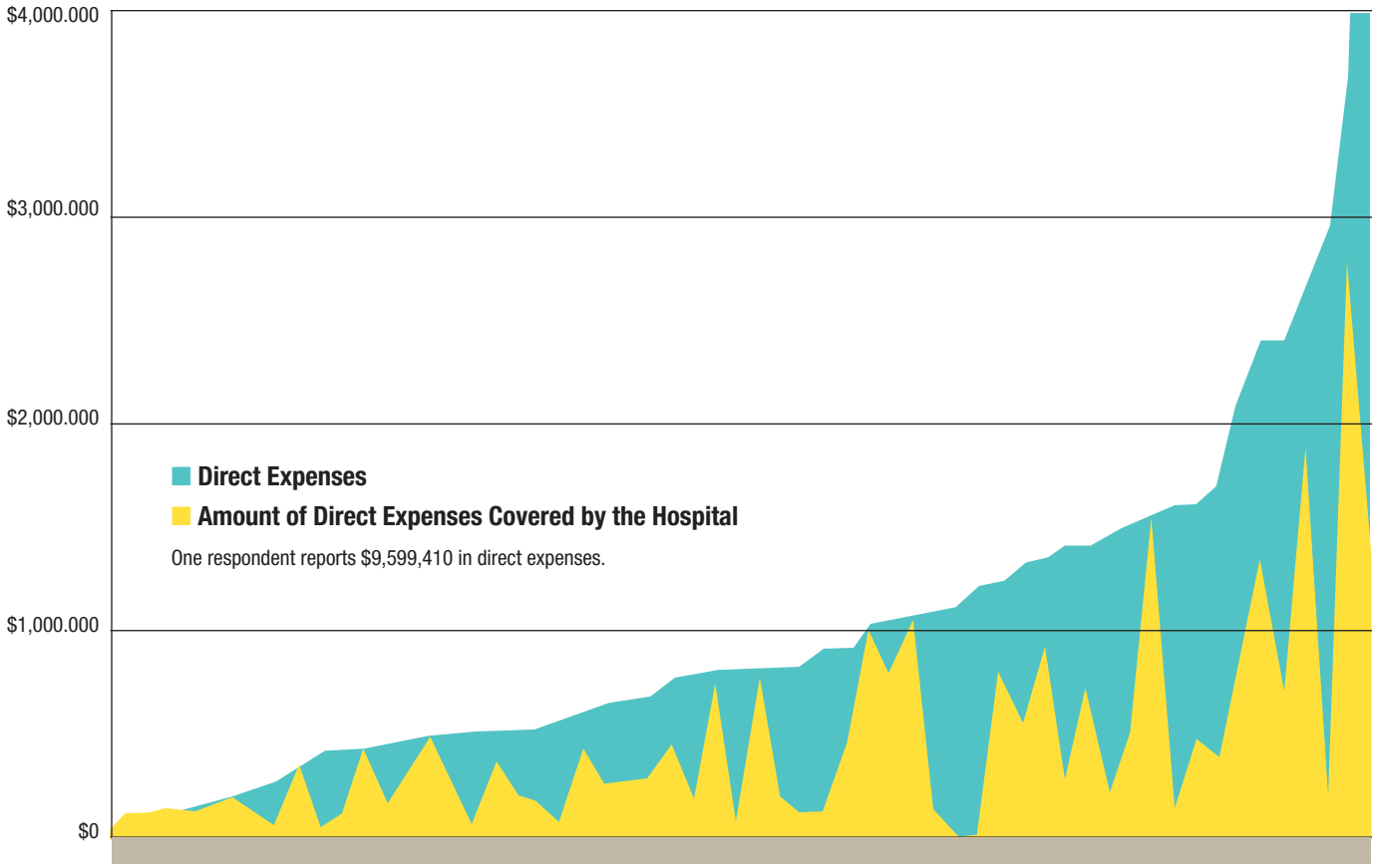
Respondents indicated the one revenue source that provided the most money to their team. Almost half revealed that either Medicaid or reimbursement for services (provided to local, county, or state agencies or university/school) was their single largest source of revenue. On average, Medicaid accounted for 30% of team revenue (n=50).

Table 3. Sources of Revenue That Provide the Most Money to Teams (n=94)

Greatest sources of revenue	Number of respondents
Medicaid	28
Reimbursement for services	16
Hospital foundation	14
Victims of crime compensation	10
State budget line item	9
Other	17

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 11.

Figure 4. Distribution of Direct Expenses and How Much the Hospital Covers (n=59)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 9.

Change in Revenue Sources

For both 2008 and 2012, 47 respondents provided revenue source data. The average number of revenue sources accessed by teams remains fairly constant: a total of 6.23 sources in 2008 and 6.09 sources in 2012. However, a possible shift in sources used was suggested by an increase in respondents who include Medicaid, reimbursement for services, and private payer as part of their funding portfolio. At the same time, fewer of the 47 respondents received revenue from SCHIP, TRICARE, state attorneys general, the hospital foundation, and the U.S. Department of Justice. There was less or little change for funds from the National Children's Alliance, other foundations, state budget line items, individual donations, victims of crime compensation, and court fees and fines.

Reimbursement for Services

Inadequate reimbursement is a persistent challenge for child protection teams and hospitals. Respondents most frequently reported that the following routine activities of child protection teams are not reimbursed: phone consults, written expert opinions, and psychosocial assessments.

Education and Training

Despite the grim financial picture, more child protection teams are educating other health care professionals and community partners than were in 2008. The largest increases are in education for child-care/daycare providers (19% more teams), psychologists (16% more teams), pediatric fellows (14% more teams), pediatric/family practices (12% more teams), child protective services (11% more teams), and prosecution (10% more teams). Other types of professionals for whom training was provided by the hospital's child protection team increased between 3% and 10%, including law enforcement, social workers, medical students, and residents.

The data show that from 2008 to 2012, there was an incremental increase in whether training was funded (the survey doesn't differ-

entiate between partial or full funding) for the majority of the training types; from 2008 to 2012, however, there was greater change in the number of respondents who indicated that training was unfunded. For example, more respondents who provided training to prosecution, law enforcement, pediatric/family practices, and psychologists noted that training was more often unfunded in 2012 than in 2008.

Children's Advocacy Centers

In 2012, a quarter of respondents (33 of 131) reported that their hospitals house a children's advocacy center (CAC). Medical services were provided to one or more independent CACs by 62% of respondents (80 of 130). Thirty-eight respondents neither housed nor provided services to a CAC.

Prevention

Recognizing that child abuse prevention activities are not the exclusive purview of the hospital's child protection team, the survey sought to understand whether others in the hospital engaged in prevention activities. A six-point Likert scale measured the frequency of prevention activities for both the team and others in the hospital: *never, rarely, sometimes, very often, always,* and *don't know.*

For most prevention activities listed, the team reported *very often* or *always* engaging in the activity more frequently than others in the hospital (Table 4). The child protection team consistently *very often* or *always* conducted screening for interpersonal violence, caregiver substance abuse, and maternal mental health about 30% more often than did others in the hospital. The team also conducted shaken baby/abusive head trauma education, general community awareness of maltreatment, and sexual abuse prevention education more frequently than others in the hospital.

Others in the hospital *very often* or *always* conducted crisis support for families in the hospital and safe sleep education more frequently than child protection team members. Both groups engaged equally in parenting education and home visiting. For many of these activities, respondents indicated between 10% and 20% of the time they *don't know* whether others in the hospital are conducting the activity, perhaps signaling a lack of communication or decentralization of prevention activities across the organization.

Table 4. Prevention Activities *Very Often or Always* Conducted by the Child Protection Team and Others in the Hospital (n=116)

Prevention activity	Child protection team	Others in hospital	Difference
Screening for IPV	88%	58%	30%
Screening for caregiver substance abuse	80%	52%	28%
Screening for maternal mental health	76%	46%	30%
Crisis support for families in the hospital	72%	80%	(8%)
Shaken baby/AHT education	68%	46%	22%
Parenting education	60%	60%	0%
General community awareness of maltreatment	59%	17%	42%
Sexual abuse prevention education	55%	17%	38%
Safe sleep education	52%	58%	(6%)
Lobbying for legislation that supports prevention	25%	11%	14%
Evaluation of, or research on, prevention activities	20%	14%	6%
Home visiting	6%	6%	0%

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 15.

Evaluation and Research

A five-point Likert scale was used to explore how the child protection team tracks its work: *never, rarely, sometimes, very often*, and *always*. More than half of the time, child protection teams either *always* or *very often* collected the number of consults they made, reports made to child protective services, previous referrals, number of teaching sessions, and case resolution. Fewer *always* or *very often* tracked the services received by families and the time from referral to the completion of services. Over half (58%) of respondents indicated the child protection team conducts original research for the purposes of publication or presentation. Of those, about a third (22 of 64) were externally funded.

Summary

Overall, the Children's Hospital Association 2012 survey of hospital-based child abuse services found that children's hospital-based child protection teams are growing in the number of cases they see. While expenses are rising, revenue is not. Respondents still rely on an assortment of revenue sources; however, it appears that teams are increasingly counting Medicaid, private payers, and reimbursement for services (including contracted) among their revenue sources. In many cases, expenses are largely absorbed by the hospital. Growing numbers of child protection teams now deliver education and training to other health professionals and community partners. Child protection teams also conduct a variety of prevention activities, typically more frequently than others in the hospital. The full findings report is available at **http://www.childrenshospitals.net/2012childabusesurvey**. Complimentary hard copies of the report and customized benchmarking data are available upon request. The next triennial survey is scheduled to be collected in 2015.

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About the Author

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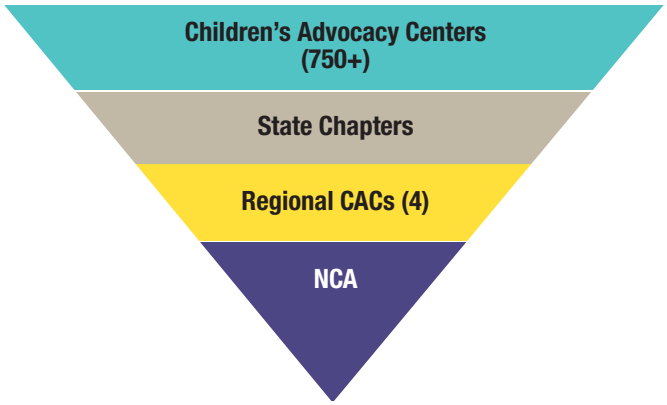
The National Children's Alliance: Empowering Local Communities to Serve Victims of Child Abuse

Karen Farst, MD, MPH

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

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

Figure 1: Organizational Structure of National Children's Alliance



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

A Trauma-Based Approach

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

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

Table 1: Listing of Regional CAC Coverage and Services

Regional CAC	States Supported	Partial List of Programs/Services
Northeast (Philadelphia, PA) http://www.nrcac.com/default.asp	CT, MA, ME, NH, NJ, NY, RI, PA, VT	-Medical Training Academy -Forensic Interview Training -National Symposium on Child Abuse -Onsite Training and Technical Assistance -New Director Orientation -Court Prep Training -Accreditation "Bootcamp" -myCaseReview -Topical Webinars -Victim Advocate Training -Child Abuse Library Online -Expert Peer Review
South (Huntsville, AL) http://www.nationalcac.org/	AL, AR, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV, DC	
Midwest (St. Paul, MN) http://www.mrcac.org/	IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, WI	
West (Colorado Springs, CO) http://westernregionalcac.org/index.php	AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY	

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

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

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

Medical Standards

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

Table 2. National Children's Alliance Standards for Accredited Members

Program Components

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

Source: NCA, NCA Standards … (2011).

The specific standards for providers of medical, mental health, and forensic interview services all stress two criteria: (1) the need for specialized training within the area of service and (2) the need for professionals providing these services to stay current in the field and participate in continuous quality improvement activities, such as expert peer review (NCA Standards, 2011). The current medical standards (Table 3) were approved in 2011, but another revision is expected within 4 years. The description of services in the standards stress that the evaluation of children should focus on their overall well-being instead of limiting the evaluation to the collection of potential evidence. Information in the current medical standard is based largely on a consensus article published in 2007 by leaders in the field of child sexual abuse (Adams et al., 2007). This article emphasizes that the child's overall health and well-being should be the focus of the medical evaluation (in addition to accurate interpretation of exam findings and collection of forensic material when indicated) because many victims of abuse have co-occurring disabilities, unmet general health needs, or both. Children are sometimes not

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

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

CRITERIA

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

Source: NCA, NCA Standards … (2011).

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

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

Support for Medical Providers

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

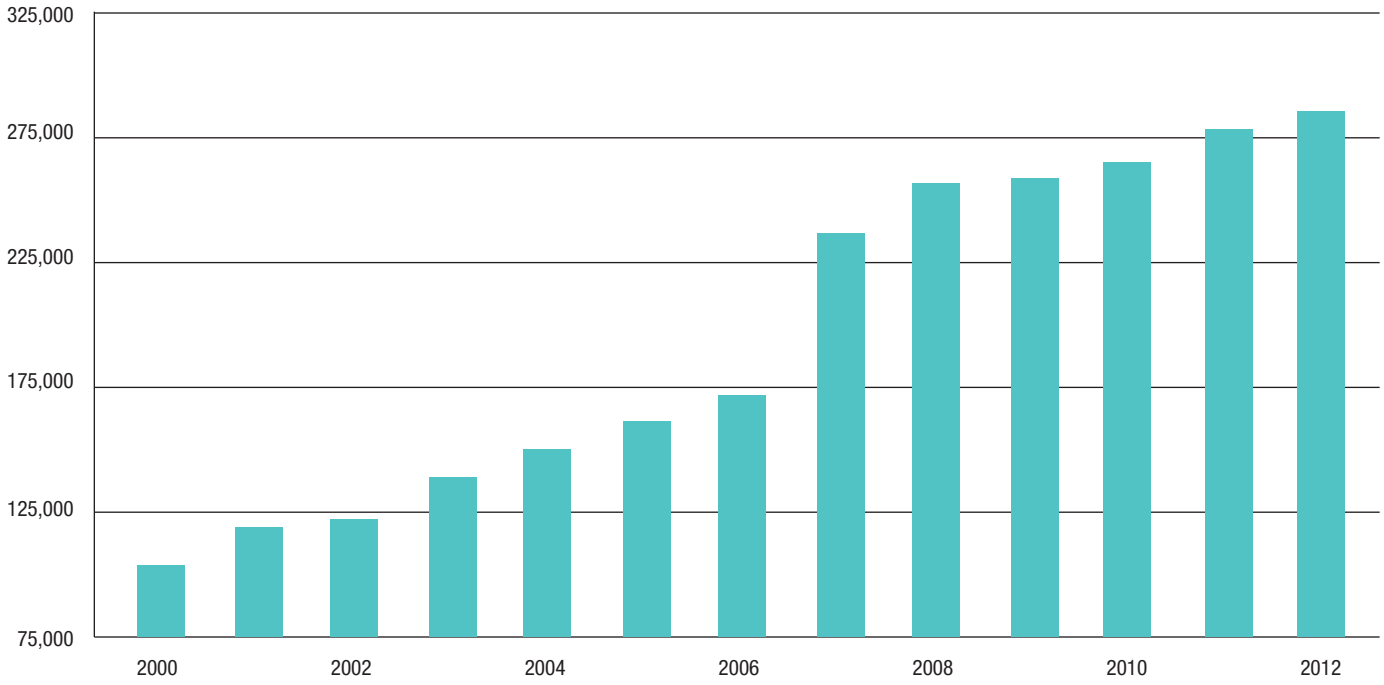
A recent review of CAC services appeared to indicate that progress is being made toward meeting best-practice standards in the field. Specifically, the survey showed that forensic interviewers and medical providers were receiving increased training, peer-review participating was increasing, and the percentage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

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

Improving Outcomes at CACs

As a nonprofit entity that receives federal funding and individual donations, the NCA is committed to good stewardship with its resources. The annual report, including fiscal information, is available in open forum online (NCA Annual Report, 2011). Over 90% of the revenue received from sources such as the federally based Victims of Child Abuse Act is disbursed to the local CACs and state chapters for growth and development (NCA Annual Report, 2011). The NCA and its member organizations also participated with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the U.S. Department of Justice for an evaluation of the CAC's response to child abuse. OJJDP (Cross et al., 2008) funded a comparative review by an external research group between four communities with CACs and four communities of similar composition that did not have CACs

Figure 2: Number of Children Served in CACs in the United States by Year



Source: National Children's Alliance (2013). Used by permission.

In this evaluation, communities with CACs had greater involvement of law enforcement in sexual abuse evaluations, more evidence of coordinated investigations, and higher rates of referrals for medical and mental health services. Children served by a CAC had a medical evaluation in 48% of the cases, which was significantly higher than those served in comparison communities (21%). Caregiver satisfaction was higher in cases served by CACs. In addition, the CACs in this particular study were identified as providing other services to their communities, including training and consultation. The MDT partners in the communities with CACs regarded the CAC staff as leaders and experts in the field of child abuse for their area.

Despite the NCA's struggles to maintain long-term effectiveness and viability as a nonprofit entity, the number of CACs available to MDTs and children across the country has more than doubled since the year 2000. Two thirds of counties in the United States now have access to a CAC. Accordingly, the number of children served by the CAC model has increased by 175% since 2000 (see Figure 2)(NCA, 2013). The news from child welfare data sources that rates of child sexual abuse continue to decline is encouraging (Finkelhor & Jones, 2012). However, there are still thousands of children affected by this issue each year, indicating the need to keep intervention and prevention efforts moving forward.

As the service areas of CACs continue to grow, the NCA will continue to evaluate ways to assist its membership with training, advocacy, and support. This has already included partnering with agencies dealing with victimization by child pornography. Other issues, such as addressing the needs of children who have been trafficked for sex and other crimes, may benefit from inclusion in CAC services when they clearly fall within the mission of the NCA.

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Peer Review and Telehealth in Child Abuse Medical Evaluations

Lori D. Frasier, MD

Peer review is a process by which professional peers oversee and review the work of others according to a set of accepted standards. The American Medical Association defines *medical peer review* as the process of improving quality and safety in health care organizations (American Medical Association, n.d.).

The purpose of peer review in any medical context is the improvement of quality of care for patients. The science of quality improvement in medicine has evolved to include methods and processes to measure improvements and document change. Standardization of medical practices and the development of care process models that reduce variability in practice have been demonstrated to improve care, reduce mortality morbidity, and decrease costs. In the field of child maltreatment, the same processes can also be applied to benefit children, providers, and society.

The specialization of medical providers in the assessment of child maltreatment is relatively new in medicine. Child Abuse Pediatrics, a board-certified subspecialty of pediatrics, was approved in 2006, and there have been two certifying examinations to date. Other medical professionals such as nurses have also become skilled through education and practice. Child sexual abuse evaluations are an important part of the practice of many providers. Medical findings can have a major impact upon the outcome of cases, and failure to appropriately diagnose significant findings may result in children being returned to abusive homes. When medical professionals indicate that findings are present that support a diagnosis of sexual abuse even though there aren't any such findings, significant legal and social consequences to families and individuals can result.

It is well recognized that the history of the events as recalled by the child is the single most important piece of evidence. However, much emphasis is placed upon the medical evaluation, although physical findings are rarely found in children examined non-acutely for sexual abuse. Several studies have attempted to address the issue of inexperience in assessing children suspected of being sexually abused. These studies show that an experienced examiner will provide more consistent and objective interpretation of examination findings (Sinal et al., 1997). Also often addressed is the concept that an examiner may be overly influenced by a child's description of the abuse and interpret an examination finding differently than if there were a limited history or less invasive contact. As knowledge evolves regarding both normal anatomy and the physical sequelae of abuse, the problem of overinterpretation of findings by less experienced examiners becomes apparent. The need for standardization of practice that includes peer review for the purpose of improvement in the quality of care is equally as important in child maltreatment as in any other medical practice (Adams, 1999).

Developing Standards for Medical Evaluations

Medical providers are strongly independent and care passionately about their patients. Specialized knowledge gained through practice and experience is important. However, evidence and objectivity must guide the practice. Reducing variability in interpretation of findings, and basing those interpretations on available literature, has long been the goal for researchers and clinicians. Joyce Adams developed classification systems for genital findings in sexual abuse throughout the 1990s in an attempt to organize anatomic, traumatic, and other findings into a paradigm based on research and case studies. These classification systems have been refined over the years as the knowledge base expanded. Classification systems were replaced by Guidelines in 2007 (Adams et al., 2007). The Guidelines have been periodically updated and are literature and expert consensus-based. Expert consensus provides guidance in interpretation of physical findings where literature is lacking (Adams, 2001). More recent studies have continued to demonstrate significant variability in how examinations are interpreted. This variability appears to be linked to level of training, profession, experience, and knowledge of the literature (Adams et al., 2012).

The National Children's Alliance (NCA), in recognition of improving the quality of care provided to children receiving medical examinations in CACs, has addressed the issue of variability through developing medical standards. Dr. Farst discusses the NCA's position in this issue of the *Advisor*, which points to the importance of peer review as central to both NCA's process and its support of a national peer review program for providers who are distant from expertise. The NCA application, myCaseReview, is a secure Web-based telehealth product in which

medical providers may submit images for review by a medical panel of board-certified child abuse pediatrics experts. Both the examiner and the reviewer are anonymous to each other. The images are evaluated based upon interpretability of the photos, technique of the examination, and interpretation of the findings. The use of programs such as myCaseReview satisfies the requirements of the NCA, but it does not go far enough in providing comprehensive assessment of the quality of examinations performed in CACs. Feedback to examiners followed by documented improvement against shared baselines would be ideal. A national focus toward quality standards should be a priority and would require more funding and resources than are currently available.

Standardization of peer review and quality improvement in child abuse medical evaluations continue to evolve as technology improves. It is critical to reduce variability by using common terminology in interpretation of anatomic findings, both normal and abnormal. This does not mean that medical providers do things exactly the same from patient to patient. There can be clinical variability based upon the patient's needs and presentation. However, individual clinical judgment alone can result in excessive variation from the standards of care. Any field relying on visual diagnosis understands this concept.

Goals of Peer Review

Regardless of practice venue, standards, and accreditation, the goal of all peer review is to improve quality of care and, ultimately, the best outcomes for patients and families. Providers and programs should develop or adopt processes that allow for peer review and quality improvement. Like NCA, many professional organizations, hospitals, and the public expect that medical programs have a process for peer review and oversight. Child abuse assessments should be no different than evaluating any other medical outcome that affects patients.

Ideally, a process of peer review should include all examiners at every level of experience. Studies of examiners who perform fewer than five examinations per month show that they perform poorly on evaluations designed to evaluate standard practice and assessment (Adams et al., 2012). There has been no well-defined number of examinations that makes an examiner an expert, and indeed an examiner who provides hundreds of examinations each year but has no quality peer review, receives little ongoing training, and has little assessment of processes may do as poorly as the examiner doing many fewer examinations.

Standardized methodology for peer review in child maltreatment is also evolving. Commonly, groups of examiners gather to review interesting cases, and this type of case conference is important for relationship building, mentoring, and education. However, true quality or peer review should involve a standardized process that includes evaluating progress and measuring quality. Few centers

have the capacity for 100% case review. The philosophy that all examiners should have all cases reviewed on an ongoing basis, regardless of experience, is a high standard that may not be practical in many settings. However, it does ensure the best possible outcomes, continued quality improvement and assurance, and ongoing education. In this way, problems with specific examiners may be detected for remediation and education; therefore, a minimum periodic, random peer review should be performed. Programs or centers without child abuse board-certified pediatricians or equivalently experienced specialists should consider sending diagnostic cases out for expert review, especially for nonacute findings.

Telehealth is a concept used much more broadly than traditional telemedicine because it is simply the use of technology to transmit information. In addition, it encompasses the broader concept of distance consultation. This can be as low tech as telephone consultation or as advanced as high-resolution cameras and moni-

tors with high-speed data transfer. This generally takes place "real time," placing patient, examiner, and clinician together "virtually." Other applications provide "asynchronous" consultation, in which the image and clinical information are accessed at different times. Both systems have advantages and disadvantages as well cost differences. Telehealth and telemedicine applications provide a format for peer review when examiners are geographically disparate. Inexperienced examiners can have access to higher levels of expertise regardless of location.

Telehealth in child maltreatment has been studied and found to be acceptable by both clinicians and patients (Frasier, Thraen, Kaplan, & Goede, 2012; Kellogg, Lamb, & Lukefahr, 2000; Thraen, Frasier, Cochella, Yaffe, & Goede, 2008). Due to the image-based nature of both physical and sexual abuse assessments, a variety of telehealth programs provide ideal platforms by which peer review and quality measures can be accomplished (MacLeod et al., 2009). Such applications may also have international applicability.

In sum, child maltreatment programs providing medical examinations need to develop a process of peer review that is designed to improve quality, consistency, and accuracy. High-quality photodocumentation, whether still or video, is the first element. Secure, HIPAA-compliant applications that protect a patient's privacy and the security of images are critical. Identification of expert reviewers can be accomplished through collaboration with local or regional centers. The ultimate goal is to provide the highest quality of care to children and families with concerns of abuse.

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WHAT'S NEW AND WHO'S DOING IT

Onsite Medical Consultation for New York City Child Protective Services Workers

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New York City's child protective services agency, NYC Children's Services (CS), handled over 50,000 reports of child abuse and neglect from among over 1.5 million city children in 2012. Covering 5 boroughs that are each a separate county, this large city agency is broken down into 16 borough offices with a total of over 1,200 caseworkers in the division that investigates reports of child abuse and neglect (New York City Council, 2013). Offices are further subdivided into zones and units, including specialized prevention and hospital teams and an office to investigate cases within the foster care system. In addition to circumstances leading to a large number of suspected child maltreatment reports made to the state's central child abuse and maltreatment registry, New York City's children face almost insurmountable ecological challenges and alarming health statistics.

In 2000, children in New York City were twice as likely to be hospitalized for asthma as children in the United States as a whole (Garg, Karpati, Leighton, Perrin, & Shah, 2003). The prevalence of diagnosed diabetes has more than doubled, and more than 200,000 additional adult New Yorkers have diabetes but have not yet been diagnosed (Kim, Berger, & Matte, 2006). Several high-profile deaths in the child welfare system have highlighted the need for caseworkers to understand and integrate knowledge about domestic violence, substance abuse, and medical and mental healthcare into their work. In addition to addressing the safety of children during investigations for suspected abuse and maltreatment, caseworkers are also being called upon to meet the ongoing health and developmental needs of the over 15,000 children in foster care in NYC at any given time (Fahim, 2008).

With the documented rise in rates of chronic illness in both parents and children, it has never been more important for child protective services (CPS) to work with medical professionals. When parents neglect the healthcare of their children, there is often more to the story. Many of the city's children and families have complex health and developmental issues, and negotiating the healthcare system can create special challenges for even the most seasoned professionals (Garcia, Collins, Herrera, Nieman, & Walsh Kieninger, 2008). Understanding the presence of medical and developmental conditions is of particular importance because such conditions can leave children more vulnerable to maltreatment and greatly impact their safety and risk. Collaboration between CPS and other professions has been increasing based on the appreciation that a single discipline or profession can not understand a problem as complex and multifaceted as child maltreatment (Lalayants, Epstein, & Adamy, 2011).

Enhancing CPS Access to Medical Services

In addition to recruiting medical providers such as physicians and advanced practice nurses to offer direct services for children, CPS in many jurisdictions has sought expert opinions and consultation of child abuse pediatricians to better determine if a child has been maltreated. Consulting with medical professionals for expert opinions regarding suspected child maltreatment has proven to be valuable in case determination and service planning. In a study from 2011, experts' opinion differed from the initial examining physician and from CPS 43% and 35% of the time, respectively, providing critical information to inform child welfare decision making (McGuire, Martin, & Leventhal, 2011).

Several states have developed programs to enhance CPS access to medical services. Michigan created a statewide medical resource system in 1999 to provide medical evaluations, case reviews, and training (Palusci, 2000). In Massachusetts, child protective services has a Health and Medical Services Team consisting of medical professionals who provide a number of services, including the assessment of healthcare needs of children in CPS care/custody. They recommend appropriate care and placement and work with healthcare providers to ensure that each child in care/custody receives timely medical screening and examination (State of Massachusetts, 2013). Orange County, California, has set up an emergency response program in which CPS staff members can request that a public health nurse accompany them in the field on a visit. These nurses provide a variety of services, including education about health issues, referrals to services, and the review of medical records (Orange County Public Health, 2013). In Florida, the State Department of Children and Families contracts

with local nonprofit organizations for medical consultation and services upon request. These teams provide medical assessment of children, expert testimony, and training (Socolar et al., 2001). Using a different approach, Chicago has a program in which all reports to CPS receive a medical review at intake to assess medical issues and make appropriate referrals to the child advocacy center (National Association of Children's Hospitals and Related Institutions, 2004).

Bringing Medical Consultations Into CPS Offices

To bring medical services into CPS offices, NYC CS designed a formal collaborative system with other disciplines to better understand and provide services for their cases. In 2002, New York City CS implemented the Clinical Consultation Program (CCP). CCP is designed to enhance decision making and case outcomes through use of consultation teams with specialized knowledge in the areas of mental health, domestic violence, and substance abuse. The consultants are not child welfare caseworkers but are obtained through contracts with social service agencies in the community. Teams are organized in each of the 16 offices under a single agency umbrella, each with a team coordinator and consultants addressing specific disciplines. Caseworkers contact one or more of these consultants on a voluntary basis as they see fit during their investigation and could consult both informally and formally with the creation of a written report, which would be available to the caseworkers and supervisors of the child welfare team, but kept separate from the child welfare case file. Although the need for consultation regarding medical issues was considered, the development of a medical clinical consultation program was delayed due to budget restrictions.

After an open bidding process in 2007, NYC CS contracted with NYC Health and Hospitals Corporation's Bellevue Hospital Center to provide the medical consultation component of CCP. Bellevue Hospital is a public facility affiliated with New York University School of Medicine. It houses a child advocacy center that is staffed by three board-certified child abuse pediatricians. The initial program model consisted of 12 full-time nurse practitioners (NPs), either pediatric nurse practitioners or family nurse practitioners with a strong background in pediatrics, acting as onsite medical consultants to CS staff. Nurse practitioners were chosen based on their experience in functioning independently, knowledge of primary care and health systems, and ability to provide health education. The medical consultants joined the preexisting CCP multidisciplinary teams in NYC CS offices but had separate supervision from the rest of the CCP team. Each medical consultant (MC) was assigned to collaborate with one of the three child abuse pediatricians (1.5 FTE) who serve as senior medical consultants and trainers for the program. These physicians review every consultation write-up and are available by phone to provide guidance with cases. A full-time social worker functions as the project coordinator to assure contract compliance, provide guidance, and liaise with CS administration. Additional program staff initially included a part-time developmental pediatrician and an administrative assistant.

Adding Value to Children's Services

The collaboration between CPS and the medical community is a familiar concept, but the Medical Clinical Consultation Program in NYC introduces an innovative model. In this city, medical professionals are located onsite, not to provide clinical care or case management but instead to provide case specific guidance, training, referrals, and recommendations with the goal of improving CPS decision making. In this model, caseworkers are the consultant's client, and no clinical care is provided at any time.

The medical consultants provide a number of services, but a majority of their time is spent providing case consultation directly to frontline caseworkers. A consult consists of meeting with a caseworker on a one-to-one basis, reviewing the initial report and case investigation, and discussing any medical and/or developmental issues. Medical issues can be present in any household member, be it the subject child, siblings, parents, or other caregivers. A consultation can include education about the disease process, information about the standard of care for that condition, and how the condition could affect parenting and school attendance, navigating the healthcare system, and making referrals to community services.

Medical consultants also model for CPS how to best ascertain medical information by joining caseworkers in their home visits and case conferences. The consultant helps caseworkers navigate the healthcare system and makes recommendations about what information should be requested from providers to help CPS form an assessment. The consultant also helps CPS explore the caregiver's resources and parenting capacity and whether an allegation of medical neglect, for example, could be due to cultural issues, parental cognitive delay, lack of appropriate resources, or the possibility that medical information was not explained to the family in the family's preferred or first language.

Medical consultants can assist CPS with obtaining relevant health information by joining CPS during home visits and case conferences with parents, providers, or both. When present, the MC can model for CPS how and what questions to ask. When taking part in a home visit, the purpose would not be to provide care but, again, to model for CPS what to ask and what to observe in the home. For example, when visiting the home of someone with poorly controlled asthma, the MC would help CPS identify possible environmental triggers, such as smoke, pets, roaches, and so forth. Onsite trainings are conducted by the medical consultants, be they nurse practitioners and physicians or medical providers from the community. These trainings are about medical and developmental topics on a one-to-one basis, in small group settings, or in large group lectures, depending on the need of the particular worker, unit, or CPS office.

Case Examples

Case example 1. A case is called in by a healthcare provider involves an adolescent female with type 1 diabetes who is noncompliant with appointments and doesn't take her insulin. The medical consultant provides the following to the CPS worker:

(1) Education about type 1 diabetes with emphasis on the health risks associated with noncompliance;

(2) Education about child development and how adolescence may be a factor in noncompliance;

(3) Guidance to caseworkers about what medical information should be requested as well as where information should be sought (hospital, office, provider), how this can be obtained, and what to ask;

(4) Methods to efficiently get information from healthcare providers caring for the child and family. The medical consultant may call the provider directly while sitting with the caseworker, giving an opportunity for the MC to model how to best interview providers and obtain relevant medical information;

(5) Recommendations regarding health-related services;

(6) Questions about family resources and parenting capacity;

(7) Ways to inquire about the health of others in the home.

Case example 2. A case is called in because a 9-year-old child has missed 30 days of school. Upon investigation, CPS discovers that the child has been staying home from school to take care of her mother, who is obese and has a serious cardiac condition. The child assists her mother with food preparation and bathing, and she seems fearful to leave the mother alone. The medical consultant provides the CPS worker with the following:

(1) Education about that cardiac condition;

(2) Assistance in reaching out to the cardiologist and recommending what questions to ask. The medical consultant and CPS could make the call together;

(3) Assistance in reviewing medical records from emergency room visits;

(4) Suggestions about possible safety plans for if/when the mother is admitted to the hospital and for permanency planning if appropriate;

(5) Suggestions about additional services, such as a visiting nurse or a home health aid to assist the mother;

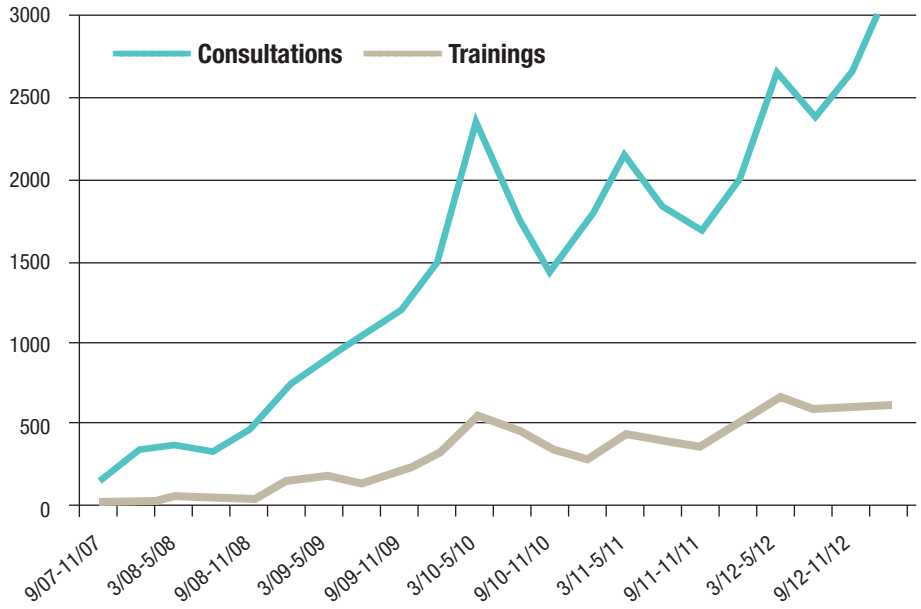
(6) Questions to ask about the child's health and medical care, such as about the child's growth, development, screening tests, and immunizations.

Program Progress

The Medical Clinical Consultation Program began in 2007 with two part-time child abuse pediatricians, four medical consultants, a coordinator, a part-time developmental pediatrician, and an administrative assistant. In FY 2013, it is staffed with 12 medical consultants covering the 16 CS offices. After 5 years in the CPS offices, the program has steadily increased utilization of consultations and trainings, and each MC now averages over 100 consults each per month (Figure 1). Staffing levels have varied greatly over the past 5 years as a result of variations in city funding, with significant decreases during 2010–2011 as the recession took hold in NYC. Though home visits have declined dramatically due to the time required, the number of conferences attended has been closely tied to NP-staffing levels (Figure 2). Following a high-profile fatality of a 4-year-old child in 2010, NYC CS policy was changed to require medical consultation when it is suspected that a child may have special medical needs (Associated Press, 2012).

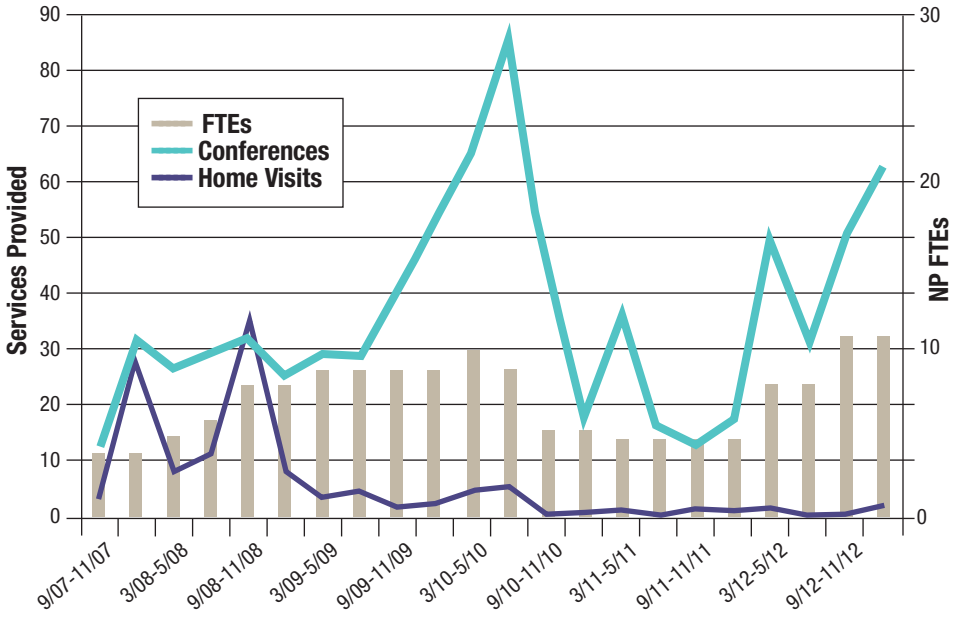
The contract between NYC CS and Bellevue Hospital Center requires that caseworkers and their supervisors be given the

Figure 1. Medical Clinical Consultations and Trainings, by Quarter, 2007–2012



Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013).

Figure 2. Medical Clinical Consultation Conferences and Home Visits, NP FTE, by Quarter, 2007–2012



Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013)

opportunity to complete performance evaluations following services. A performance evaluation tool was developed by NYC CS for all of the consultants (medical, domestic violence, substance abuse, and mental health) and is now available online. The survey consists of six questions using a 5-point Likert scale, with a rating of 1 being the least helpful and 5 being the most helpful. Evaluations of medical program services have been uniformly positive over the past 5 years; 2,888 evaluations were completed between September 2007 and February 2013 with an average overall rating of 4.7 (Table 1). The ratings have been consistently high during 2007–2012, ranging from 4.5 to 4.9 over time for the various services, their value, and the response time of the medical consultants.

Research Findings in the Program

Several research projects have been carried out to assess the nature of the cases and needs of the ACS workers in the program. The majority of medical issues identified in cases have been found to revolve around common pediatric conditions and medical conditions affecting family members, rather than specific issues with injuries and conditions directly resulting from child abuse and neglect (Table 2). CS workers have increasingly become aware of medical issues in families that contribute to maltreatment. The most common medical conditions encountered have been diabetes, asthma, failure to thrive, and issues related to obesity, including high blood pressure and sleep apnea. The medical consultants frequently consult on cases involving HIV, autism, and other developmental disabilities, as well as answer questions about medications and their side effects. Even though usually not the primary reason for a child welfare investigation, these medical issues can be found during the investigation for any form of abuse or maltreatment, including medical care and educational neglect.

A variety of medical issues have been identified in children and families, with 50% or more of consultations including requests for basic medical information concerning routine pediatric health supervision visits and immunizations and common chronic conditions such as asthma or lead exposure. Cases with complex conditions (such as mental retardation, developmental delays, autism, and physical disability) comprise an additional 25% of consultations. Questions regarding the mechanism of specific injuries identified in the active investigation were noted in 20% of consultations. Recommendations made by the NPs include referral for the need for additional medical evaluation of the child (75%), provision of additional services and therapies for children with special medical needs (25%), and the need to obtain additional medical information to better evaluate the active ACS investigation (30%). In many cases, the interpretation of medical information concerning the parents has been critical to assist the CS worker's understanding of their ability to care for a child (McHugh, Legano, Nieman, & Palusci, 2008).

Among 527 consultations in the first quarter of 2009, 19.2% were found to have allegations of educational neglect. There was a variety of chronic medical conditions, including asthma, diabetes, neurologic impairment and chronic pain syndromes which were offered as possible causes of missed school. Approximately one third of these cases had parents who were affected by a medical condition causing their child to miss school. The issues surrounding healthcare neglect included inadequate medical treatment, lack of adherence to treatment, lack of access to care, and no primary care provider to coordinate care. There were also several cases where a parent or caseworker incorrectly believed that the disease interfered with the child's ability to attend school (Legano, McHugh, & Palusci, 2009).

As part of a community nursing school rotation, 27 nursing students were placed at an NYC CS office for one semester with one of the nursing consultants and nursing school faculty during

Table 1. Program Evaluation by CPS Workers, 2007–2013

Question	Mean Score*
In general, how helpful did you find this service?	4.6
How helpful, was this service in acquiring new information, resources, understanding, etc.?	4.6
How was the response time?	4.8
How helpful did you find the service in your making decisions about the case?	4.6
How helpful was the service in locating appropriate referrals?	4.6
How helpful would the service be to your co-workers?	4.7
0verall	4.7

***1=Not Helpful; 2=Somewhat Helpful; 3=Helpful; 4=Very Helpful; 5=Extremely Helpful**

Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013).

Table 2. Specific Diagnoses Noted in Consultations, 3 Months, 2009

Diagnosis	N=527	%
General pediatric care/health supervision	191	36.2
Child abuse/neglect	112	21.3
Chronic medical problem	108	20.5
Dental problem	20	3.8
Development/failure to thrive	5	1.0
Genitourinary	52	9.9
Medication information	15	2.8
Substance abuse	6	1.1

Source: McHugh, Legano, Nieman, & Palusci, 2008.

2010–2011. Nursing students learned about NYC CS and were tested on their knowledge of abuse identification and reporting before and after the rotation. Posttests showed they were better able to identify and report child maltreatment in case scenarios. Additionally, the nursing students provided education for NYC CS caseworkers on health topics and surveyed them regarding their own health information and stressors. They identified several worker issues, including lack of sleep, illness, changes in appetite and weight, smoking, headaches, back pain, and hypertension (Ince, Geary, Pawlowicz, & Palusci, 2010).

Conclusions and Future Directions

The Medical Clinical Consultation Program highlights the need for basic medical information among caseworkers and supervisors and the value of case consultation and training given by medical providers in child welfare offices. Medical consultations from the program are well received and increasing in volume as caseworkers accept and utilize the medical consultants more frequently.

There are a number of challenges and potential barriers to replication that could be addressed by those wishing to implement a similar program in CPS offices. One area is the consultation initiation process. Unlike in Chicago, where there is active surveillance and cases are assigned for medical services, NYC CS must initiate a medical consultation with the nurse practitioner by formally requesting a case consult, training, or attendance at a meeting or home visit. Certain diagnoses that identify the child as medically fragile are supposed to require medical consultation, but implementation varies from office to office and relies on caseworkers, supervisors, and managers to assure that it occurs. It is our perception that, despite changes in policy requiring consultation for special medical needs children, there are still a number of children and families that do not receive medical consultation because the case is not flagged and/or the caseworker does not seek consultation.

Likewise, using a medical model, the medical consultant provides recommendations but does not make directives or provide supervision to the caseworker. While the medical consultant gives CS a consultation write-up documenting what transpired during the consult, any recommendations or referrals, and links to educational resources and handouts, it is CS workers and supervisors who decide whether a consult is needed and whether to follow one or more of the recommendations. Specific to the implementation of medical CCP, having medical consultants join preexisting CCP teams with domestic violence, substance abuse, and mental health consultants has had its benefits and challenges. While the other disciplines had a team structure, had laid the groundwork for the program, and had already provided CS staff with a good understanding of the consultation process, the other consultants worked for different agencies and had already developed procedures that often did not take medical issues into account. For example, consultation write-ups are not part of the CS record system and are kept separate from the CS record. Creating a system integrating consultation reports across disciplines as well as with CS information would be invaluable for the CS worker in addition to the medical consultant, especially as additional cases are opened over time or the family moves and cases are transferred to different workers and consultants.

NYC CS consists of 16 borough offices, which are located within different communities. While each office under NYC CS follows the same set of policies, each office has its own culture and potentially different procedures. The sheer numbers of workers, fami-

lies, and children is daunting. It is estimated that each medical consultant serves roughly 100 CPS staff in one or two offices. Perhaps it would be helpful to have medical consultants assigned to each zone to allow them to get involved earlier in the case, be involved in more cases, and provide more modeling while helping to obtain crucial medical information. With more time, for example, medical consultants could sit with the CPS caseworker while he or she makes calls to medical providers, joins them in case conferences, and spends more time talking with families.

It can be a challenge for medical professionals to work in a large city agency where staff is dealing with high levels of stress and trauma. Large child welfare agencies have historically high staff turnover that results in an ongoing need to repeat trainings and to re-educate CPS staff about situations that would warrant a medical consult. It would be beneficial to the child and family to contact medical consultants earlier in a case if any medical or developmental conditions are mentioned in the mandated report. This would allow the MC to provide CPS with some basic fact-finding questions to begin the investigation and to use when speaking with families and medical providers early in the investigation.

In addition, as a governmental program, CCP has suffered from changing funding levels and office staffing, which have slowed full implementation. The number of funded positions has varied dramatically, and support for administrative assistance, particularly in program support and statistics, would be helpful for the medical component and for CCP overall. As currently designed, CCP does not have a funded evaluation component, and it would be invaluable to conduct research that can look at the potential improvements in case outcomes from the consultation process.

Hiring appropriate staff has been difficult. NPs are in high demand to provide clinical services in our community, and it is a challenge to find qualified NPs who are interested in working in child welfare in a nonclinical position full-time. Working in a nonmedical, child welfare environment can be isolating because being the only medical professional in an office can be challenging for a young or inexperienced clinician. Given the complex nature of the cases and the need to provide training for nonmedical professionals, nurse practitioners need to be experienced clinicians and have experience with the child welfare system to be most effective as medical consultants. Furthermore, salaries are lower than other agencies and hospitals can offer for clinical positions, affecting NP recruitment and retention.

Overall, the Medical Clinical Consultation Program has provided a level of medical expertise and direct case involvement that can occur only when medical professionals are available on a daily basis to child protective services workers and can work within the child welfare system for children and families. It is our perception that this has changed the culture within CPS to value the role of medical providers and to actively seek their opinion for their cases. They have taken ownership of the process and are actively reintegrating medicine into child welfare. Medical CCP has also given medical providers a unique understanding of the problems and stresses within CPS, enhancing our ability to respond to nonmedical as well as medical issues that affect children and families. The program has developed a cadre of experienced clinicians who are knowledgeable about our child welfare system and who are able to help others understand and be more effective advocating for children and families within the community. While the barriers may seem insurmountable, implementation of a program using healthcare providers in CPS offices offers children, families, and the child welfare system unique, accessible resources to promote the health and welfare of the community.

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Journal Highlights

Vincent J. Palusci, MD, MS

While sometimes marginalized, physicians and medical services continue to play a central role in the professional response to child abuse and neglect. A growing number of articles highlight the outcomes and contributions made by health professionals in the identification, assessment, and prevention of child abuse and neglect.

Early Identification and Prevention

Medical professionals continue to evaluate methods that have the potential to capitalize on parental receptiveness to cognitive interventions during the newborn period as a form of universal, primary prevention. In a classic study that has been used as a model to replicate programs across the U.S., Dias et al. (2005) showed that a comprehensive, regional, hospital-based, parent education program administered at the time of the child's birth was associated with 47% decrease in abusive head injuries. Incidence decreased from 41.5 cases per 100 000 live births during the 6-year control period to 22.2 cases per 100 000 live births during a 5.5-year study period.

More recently, Altman et al. (2011) studied a consortium of the 19 community hospitals and 1 tertiary care children's hospital that provide maternity care in the New York State Hudson Valley region. The researchers implemented a similar program to teach parents about the dangers of shaking infants and how to cope safely with infant crying. To facilitate the study, maternity nurses delivered a program that included a leaflet explaining abusive head trauma (i.e., shaken baby syndrome) and how to prevent it, an 8-minute video on the subject, and a statement signed by parents acknowledging receipt of the information and agreeing to share it with others who will care for the infant. There was a decrease from 2.8 injuries per year in controls (14 cases in 5 years) to 0.7 injuries per year during the intervention (2 cases in 3 years), representing a 75% reduction. The authors concluded that this study provides strong corroborating evidence that a low-cost prevention program delivered by maternity nurses can substantially reduce newborns' risk of sustaining an abusive head injury resulting from shaking during the first year of life.

Identifying high-risk families and infants for targeted or secondary prevention has also been implemented during health-care visits. In an early study, Brown, Cohen, Johnson, and Salzinger (1998) found that different patterns of risk factors predicted the occurrence of physical abuse, sexual abuse, and neglect, although maternal youth and maternal sociopathy predicted the occurrence of all three forms of child maltreatment. They concluded that assessment of a number of risk factors might permit health professionals to identify parents and children who are at high risk for child maltreatment, facilitating appropriate implementation of prevention and treatment interventions.

In the newborn period, Brownell et al. (2011) used a screening tool designed to predict family risk in Manitoba, Canada. Using linked data for 40,886 infants, they found that those who were at risk at birth were 15 times more likely to enter foster care than those screening "not at risk." Screening efforts to identify vulnerable families missed a substantial portion of families needing support, but the screening tool demonstrated moderate predictive validity for identifying children at risk of entering care in the first years of life.

Various authors also note attempts to identify families and children at risk during emergency department and pediatric visits. Although systematic screening for child abuse of children presenting at emergency departments might increase the detection rate, studies to support this have been scarce. Louwers et al. (2012) investigated whether introducing screening and training emergency department nurses increases the detection rate of child abuse. In a Dutch intervention cohort study, 104,028 children aged 18 years or younger were screened in the emergency departments of seven hospitals, and significant trend changes were observed after training the nurses and after the legal requirement of screening by the Dutch Health Care Inspectorate. These results indicate that systematic screening for child abuse in emergency departments is effective in increasing the detection of suspected child abuse, and both a legal requirement and staff training are recommended to significantly increase the extent of screening.

Dubowitz, Lane, Semiatin, and Magder (2012) examined the effectiveness of the Safe Environment for Every Kid (SEEK) model of enhanced pediatric primary care to help reduce child maltreatment in a relatively low-risk office population of 18 pediatric practices. The study recruited 1,119 mothers of children ages 0 to 5 years, and the SEEK model included screening and training health professionals to address targeted risk factors (e.g., maternal depression). The researchers found that SEEK was associated with reduced maternal psychological aggression and minor physical assaults in this population and concluded that SEEK offers a promising and practical enhancement of pediatric primary care.

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Reporting and Accuracy of Evaluations

While physicians have historically underreported child maltreatment, a number of studies have noted improvements in medical practice. Sege et al. (2011) examined the validity of primary health care providers' (PHCPs) assessment of suspicion that an injury was caused by child abuse and their decision to report suspected child abuse to child protective services. They used a subsample of injuries drawn from the 15,003 childhood injuries evaluated in the Child Abuse Recognition and Evaluation Study. The study also employed expert review of providers' retrospective self-assessment of 111 clinical vignettes to assess PHCPs' opinions 6 weeks and 6 months after the injury-related visits. PHCPs and experts agreed about the suspicion of abuse in 81% of the cases of physical injury, but PHCPs did not report 21% of injuries that experts would have reported. Compared with expert reviewers, PHCPs had 68% sensitivity and 96% specificity in reporting child abuse. It is interesting that a PHCP's decision to report suspected child abuse to CPS did not reduce the frequency of primary care follow-up in the 6 months after the index visit The authors concluded that future training should focus on (a) clear guidance for better recognition of injuries that are suspicious for child abuse and (b) state laws that mandate reporting.

Anderst and Dowd (2010) used a qualitative study to better understand specific comparative educational needs regarding child abuse diagnosis and management among physicians from differing specialties and practice types. A total of 22 physicians participated in focus groups facilitated by a professional moderator using a semi-structured interview guide. Five specific domains of child abuse education needs were identified from previously published literature, including (1) general impressions of evaluating child abuse, (2) identification and management, (3)

education–resource formats, (4) child–caregiver interviews, (5) medical evaluations, and (6) court testimony. Participants identified common areas of educational need but the specifics of those needs varied among the groups. Neglect, interviewing, court testimony, and subtle findings of abuse were educational needs for all groups. All groups may benefit from specialty-specific education regarding appropriate medical evaluations of potential cases of abuse and neglect. The authors concluded that significant educational needs exist regarding child abuse/neglect, and educational needs vary based on physician training and practice type.

McGuire, Martin, and Leventhal (2011) compared the opinions of the likelihood of child maltreatment of the initial physician, Child Protective Services (CPS), and the child abuse pediatrician for physical abuse cases. Of the 187 cases evaluated, 50.3% occurred in children younger than 1 year of age, and injuries included fractures (50.8%), burns (16.6%), and bruises/abrasions (15.0%). The child abuse experts' opinions were 47.6% definite or probable maltreatment, 8.6% uncertain, and 43.9% definite or probable benign. Of the 119 cases with opinions from all three assessors, the expert agreed with the initial physician in 57.1% of cases and with CPS in 64.7%. The best predictor of the expert's opinion that the injury was due to maltreatment was agreement between the physician and CPS that maltreatment had occurred. Levels of agreement were fair to poor between the child abuse expert and either the physician or CPS. The authors concluded that child abuse experts' opinions have important value in selected cases to confirm previous assessments by the physician and/or CPS, or to change the opinion of the case.

Adams et al. (2012) studied the ability of clinicians who examine children for suspected sexual abuse to recognize and interpret normal and abnormal anogenital findings in magnified photographs and to determine which factors in education, clinical practice, and case review correlate with correct responses. After viewing photographs and clinical information from 20 cases, participants answered 41 questions regarding diagnosis and medical knowledge. The mean number of correct answers among the 141 first-time survey respondents was 31.6 out of 41. Child abuse pediatricians had mean total scores (34.8) that were significantly higher than general pediatricians (30.1) and sexual assault nurse examiners (29.3). The study found that child abuse pediatricians, examiners who perform many CSA examinations on a regular basis, examiners who regularly review cases with an expert, and examiners who keep up to date with current research have higher total scores, suggesting that they have greater knowledge and competence in interpreting medical and laboratory findings.

To further determine how well experts agree when assessing child sexual abuse cases, Starling, Frasier, Jarvis, and McDonald (2013) recruited a total of 12 physician subjects in an existing peer-review network where they had been chosen for their experience in the field and affiliation with children's advocacy centers. Each expert submitted three cases of prepubertal female genital examinations clearly demonstrable of the case findings, reviewed each submitted case, and labeled the case negative for physical finding(s), positive for physical finding(s), or indeterminate. The study found that experts exhibit consensus in cases where the findings clearly are normal and abnormal, but they demonstrate much more variability in cases where the diagnostic decisions are less obvious. Most of the diagnostic variability was due to interpretation of the findings as normal, abnormal, or indeterminate, not the identification of the examination findings themselves.

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Impact on Child Welfare Cases

Primary care and specialty medical services are also being found to have new impact on outcomes in the child welfare system. Anderst, Kellogg, and Jung (2009) sought to characterize the changes regarding the diagnosis of physical abuse provided to Child Protective Services when CPS asks a child abuse pediatrician (CAP) for a second opinion and works in concert with the CAP on that case. Study subjects were reported to CPS for suspected physical abuse and were first evaluated by a physician without specialized training in child abuse pediatrics. The subjects were then referred to the area's only CAP physician group. The researchers then compared the diagnoses regarding abuse provided by CAP physicians (working in concert with CPS) with those provided to CPS by other physicians. In 42.5% of cases, non-CAP physicians did not provide a diagnosis regarding abuse despite initiating the abuse report to CPS or being asked by CPS to evaluate the child for physical abuse. Sometimes, CAPs found that abuse did not occur, and differences in diagnosis were 3 times more likely in children from a nonurban location. The study concluded that in many cases of possible child physical abuse, non-CAP providers do not provide CPS with a diagnosis regarding abuse and that CPS's consultation with a CAP as a second opinion, along with continued information exchange and team collaboration, frequently results in a different diagnosis regarding abuse.

Although pediatric sexual assault nurse examiners (P-SANEs) have been providing care for longer than two decades, there are major gaps in the literature describing the quality of P-SANE care and legal outcomes associated with their cases. Hornor, Thackeray, Scribano, Curran, and Benzinger (2012) compared quality indicators of care in a pediatric emergency department before and after the implementation of a P-SANE program, looking at trace forensic evidence yield, identification of perpetrator DNA, and judicial outcomes in pediatric acute sexual assault. The study found that detection and documentation of anogenital injury, evaluation and documentation of pregnancy status, and testing for *N. gonorrhea* and *C. trachomatis* were significantly improved after implementation of a P-SANE program compared with historical controls.

More than $55 million are reportedly spent on hospital-based child protection teams (CPTs) annually, but there is no consensus on what makes CPTs effective. In the hospital setting, Goessler, Bonfert, and Fasching (2011) sought to follow up on child protection children after discharge to assess efficiency of the hospital child protection team (CPT) and collaboration with child welfare agencies. Clinical cooperation of the families and outcome were good overall, but in a small number of cases, injuries were reported to the police that led to convictions. Cooperation of the families with the child welfare workers was good in 50% of cases, ambivalent in 15%, and nonexistent in 8%. The authors concluded that measures initiated by the hospital-based team to protect children were efficient.

Kistin, Tien, Bauchner, Parker, and Leventhal (2010) created expert consensus on tasks that CPTs should perform and factors that contribute to effectiveness using a modified Delphi approach to create expert consensus among professionals with experience working with hospital-based CPTs. The study found that experts believed that CPTs should provide communication of findings to appropriate agencies, court testimony, medical consultations, multidisciplinary case review, and forensic interviews. It also found that professionals who use CPT services and CPT members should determine CPT success. Variables that were ranked most often as critical to effectiveness included interdisciplinary collaboration (95% of participants), provision of resources (80%), and team collegiality (75%). Variables that were ranked as most detrimental included inadequate staffing (85%) and lack of collegiality (80%). The authors concluded that a multidisciplinary team working in a collegial atmosphere seems to be the major key to CPT effectiveness. In addition to providing services, CPTs should focus on improving collegiality and interdisciplinary collaboration and should seek performance feedback from referring professionals and CPT members.

Anderst, J., Kellogg, N., & Jung, I. (2009). Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion? *Child Abuse & Neglect, 33*(2), 481–489.

Goessler, A., Bonfert, K., & Fasching, G. (2011). The impact of clinical child protection programs. *Pediatric Surgery International, 27*(6), 659–664.

Hornor, G., Thackeray, J., Scribano, P., Curran, S., & Benzinger, E. (2012). Pediatric sexual assault nurse examiner care: Trace forensic evidence, anogenital injury, and judicial outcomes. *Journal of Forensic Nursing, 8*(3), 105–111.

Kistin, C. J., Tien, I., Bauchner, H., Parker, V., & Leventhal, J. M. (2010). Factors that influence the effectiveness of child protection teams. *Pediatrics, 126*(1), .

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Washington Update

John Sciamanna

Washington Still Trying to Find Budget Direction

The 112th Congress (2011–12 sessions) ended in the first days of 2013 with the President and Congress coming to a partial deal on budget and taxes. They passed HR 8, which increased the top tax rate to 39.6% for individuals making $400,000 and couples making $450,000. In addition, they let the temporary decrease in the payroll tax (Social Security and Medicare–FICA) expire and restored it to 6.2%, enacted several other tax changes, extended unemployment insurance benefits. They also restored the 1998 Medicare payments cuts to physicians ("the doc-fix") for one year and extended the agriculture reauthorization for the remainder of the fiscal year. Despite that end of year agreement, they left the big issue of budget cuts on the table and instead suspended the cuts by 2 months, which did happen on March 1. The 2-month delay required a down payment of $24 billion in deficit reduction through tax revenue and program cuts of $24 billion. They found $12 billion in revenue and $12 billion in spending cuts with $6 billion from defense and $6 billion in domestic spending. That left an additional $85 billion cut for March but spread the reduced level of cuts from a 9-month period to 7 months.

Now Congress and the President face a deadline of late summer or early fall, when they will have to agree to raise the national debt ceiling. In March, the Congress and the Administration extended FY-2013 funding for the rest of the fiscal year, allowing the across-the-board cuts (sequestration) to take place.

President Includes Mental Health and Research Issues in Gun Proposals

The President has proposed several changes regarding mental health care and research on gun violence as part of his gun violence proposals. The details were included in the official release of the 2014 budget; the President is calling for greater research on the causes and prevention of gun violence, including links such as video games and media images. He would do this by removing some of the current congressionally mandated restrictions on research by the Centers for Disease Control and Prevention (CDC). In 1996, Congress passed an amendment backed by the NRA to a CDC appropriations bill that prohibited spending federal dollars on research that could be used to "advocate or promote gun control." The bill cut $2.6 million from the CDC's National Center for Injury and Control. Although the appropriations language has not explicitly prohibited such research, some point to the chilling effect it has had on CDC research into gun violence. He is also calling for an expansion of the National Violent Death Reporting System from 18 states to all 50 states.

The President calls for reaching 750,000 young people through programs to identify mental illness early by referring them to treatment. He would train teachers and other adults who regularly interact with students to recognize young people needing help and ensure they receive the proper mental health services. He is proposing a training program called Mental Health First Aid for this purpose. He is also proposing $25 million to support youth ages 16–25 who are at high risk for mental illness. The funding would go for innovative state-based strategies addressing mental health or substance abuse issues among this population. The President has promised to finalize regulations and requirements for private health insurance plans to cover mental health services that were enacted as part of the Mental Health Parity and Addiction Equity Act of 2008.

Violence Against Women Act Reauthorization Passes

One of the first actions of the new Senate was the re-passage of the Violence Against Women Act (VAWA). The bill, S 47, passed by a margin of 78 to 22. On Thursday, February 28, the House of Representatives approved the same bill by a vote of 286 to 138, roll call 55 (http://clerk.house.gov/evs/2013/roll055.xml). This ends a legislative fight that began in the spring of 2012. Last year's bill

died late last year in the House when it was unable to come to an agreement with the Senate over the differences between the two bills. This year the House Republicans offered a different version of the bill. When they failed to get the needed votes to pass their own bill, however, they voted on the Senate bill. Differences between the House and Senate center on provisions that allow tribal authorities to prosecute non-Indian men who abuse Indian women and that provide clarification of language that formally extends the law to cover domestic violence when it involves issues of gender identity and sexual orientation.

Appropriations total more than $600 million a year with nearly $200 million flowing through HHS. The programs generally fall under the categories of law enforcement, prevention efforts, and human service programs to assist victims. The biggest grant of S 47 is the Services–Training–Officers–Prosecutors (STOP) program, which targets law enforcement efforts. VAWA includes a number of programs that address or overlap with 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.

Commission on Child Deaths to Be Established

The Senate acted on January 2 in the last hours of the 112th Congress to approve the Protect Our Kids Act (HR 6655). The bill establishes a commission to examine child deaths in the United States. The legislation was championed by Congressman Lloyd Doggett (D-TX) and later by the Chairman of the House Ways and Means Committee, Congressman David Camp (R-MI). The original bill was introduced by Senator John Kerry (D-MA) (S 1894) in the Senate. Among the responsibilities of the commission were the following: examine the effectiveness of best practices in preventing child deaths that are intentionally caused or occur due to neglect; the effectiveness of policies in collecting accurate, uniform data on child fatalities; barriers to preventing child deaths; trends in demographic and other risk factors that predict child abuse and neglect, including the impact of the age of the child, child behavior, family structure, parental stress, and poverty. The commission, which will have 12 members, is directed to make recommendations on ways to prioritizing child abuse and neglect prevention. The President will select six of the members, and the House and Senate will each appoint three members with the majority parties selecting two of the three members. Under the bill, membership is to be appointed within 90 days of enactment with the first meeting scheduled for 60 days after those appointments but those timeframes have already passed and a final announcement by the President is still pending. The commission is to issue a report within 2 years, but the President can extend this by another year. The work of the commission will be paid for by a reallocation of $2 million from the Temporary Assistance for Needy Families (TANF) contingency funds. No appointments have been made yet to the commission, and it is not certain where it will be housed. It could end up under HHS, the Department of Justice, or the White House. Nominations were still being considered at the start of March.

Government Accountability Office Looks at Prevention–Intervention Funding

On January 30, the Government Accountability Office (GAO) issued a report that examined the use of Title IV-B part 1, Child Welfare Services (CWS), and part 2, Promoting Safe and Stable Families (PSSF). The report examined how states use their flexible funds, what additional funds are available, and how adequate the supply of funding is to address need. The report found services lacking and suggested possible harm due to the inability to provide adequate services for vulnerable families involved with the child welfare and child protective services systems. The two funding block grants generally establish prevention and intervention services that are to provide services that reduce or prevent placement of children into foster care.

The GAO pointed to 2008–09 U.S. Department of Health and Human Services findings that

> …[l]ocal child welfare officials in four selected states reported service gaps in multiple areas. Service gaps may harm child well-being and make it more difficult to preserve or reunite families. For example, officials from one locality noted 2- to 3-month wait times for substance abuse services. Due to the chronic nature of the disease, delays in receiving services may make it more difficult to reunify families within mandated deadlines. Officials cited factors contributing to service gaps that included provider shortages and lack of transportation. Additionally, officials noted difficulty securing services from partner agencies, such as housing authorities. (2013, January 30, *States Use Flexible Federal Funds, but Struggle to Meet Service Needs* at Highlights, What GAO Found. Retrieved from: **http://www.gao.gov/products/GAO-13-170)**

States tap into other sources of funding to supplement IV-B funding and services, such as Temporary Assistance for Needy Families (TANF) and Social Services Block Grant (SSBG) funds. The $1.7 billion in SSBG funding has been targeted for complete elimination by House leadership. The GAO indicated that 31 states reported spending TANF funds, and in fiscal year 2010, 44 states reported spending SSBG funds on these purposes. The GAO-13-170 study, titled *States Use Flexible Federal Funds…,* can be read at: **http://www.gao.gov/assets/660/651667.pdf**

Reichert Is New Chairman of Human Resources Subcommittee

Congressman Dave Reichert (R-WA) is the new chair of the Human Resources Subcommittee, which has key oversight of child welfare legislation in the House. Reichert is not new to the Ways and Means Committee, but he will be new to this subcommittee. Chairman Reichert was first elected in 2004 and at times has split with the majority of his party on some environmental issues to support the repeal of the "don't ask don't tell" policy on gays in the military. He has an associate degree in social work and was a law enforcement officer in the Kings County sheriff's department. At his appointment, he stated,

> As the oldest of seven kids growing up in a home of scarce means, I ran away on several occasions. There were times I attended high school out of my car in order to escape difficult family circumstances. Yet, there were those along the way who prevented me from falling through the cracks. I know what it's like to struggle, and I know the vital role that hope plays when trying to find a pathway to a better tomorrow." (2013, January 15. Retrieved from: http://reichert.house.gov/press-release/reichert-named-chairman-house-ways-and-means-human-resources-subcommittee)

The subcommittee's first hearing focused on the reauthorization of the Adoption Incentives Fund and the $15-million-a-year Family Connections Grants. In his opening remarks, Reichert discussed his work in the King County sheriff's department. He described how he worked on a serial killer case and, during the course of that investigation, met many young people living on the streets who had run from foster care. Reichert said that he is a grandparent to two children who have been adopted from foster care after exposure to drug addiction. The reauthorization must be passed by October 1. The subcommittee also held a hearing on the Temporary Assistance for Needy Families (TANF) block grant. The welfare assistance block grant has been due for a reauthorization since 2010 but has undergone a series of temporary extensions with the latest due to expire on March 27. TANF provides over 20% of the federal funds used for child welfare.

HHS Releases Child Abuse Numbers for 2011

Last December, the Children's Bureau released *Child Maltreatment 2011*, which claimed an estimated 3.4 million referrals or calls to child protective services agencies. The reports of child abuse or neglect were estimated to include 6.2 million children. Of the reports, an estimated 60.8% were screened in (i.e., resulted in further investigation by the child protective services agency—CPS), and 40% were screened out with no additional investigation. The report showed a continued decrease in the estimated number of cases resulting in substantiation of child neglect or abuse. The number of victims of child abuse and neglect was estimated at 681,569, down from 698,000 in 2010. The figures are unique counts.

The report indicated that 1,570 child deaths occurred as a result of abuse and neglect, a slight decrease from 1,580 in 2010. Consistent with previous years, 81% of the child deaths were to children less than 4 years of age. The cause of death in the majority of cases (71%) was child neglect alone or in combination with other forms of abuse. The child death figure is gathered from the National Child Abuse and Neglect Data Systems (NCANDS) so it may not take into account other sources of child deaths, such as those identified only through law enforcement departments.

Other abuse–neglect demographics include the following:

- Victims in the age group of birth–1 year had the highest rate of victimization at 21.2 per 1,000 children of the same age group in the national population.
- Victimization was evenly split between the sexes, with boys accounting for 48.6% and girls accounting for 51.1%.
- Eighty-seven percent of (unique count) victims came from three races or ethnicities—African American (21.5%), Hispanic (22.1%), and white (43.9%). (US-DHHS, Children's Bureau, 2012. Retrieved from: http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf)

The greatest percentage of children suffered from neglect. A child may have suffered from multiple forms of maltreatment and was therefore counted once for each maltreatment type. CPS investigations or assessments determined that, for unique victims, more than 75% (78.5%) suffered neglect, 17.6% suffered physical abuse, and 9.1% suffered sexual abuse. To read the full report, go to the National Child Abuse Coalition Web site at: http://www.nationalchildabusecoalition.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, he 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: john.sciamanna962@gmail.com

APSAC News

APSAC Advisor Celebrates 25th Anniversary

The *APSAC Advisor* has served as a key member benefit for APSAC members and a source of useful information for the field for 25 years. Articles have covered topics and provided guidance in a variety of areas affecting the professionals who respond to abuse and neglect—from medicine to nursing, from law to law enforcement, and from social work to psychology. On page 1 of the first issue in August 1988, Jon Conte announced that the *Advisor* serves as a "means for communicating with other professionals about the many problems, questions, and insights they have gained through their work with and for abused children." The *APSAC Advisor* continues this important work today.

In honor of these 25 years and 25 volumes, the Board of Directors is pleased to acknowledge the editors for their contributions to the *Advisor* and all the important work they do for APSAC as an organization and the children and families we serve.

Editors in Chief	Years	Volumes (Issue)
David Corwin, MD	1988–1990	1(1)–3(3)
Susan Kelly, RN, PhD, FAAN	1990–1996	3(4)–9(4)
Debra Whitcomb, MA	1997–2001	10(1)–13(3/4)
C. Terry Hendrix, MA	2002–2002	14(1)–14(2)
Erna Olafson, PhD, PsyD	2002–2004	14(3)–16(3)
Ronald C. Hughes, PhD, MScSA	2004–2009	16(4)–21(4)
Judith S. Rycus, PhD, MSW	2010–2011	22(1)–23(2)
Vincent J. Palusci, MD, MS	2011–Current	23(3)–

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APSAC Online Store Open for Business

Are you "achieving" every reward you can? Not long ago, APSAC announced our partnership with AchieveLinks,® the unique rewards program created exclusively for associations.

If you've activated your account, you already know how fast your *Links*® Reward Points can add up. Just by making the same purchases you would usually make for your business and personal life, you'll been earning valuable *Links* toward must-have merchandise, valuable gift cards, and once in a lifetime experiences.

If you haven't activated yet, we encourage you to do so. There is no cost, no risk, and no obligation. You've already earned all the benefits and privileges of your AchieveLinks® account, just by being a member of APSAC.

To join your colleagues and begin earning rewards, visit **http://www.apsac.achievelinks.com** and activate your account today. If you were an APSAC member prior to January 15, 2013, you were automatically enrolled and simply need to activate your account. You can do this by selecting the Contact feature in the bottom right corner of the screen and requesting that your activation e-mail be re-sent. If you joined APSAC after January 15, select the "Start earning now. Click here to sign up!" button in the middle of the page. When requested to search for your association, enter "APSAC."

2013 APSAC Child Forensic Interview Clinic Scheduled for Seattle

APSAC is offering its Child Forensic Interview Clinic in Seattle this July. The clinic offers 40 hours of intensive training on investigative interviewing of children.

APSAC pioneered the Child Forensic Interview Training Clinic model to focus on the needs of professionals responsible for conducting forensic–investigative interviews with children in suspected abuse cases. Interviews with children face intense scrutiny and increasingly require specialized training and expertise. These comprehensive clinics provide a unique training experience that provides personal interaction with leading experts in the field of child forensic interviewing.

Developed by top experts, APSAC's curriculum teaches a structured narrative interview approach that emphasizes best practices based on research and is guided by best interests of the child. Attendees will receive a balanced review of several protocols and will develop their own customized narrative interview approach based on the principles taught during the training.

The clinic will be held July 22–26, 2013, in Seattle, Washington. Details and registration are available on the APSAC Web site, **http://www.apsac.org**.

APSAC Enhances Web Site; Social Community Now Online for Members

APSAC recently added a "My Community" feature to its Web site at **http://www.apsac.org**. Now, when a member logs in with a username and password, he or she will access the My Community option under the Members Only tab. This replaces an older menu item called My Profile.

My Community brings a social network experience, similar to Facebook, to the Web site. Members can create "circles" or discussions, invite other members to "connect," view transaction histories, browse the Directory, update online profiles, renew membership, and much more.

With these changes, members will now find the Directory in My Community under Connections. You can access the main Directory or perform an Advanced Search, including cross-tabulation by name, agency/company, country, discipline, function, and area of expertise.

If you are on a committee or a participant in one of the Forensic Interview SIGs, you can access this information under the My Features section.

Members can find a brief APSAC Social Community Overview document by logging in to the Web at **http://www.apsac.org** and visiting the APSAC Library under the Members Only tab. The Overview highlights many of these features and explains how to use them.

Successful Institutes Offered by APSAC in San Diego

Nearly 170 individuals participated in APSAC Advanced Training Institutes January 27 in San Diego, California. The programs were a part of the Annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center.

APSAC programs included the following:

- Advanced Issues in Child Sexual Abuse Medical Evaluations
  Lori D. Frasier, MD, and Suzanne Starling, MD
- Cognitive Processing: Advanced Clinical Strategies for CBT Trauma Therapist
  Monica Fitzgerald, PhD, and Kimberly Shipman, PhD
- Maximizing Corroborative Information in Child Abuse and Witnessing Violence Cases
  Julie Kenniston, MSW, LSW, and Chris Kolcharno

In addition to offering three educational programs, APSAC exhibited in the conference and many of its members served as conference faculty. APSAC's Board of Directors held a meeting January 28–29 in conjunction with the conference.

Conference Calendar

July 12–13, 2013

Bar Association National Conference on Children and the Law

"Raising the Bar: Lawyers as Partners for Family Well-Being"
American Bar Association/Center on Children and the Law
Washington, DC
202.662.1000
http://www.americanbar.org/groups/child_law/conference2013.html

July 22–26, 2013

APSAC's Child Forensic Interview Clinic

American Professional Society on the Abuse of Children
Seattle, WA
877.402.7722
apsac@apsac.org
http://www.apsac.org

August 26–28, 2013

36th National Child Welfare, Juvenile, and Family Law Conference

National Association of Counsel for Children (NACC)
Atlanta, GA
taylor.stockdell@childrenscolorado.org
http://naccchildlaw.site-ym.com/?National_Conference

September 12–15, 2013

18th International Conference on Violence, Abuse, and Trauma

"Uniting for Peace: Linking Research, Policy, and Practice to End Violence and Abuse in Homes and Communities Worldwide"
Institute on Violence, Abuse, and Trauma (IVAT)
San Diego, CA
858.527.1860
ivatconf@alliant.edu
http://www.ivatcenters.org/Conferences.html

September 15–18, 2013

13th ISPCAN European Regional Conference on Child Abuse and Neglect

International Society for Prevention of Child Abuse and Neglect
Dublin, Ireland
303.864.5220
ispcan@ispcan.org
http://www.ispcan.org/event/Dublin2013%20

September 17–19, 2013

Extended Forensic Interviewing Training

National Children's Advocacy Center
St. Louis, MO
256.533.5437
http://www.nationalcac.org/ncac-training/efi-training.html

October 5–9, 2013

8th ISPCAN Latin American International Conference on Child Abuse and Neglect

International Society for Prevention of Child Abuse and Neglect
Viña del Mar, Chile
303.864.5220
ispcan@ispcan.org
http://www.conferenciainternacional.cl

October 23–25, 2013

8th Annual Conference on Differential Response in Child Welfare

Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
University of Colorado Denver
Vail, CO
303.630.9429
amy.hahn@childrenscolorado.org
http://bit.ly/WtEsXd

October 26, 2013

American Academy of Pediatrics National Conference and Exhibition

"Accident, Abuse, or Abnormal Bleeding: A Scientific Approach to Evaluate Bleeding or Bruising That Is Concerning for Abuse"
Orlando, FL
847.434.4000
THurley@aap.org
http://www2.aap.org/sections/childabuseneglect/PDFs/2013_NCE_schedule.pdf

November 8, 2013

Child-Friendly Faith Project Conference 2013

"How Do We Make Faith Child-Friendly?"
Austin, TX
info@childfriendlyfaith.org
http://childfriendlyfaith.org/conference-2013/

APSAC ADVISOR

Opinions expressed in the *APSAC Advisor* do not reflect APSAC's official position unless otherwise stated. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

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