National Children's Alliance®

The Force Behind Children's Advocacy Centers

Annotated Bibliography to the NCA Standards

An update to the bibliography of the empirical and scholarly literature supporting National Children's Alliance's *Standards for Accredited Members*

2020 Edition

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Introduction

First Edition

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

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

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

Faculty, researchers, and knowledgeable practitioners were engaged to recommend seminal publications and to review candidate publications for quality. The group of reviewers included: Lisa Jones, PhD; Harold Johnson, PhD; Linda Cordisco Steele, MEd, LPC; Betsy Goulet, MA; Karen Farst, MD, MPH; Charles Wilson, MSSW; Dan Powers, ACSW, LCSW; Julie Pape Blabolil, MA, RN, CNP; Chris Newlin, MS, LPC; and Andra Chamberlin, MA. The compilation of 87 articles was prepared by NCAC Research Librarians, David N. King, MSLS, PhD; Cindy Markushewski, MA, MLIS; and Muriel K. Wells, MA, MLIS.

Second Edition

In 2013, National Children's Alliance engaged the NCAC to identify and explicate additional research, published between 2010 and 2013 (2010-2013), providing further bases for the standards for accreditation. Articles were selected and evaluated by Lisa Jones, PhD; Harold Johnson, PhD; Linda Cordisco Steele, MEd, LPC; Betsy Goulet, MA; Karen Farst, MD, MPH; Charles Wilson, MSSW; Dan Powers, ACSW, LCSW; Julie Pape Blabolil, MA, RN, CNP; Chris Newlin, MS, LPC; and Andra Chamberlin, MA. Articles were reviewed by Chris Newlin, MS, LPC and Linda

Cordisco Steele, MEd, LPC. The compilation of 49 additional publications was prepared by NCAC Research Librarian, Muriel K. Wells, MA, MLIS.

Third Edition

In 2019, National Children's Alliance engaged the Chadwick Center for Children and Families at Rady Children's Hospital San Diego to identify and summarize new research, published between 2014 and 2019 (2014-2019), providing additional support for the standards for accreditation. In addition to the ten standards of accreditation, three additional areas of focus were included in this bibliography: child abuse prevention, commercial sexual exploitation of children (CSEC) as defined by the Office of Juvenile Justice and Delinquency Programs (OJJDP), and child physical abuse. Literature relevant in research, theory, scholarly discourse, and management practices; and/or pertinent to the standards or additional three focus areas, was identified and reviewed by a panel of topic experts, including Corey Brodsky, MA; Andra Chamberlin, MA; Greg Flett, MSW; Betsy Goulet, MA; Jordan Greenbaum, MD; Lisa Jones, PhD; Bart Klika, PhD; Thomas Lyon, JD, PhD; John Melville, MD; Shalon Nienow, MD; Carole Campbell Swiecicki, PhD; Wendy Walsh, PhD; and Charles Wilson, MSSW. Articles were reviewed by Jennifer Rolls Reutz, MPH. The compilation of 76 additional publications was prepared by Jennifer Rolls Reutz, MPH; Kelly Curtis-Hughes, MFT; and Jennifer Demaree, MS.

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Section I: Standards for Accredited Members

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1 | Multidisciplinary team

Duron, J. F. (2018). Legal decision making in child sexual abuse investigations: A mixed-methods study of factors that influence prosecution. *Child Abuse & Neglect*, 79, 302–314. https://doi.org/10.1016/j.chiabu.2018.02.022

Type of article: Mixed-methods multiphase design study
Subject of article: Examines the factors associated with child sexual abuse cases that are accepted for prosecution and the process followed by prosecutors
Location: Suburban county in the southern United States

Summary: Prosecution of child sexual abuse cases is an important aspect of a community's response for holding perpetrators accountable and protecting children. Differences in charging rates across jurisdictions may reflect considerations made in prosecutors' decision-making processes. This mixed-methods multiphase study used data from a Children's Advocacy Center in a suburban county in the southern United States to explore the factors associated with child sexual abuse cases that are accepted for prosecution and the process followed by prosecutors. Previous research focusing on children's disclosure narratives has not explored how the number of details provided or the specific questions used to transition a child into a narrative disclosure describing sexual abuse experiences relate to a decision to prosecute a case. Thus, this study builds on the existing literature by considering a child's disclosure narrative and investigative stages. Data were sequentially linked in three phases (qualitative-quantitative-qualitative), incorporating 1) prosecutor perceptions about what case characteristics affect charging potential, 2) 100 case records and forensic interviews, and 3) in-depth reviews of cases prosecuted. Content analysis was used to identify influential case elements, logistic regression modeling was used to determine factors associated with a decision to prosecute, and framework analysis was used to further confirm and expand upon case factors. Results across all study phases revealed the consistent influence of caregiver support and other evidence on prosecutorial decision-making. Three variables (caregiver support, other evidence, and number of services received) accounted for 59.5% of the variances in the logistic regression model. Strikingly, children who had caregiver support at disclosure had more than a 400% greater chance of having a case accepted for prosecution than those children who did not have caregiver support. Furthermore, the child's disclosure, along with three underlying elements (an immediate outcry, details, and

credibility), were reported by prosecutors as pivotal to prosecution. The decision to prosecute was found to include a process of ongoing evaluation of the evidence and determination of a balanced approach to justice. The decision to prosecute a case can be influenced by strong and supportive investigative practices. An important implication is that interaction among multidisciplinary professionals promotes communication and collaborative efforts, further enhancing discretion in potential legal actions.

Elmquist, J., Shorey, R. C., Febres, J., Zapor, H., Klostermann, K., Schratter, A., & Stuart, G. L. (2015). A review of children's advocacy centers' (CACs) responses to cases of child maltreatment in the United States. *Aggression and Violent Behavior*, 25, 26–34. https://doi.org/10.1016/j.avb.2015.07.002

Type of article: Review article
Subject of article: Reviews the Children's Advocacy Center (CAC) model and how CACs respond to cases of maltreatment
Location: United States

Summary: Child maltreatment is a serious and prevalent problem in the United States. Children's Advocacy Centers (CACs) were established in 1985 to better respond to cases of child maltreatment and address problems associated with an uncoordinated community-wide response to child maltreatment. CACs are community-based, multidisciplinary organizations that seek to improve the response and prosecution of child maltreatment in the United States. The primary purpose of this manuscript is to present a review of the literature on CACs from 1996 to 2012, including the CAC model (e.g., practices, services, and programs) and CACs' responses to cases of child maltreatment. This review suggests that there is preliminary evidence supporting the efficacy of CACs in reducing the stress and trauma imposed on child victims during the criminal justice investigation process. For example, the review found that on-site mental health services, referral to other providers, and forensic interviews provided by CACs, coupled with the child-friendly atmosphere of CAC programming, aided in reducing the stress experienced by child victims and their nonoffending family members during the investigation phase. Existing research also found high levels of child and parent satisfaction with CAC services. The review found that CACs were also more likely than traditional community agencies to provide vital services, such as forensic medical examinations, psychological evaluations, pregnancy and sexually transmitted infection (STI)

screenings, and STI treatment. However, this review also identified important CAC polices, practices, and components that need further evaluation and improvement. In addition, due to the methodological limitations and gaps in the existing literature, research is needed on CACs that employs longitudinal designs and larger samples sizes and that evaluates a larger array of center-specific outcomes. Finally, this review suggests that CACs might benefit from incorporating ongoing research into the CAC model and accreditation standards and by recognizing the importance of integrating services for child and adult victims of interpersonal violence.

Herbert, J. L., & Bromfield, L. (2016). Evidence for the efficacy of the child advocacy center model: A systematic review. *Trauma, Violence & Abuse, 17*(3), 341–357. https://doi.org/10.1177/1524838015585319

Type of article: Systematic review
Subject of article: Reviews the research base for the Children's Advocacy Center (CAC) model
Location: Not applicable – no location criteria used in the search process

Summary: The Children's Advocacy Center (CAC) model has been presented as the solution to many of the problems inherent in responses by authorities to child sexual abuse. The lack of referral to therapeutic services and support, procedurally flawed and potentially traumatic investigation practices, and conflict between the different statutory agencies involved are all thought to contribute to low conviction rates for abuse and poor outcomes for children. The CAC model aims to address these problems through a combination of multidisciplinary teams, joint investigations, and services, all provided in a single child-friendly environment. Using a systematic search strategy, this research aimed to identify and review all studies that have evaluated the effectiveness of the approach as a whole. This was done in order to understand what study designs were being used to evaluate effectiveness of CACs and to determine the evidence that exists for the efficacy of the CAC model, while recognizing that a separate evidence base exists for parts of the approach (e.g., victim advocacy and therapeutic responses). The review found that while the criminal justice outcomes of the model have been well-studied, there was a lack of research on the effect of the model on child and family outcomes. Overall, the review suggests that the CAC model appears to increase the availability of types of practices (e.g., forensic interviews, medical examinations, referral to counselling, and treatment for sexually transmitted infections [STIs]) that are assumed to lead to positive outcomes, but that

research into these subsequent outcomes is limited. There does seem to be some evidence for the CAC multidisciplinary approach to yield better outcomes than non-integrated services early in the criminal justice/investigative process. One study demonstrated the rate of prosecutions was 69% greater in the CAC community. More CAC cases resulted in a guilty plea or finding (56% vs. 24%), when compared to traditional service delivery. Offenders were more likely to plead guilty in the CAC sample (82% vs. 18%), reflecting that these cases may have resulted in more compelling evidence. Although some modest outcomes were clear, the lack of empirical research, and overreliance on measuring program outputs, rather than outcomes, suggests that some clarification of the goals of the CAC model is needed. It also shows that there is a clear need for more rigorous empirical research of the CAC model, particularly on the impact that both therapeutic interventions and coordinated/co-located services have on child trauma symptoms. There is also a need to develop a clearly articulated theory of change, both for the proper evaluation of CACs and for their ongoing practice improvement. This theory of change needs to recognize the outcomes for which CACs can presumably effect some change (e.g., knowledge of trauma, improved capacity to support traumatized children) and those on which the CAC has a limited direct effect (e.g., sentencing outcomes).

Herbert, J. L., Walsh, W., & Bromfield, L. (2018). A national survey of characteristics of child advocacy centers in the United States: Do the flagship models match those in broader practice? *Child Abuse & Neglect*, *76,* 583–595. https://doi.org/10.1016/j.chiabu.2017.09.030

Type of article: Research – Cross-sectional survey
Subject of article: Provides a snapshot of the characteristics of CACs in the United States but also to identify potential types of CACs based on the extent of integration of services
Location: United States

Summary: Children's Advocacy Centers (CACs) emphasize developing effective cross-agency collaborations between workers involved in serious abuse investigations to foster improvements in agency outcomes and to minimize distress, confusion, and uncertainty for children and families. This study examined the characteristics of CACs and whether models in practice match the predominant model presented in the research literature. All National Children's Alliance (NCA) accredited CACs, developing CACs, and nonmember CACs in the United States (N = 796) received an email invitation in 2016 to participate in the online survey, and 361

CAC directors completed the survey. CACs in the sample had been operating for more than ten years, with an average of 14 years. On average, CACs saw 487 children per year and averaged nine full-time equivalent staff. Results seem to reflect at least three theorized types of CACs. Firstly, there are basic CACs that provide the core services of interviewing and advocacy, as well as a framework and site for core agencies (e.g., law enforcement, child protection, prosecutors) to meet and collaborate on cases. Secondly, there are aggregator CACs that mostly have many of the expected services integrated into their responses, but have fewer partner agencies, services on-site, and services by CAC staff compared to the full-service model. These CACs are more likely to rely on referral to other service providers. Finally, there are centralized full-service CACs, which provide comprehensive, wraparound services for children and families affected by abuse. These CACs have many partner agencies and services on-site, mostly provided by separate agency staff members.

Interestingly, aggregator CACs were most likely to have more governance features in place (e.g., case tracking, steering group, joint performance measurement). Researchers found no difference between the aggregator and full-service CAC types on the number of years open, size, and area type; suggesting that full-service CACs are not exclusively large, urban centers that have been open many years. Further research is needed to understand how these variations may impact practice and outcomes. This is particularly important considering many CACs do not match the full-service models most commonly examined in the research literature, which limits the degree to which these findings apply to CACs generally. The results suggest that, while there are differences across CACs, the two core services of CACs, interviewing and victim advocacy, as well as some features aimed at supporting and fostering cross-agency work, are almost universal. There were clear differences across CACs in terms of whether services were provided on-site at the CAC, the number of agencies co-located at the CAC, and whether services were provided by CAC staff members. As the literature is based largely on full-service CACs, the minimum components of a CAC needed to achieve positive outcomes are unknown, as well as whether the components are different for criminal justice versus mental health outcomes. For jurisdictions that are not in the position to implement a full-service type CAC, there are important questions around what effect a CAC with only some of the components might be expected to have.

2 | Cultural competency and diversity

DeNard, C., Garcia, A., & Circo, E. (2017). Caseworker perspectives on mental health disparities among racial/ethnic minority youth in child welfare. *Journal of Social Service Research, 43*(4), 470–486.
https://www.doi.org/10.1080/01488376.2017.1299827

Type of article: Research – Qualitative study utilizing focus groups
Subject of article: Gives perspectives on mental health disparities by child welfare caseworkers employed by recently developed decentralized Community Umbrella Agencies. These agencies are contracted to provide case management services to children and families in their own communities
Location: Large Mid-Atlantic city in the United States

Summary: Disparities in mental health service use exist for children of color in the child welfare system. Studies exploring a theoretical link of provider racial bias to disparities in service use recommend further inquiry into this association. Since measuring caseworker racial bias may be difficult, examining language, particularly as to whether caseworkers attribute racial disparities to structural mechanisms or individual agency and beliefs, may illuminate unconscious racial bias that caseworkers have towards their clients. Therefore, this study employed discourse analysis to examine child welfare caseworker racial explanations of mental health disparities. Qualitative data derived from focus group transcripts of 36 caseworkers who discussed barriers and facilitators of mental health service use were used in this study. Results showed that caseworkers cited factors at the institutional and community levels, such as availability of services, funding, institutional racism, and community-level sentiments about mental health; and at the organizational level, such as interagency collaboration, agency culture, and cultural competency of practitioners and agencies, as causes of racial disparities. However, they placed ultimate responsibility for mental health service use on primary caregivers and on caseworkers to facilitate access to services. Future research should examine referral patterns and mental health service use outcomes based on casework bias, as this can further demonstrate whether child welfare caseworker bias is a causal mechanism for mental health disparities. In addition, systems should evaluate the effectiveness of integrating Critical Race Theory and other antiracist training in reducing caseworker racial bias. Several limitations are present in the study, including that there is no data

on actual caseworker-client interactions, as all data was obtained retrospectively from caseworkers. In addition, the majority of the caseworkers and all of the researchers were racial and ethnic minorities, which may have impacted the results.

Fish, J. N., Baams, L., Wojciak, A. S., & Russell, S. T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. *Child Abuse & Neglect, 89,* 203–211. https://doi.org/10.1016/j.chiabu.2019.01.005

Type of article: Research – Secondary analysis of data from two nationally representative, longitudinal surveys (the National Longitudinal Study of Adolescent to Adult Health and the National Survey of Child and Adolescent Well-Being II)
Subject of article: Examines national representative samples to determine whether sexual minority youth are overrepresented in child welfare, foster care, and out-of-home placement
Location: United States

Summary: Preliminary evidence suggests that sexual minority (e.g., lesbian, gay, and bisexual) youth are overrepresented in child welfare services. Yet, no study to date has been able to test this hypothesis with national data. Using a two-study design, the authors tested whether sexual minority youth are overrepresented in child welfare, foster care, and out-of-home placement using nationally representative data. Using data from the National Longitudinal Study of Adolescent to Adult Health, the authors tested differences in lifetime foster care involvement between sexual minority and heterosexual youth and found that sexual minority youth are nearly 2.5 times as likely as heterosexual youth to experience foster care placement. Data from wave three of the National Survey of Child and Adolescent Well-Being II was used to calculate a Disproportionality Representation Index (DRI)—a ratio of sample prevalence relative to the general population—to estimate whether sexual minority youth were overrepresented in child welfare and out-of-home care. Results showed that sexual minority youth were largely overrepresented in child welfare services and out-of-home placement. The findings are the first to demonstrate sexual minority youth's overrepresentation in child welfare, foster care, and out-of-home placement using nationally representative data. Continued focus on this population is needed to help inform policies and practices that improve the experiences of sexual minority youth involved with child welfare. Limitations in the study include a lack of consistent and comprehensive measures of sexual orientation across the surveys, differences in the

administration timeframes between the two surveys, and a lack of in-depth information about the mechanisms that explain the overrepresentation of sexual minority youth in foster care, such as parental rejection, discrimination, and stigma.

Fontes, L. A., & Tishelman, A. C. (2016). Language competence in forensic interviews for suspected child sexual abuse. *Child Abuse & Neglect*, *58*, 51–62. https://doi.org/10.1016/j.chiabu.2016.06.014

Type of article: Research – Qualitative study using telephone interviews
Subject of article: Studies the ability of Children's Advocacy Center (CAC) personnel to communicate with clients, regardless of clients' preferred language
Location: United States

Summary: Forensic interviews with children for suspected child sexual abuse (CSA) require meeting children "where they are" in terms of developmental level, readiness to disclose, culture, and language. The field lacks research indicating how to accommodate children's diverse cultural and linguistic backgrounds. This article focuses on language competence, defined here as the ability of CACs and forensic interviewers to communicate effectively with clients regardless of clients' preferred language(s). In this study, 39 U.S. child forensic interviewers and CAC directors were recruited via an electronic mailing list for forensic interviewers. Respondents discussed their experiences, practices, and opinions regarding interviews with children and families who are not native speakers of English. Topics included the importance of interviewing children in their preferred language, problems in interpreted interviews, bilingual interviews, and current and recommended procedures. Participants stressed the importance of language access and the difficulty finding forensically trained interpreters. Often, CACs did not have a standard or entirely satisfactory means of resolving language issues, especially given the multiple languages they encounter, some of which are rare in their location or specific to a small population. Participants varied in their comfort in using both in-person and telephone interpreter services. Notably, only a small number of CACs employed bilingual forensic interviewers. Usually these were in urban areas and the bilingual interviewers were Spanish-speaking.

This study found a lack of consistency of resources and language-relevant practices across CACs. A language-minority child might have widely divergent experiences depending on the CAC and/or the language(s) spoken by the particular child and

their family. The authors strongly recommend the development of CAC guidelines on language competence, including best practices with regard to working with children and their families who speak a language other than English, and further research related to language competence in CSA forensic interviews. Limitations include the small sample size, the voluntary nature of subject recruitment, and concerns about the generalizability of their responses to the field at large.

Lanier, P., Maguire-Jack, K., Walsh, T., Drake, B., & Hubel, G. (2014). Race and ethnic differences in early childhood maltreatment in the United States. *Journal of Developmental & Behavioral Pediatrics, 35*(7), 419–426. https://doi.org/10.1097/DBP.0000000000000083

Type of article: Cross-sectional research – State-by-state report of disproportionality ratios (DRs) of early child maltreatment for racial/ethnic and poverty level groups
Subject of article: Uses aggregated state-level data to examine the impact of risk factors, such as poverty, on child maltreatment victimization rates for young children, ages 0-3 years
Location: 48 states in the United States

Summary: In the United States, Black children are overrepresented among children investigated for child abuse and neglect. Understanding why Black children are disproportionately reported for maltreatment is critical to informing policy and practice solutions. Two competing theories attribute disproportionality to either racial bias or concentrated risk factors. Although prior work has focused on national data, this study examines the relationship between early childhood poverty and maltreatment victimization across White, Black, and Hispanic children (0–3 years). Using state-level data from the National Child Abuse and Neglect Data System (NCANDS) Child File, the National Center for Children in Poverty, and the US Census, the authors determined disproportionality ratios (DRs) for child maltreatment, poverty, and other risk factors. The DR is defined as the ratio of rate among minority populations divided by the rate among the White population. For example, if the state rate of maltreatment of Black children is 10 reports per 1000 Black children and the rate of maltreatment of White children is 5 reports per 1000 White children, then the DR equals 2. In other words, the rate for Black children is twice that of White children.

Results showed that, an average, the state poverty rate for both Black and Hispanic children were about three times higher than the rate for White children. Black and Hispanic rates of single/teen mothers were about twice that of White children. Analyses indicate a strong positive relationship between risk factor disproportionality and maltreatment disproportionality: as the difference between minority children and White children increases for rates of poverty and single/teen mothers, the difference in maltreatment rates also increases. In addition, there is a consistent linear relationship between poverty and maltreatment for both Black and Hispanic children, such that as a state's poverty DR increases, so does the state's maltreatment DR. In other words, states with high poverty DR tended to also have high maltreatment DR.

This examination of state-level data indicates that unequal exposure to social risk factors is strongly associated with state-level racial disproportionality in maltreatment for Black and Hispanic children. Thus, exposure to risks such as poverty is an important factor driving the overrepresentation of minority groups in the child welfare system. Effective strategies for reducing maltreatment must include strategies for reducing poverty and supporting young, at-risk mothers.

Maguire-Jack, K., Lanier, P., Johnson-Motoyama, M., Welch, H., & Dineen, M. (2015). Geographic variation in racial disparities in child maltreatment: The influence of county poverty and population density. *Child Abuse & Neglect*, *47*, 1–13. https://doi.org/10.1016/j.chiabu.2015.05.020

Type of article: Cross-sectional research – Analyses of county-level variables using mapping techniques and multivariate regression analyses
Subject of article: Compares county rates of maltreatment disparity in relation to rates of poverty disparity and population density
Location: United States (48 states plus Washington, DC [Oregon and Pennsylvania not included])

Summary: There are documented disparities in the rates at which Black children come into contact with the child welfare system in the United States compared to White children. A great deal of research has proliferated aimed at understanding whether systematic biases or differential rates of risk among different groups drive these disparities. In the current study, county rates of maltreatment disparity are compared across the United States and examined in relation to rates of poverty disparity as well as population density. Specifically, using hierarchical linear modeling

with a spatially lagged dependent variable, this study examined data from the National Child Abuse and Neglect Data System (NCANDS) and found significant support for a relationship between poverty disparity and maltreatment disparity, for both Black and Hispanic children. In addition, densely populated metropolitan counties tended to have the greatest levels of maltreatment disparity for both Black and Hispanic children. A significant curvilinear relationship was also observed between these variables, such that in addition to the most densely populated counties, the most sparsely populated counties also tended to have higher rates of maltreatment disparity for Black and Hispanic children (this finding is especially pronounced for Hispanic children). Given the association between poverty disparities and maltreatment disparities, future research must examine the mechanisms through which neighborhood and individual poverty may be driving the disparities in maltreatment. Limitations include the cross-sectional nature of the study, differences in maltreatment reporting policies across counties and states, and the diversity of populations that fall under the NCANDS category of "Hispanic."

Maguire-Jack, K., Font, S. A., & Dillard, R. (2019). Child protective services decision-making: The role of children's race and county factors. *American Journal of Orthopsychiatry*. Advance online publication. https://doi.org/10.1037/ort0000388

Type of article: Research – Cross-sectional analyses of county-level variables
Subject of article: Studies the role of race and county-level characteristics in the decision-making process in the child welfare system for children investigated for maltreatment
Location: United States (all 50 states and Washington, DC)

Summary: The current study investigates the role of race and county characteristics in substantiation and out-of-home placement decisions in the United States. Using multilevel models, the authors analyzed data from counties in the United States available through the National Child Abuse and Neglect Data Systems and Adoption and Foster Care Analysis and Reporting System to investigate the interactions between children's race and the context in which they live. The sample consisted exclusively of children whose cases had been investigated; therefore, the authors were able to focus on the role played by race and county characteristics in substantiation and out-of-home placement decisions made by child protective services, net of the heightened risk factors (or potential biases) that lead to disparate rates of reporting. Results showed that, adjusting for state and county of investigation, Black, American Indian/Alaskan Native, and multiracial children were

more likely than White (non-Hispanic) children to be substantiated or placed out of home, whereas Asian children were less likely to be substantiated or placed out of home. Notably, differences across groups are far smaller in magnitude when demographic and geographic differences are taken into account. Higher county-level poverty, percentages of Black residents, and juvenile arrest rates were associated with lower odds of substantiation and out-of-home placement among investigated children; whereas an elevated percentage of single-headed households was associated with higher odds of both outcomes. The authors also found that living in a rural county was associated with greater odds of substantiation but lower odds of out-of-home placement. Important differences by race were found for these associations. Limitations include the inability to fully distinguish between actual differences in both maltreatment behaviors and decision-making; missing data from some states; and the presence of significant variability within counties in terms of poverty, racial composition, and other attributes.

Nazer, D. (2017). Medical evaluation and management of sexual abuse in children with disabilities. *Journal of Alternative Medicine Research*, *9*(3), 249–256.

Type of article: Review
Subject of study: Provides an overview of the medical evaluation and management of sexual abuse in children with disabilities
Location: Not applicable

Summary: Child sexual abuse is a public health problem with grave consequences affecting the child and the community. Children are vulnerable merely because of their age; furthermore, the presence of a developmental or intellectual disability increases vulnerability, making children with disabilities at a greater risk for abuse as compared to children with no disabilities. Children with disabilities may exhibit behaviors that correspond to their development, rather than their chronological age. When assessing these behaviors, one should consider the developmental age as opposed to the chronological age. It is thus important not only to consider the age when evaluating cases of sexual assault but also the developmental abilities of the child and their understanding and ability to provide consent.

Evaluations need to be completed by a multidisciplinary team specialized in evaluating victims of sexual abuse. The medical evaluation is an integral part of this evaluation. Specifically, the medical evaluation and assessment for a child with

disabilities should follow a similar approach with various modifications in the communication and examination techniques to address the child's special needs. Most children who are victims of sexual abuse have a normal exam, making the child's disclosure the strongest evidence that abuse has occurred. The medical provider needs to be trained on the appropriate evaluation, management, and interpretation of findings, or lack thereof, in children who were sexually abused. Future efforts need to focus on the training of healthcare providers and professionals on how to detect, evaluate, and respond appropriately to child sexual abuse in this increasingly vulnerable group.

Santa-Sosa, E. J., & Runyon, M. K. (2015). Addressing ethnocultural factors in treatment for child physical abuse. *Journal of Child and Family Studies*, *24*(6), 1660–1671. https://doi.org/10.1007/s10826-014-9969-5

Type of article: Review
Subject of article: Presents strategies to address ethnocultural factors (ECFs) in evidence-based treatments for families at risk for child physical abuse through three vignettes
Location: Not applicable

Summary: This article used an ecological model to identify relevant ECFs and to suggest intervention strategies targeting these factors within combined parent-child cognitive-behavioral therapy, an evidence-based treatment for families at risk for child physical abuse. Three case vignettes were presented of families of diverse ethnocultural backgrounds, including a multiracial African American and European American family, an African American family, and an Arab American family, each referred to a specialty clinic after an allegation of inappropriate physical discipline or substantiated physical abuse. The vignettes illustrate strategies to address ECFs including race and ethnicity, immigration, acculturation, religious beliefs, and sociocultural context, related to parental beliefs and practices about child discipline. Intervention strategies presented provide practical guidance for clinicians working with diverse families. The ECFs identified in this paper can also guide future research in selecting relevant variables for empirical studies on the association between ECFs and the primary domains of intervention in evidence-based treatment for families at risk for child physical abuse.

Trent, M., Dooley, D. G., & Dougé, J. (2019). The impact of racism on child and adolescent health. *Pediatrics*, *144*(2), Article e20191765. https://doi.org/10.1542/peds.2019-1765

Type of article: Policy statement from the American Academy of Pediatrics
Subject of article: Utilizes literature search to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes
Location: Not applicable

Summary: Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. This policy statement provides an evidence-based summary of the role of racism in child and adolescent development and health outcomes, as well as research-based recommendations for how pediatric health professionals can address and ameliorate the effects on racism on children and adolescents. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals can proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

3 | Forensic Interviews

Brubacher, S. P., Poole, D. A., & Dickinson, J. J. (2015). The use of ground rules in investigative interviews with children: A synthesis and call for research. *Developmental Review*, *36*, 15–33. https://doi.org/10.1016/j.dr.2015.01.001

Type of study: Literature review and study space analysis
Subject of study: Literature on the use of ground rules in investigative interviews, the developmental differences that may impact children's ability to make sense of these rules, and published, peer-reviewed research pertaining to the effects of the ground rules on children's reports
Location of study: Not specified – studies were published in peer-reviewed journals – no location-based exclusion criteria are mentioned

Summary: Guidelines for conducting investigative interviews with children often include instructions that explain the conversational rules of the interview. Despite the widespread and international use of such instructions (also referred to as "ground rules"), the body of research characterizing children's understanding of these rules and documenting the impact of instruction on memory reports is relatively small. This study reviews the use of ground rules in investigative interviews, the developmental differences that likely underlie children's ability to make sense of these rules, and research pertaining to the effects of the ground rules commonly included in interview guidelines on the reports of 3- to 13-year-old children. A study space analysis was conducted concerning the five ground rules reviewed: (a) a statement about interviewer naïveté regarding the target events, (b) instructions to tell the interviewer when a mistake has been made, (c) cautions that some questions may be repeated, and instructions to say (d) "I don't understand" and (e) "I don't know." The results demonstrate obvious gaps in the research literature, with only the "I don't know" ground rule having received significant attention. In addition, the research reveals neither a clear lower nor upper bound on the ages at which individual ground rules improve performance. Some ground rules appear to be conceptually difficult for children (or at least difficult to implement as intended), and for these rules, practice or more thorough explanation is necessary to produce the desired effects.

The authors note that there are few studies of the ground rules that have been conducted in the field. Most of the research has been highly controlled, with some

including lengthy training packages that, in practice, would be impractical in forensic interviews and others that would be impossible in the real world (e.g., giving tokens for "correct responses"). Examination is also needed of the impact of interviewers not following a ground rule after establishing it. For example, if an interviewer delivers a ground rule (e.g., "Tell me when you don't understand") and then reject a child's attempt to use the rule (e.g., "I think you do really know"), what happens to a child's report in terms of their accuracy, motivation, and willingness to use the rule on subsequent opportunities?

In addition to exploring how individual rules impact interview performance, the authors encourage more process-oriented studies that relate developmental differences in children to the efficacy of ground rules and to the cognitive processes that underlie rule understanding and implementation. Optimally, this research should identify the most suitable format and placement of instruction in interviews and broaden to more often include field studies of child witnesses.

Faller, K. C. (2015). Forty years of forensic interviewing of children suspected of sexual abuse, 1974–2014: Historical benchmarks. *Social Sciences*, *4*(1), 34–65. https://doi.org/10.3390/socsci4010034

Type of study: Literature review
Subject of study: Overviews and summarizes the development of the forensic interviewing field over the past four decades
Location of study: United States (primarily)

Summary: This article describes the evolution of forensic interviewing as a method to determine whether or not a child has been sexually abused. It notes that forensic interviewing practices are utilized to successfully identify children who have been sexually abused and successfully exclude children who have not been sexually abused. It describes models for child sexual abuse investigation, early writings, and practices related to child interviews; and the development of forensic interview structures from scripted to semistructured to flexible. The article discusses the controversies related to appropriate questions and the use of media (e.g., anatomical dolls and drawings). It summarizes the characteristics of four important interview structures:

1. the American Professional Society on the Abuse of Children (APSAC) Practice Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse;

2. the Memorandum of Good Practice and its revision, Achieving the Best Evidence;
3. the Cornerhouse Forensic Interview Protocol known as RATAC (Rapport, Anatomy Identification, Touch Inquiry, Abuse Scenario, and Closure), and;
4. the National Institute of Child Health and Human Development (NICHD) Protocol;

and describes their impact on the field of forensic interviewing. The article describes forensic interview training and several strategies to assist with implementing training in actual practice, such as quick guides, supervisor feedback on adherence, and peer review. The article concludes with a summary of progress, remaining areas of debate, and ongoing challenges for the field of forensic interviewing, such as racial/ethnic differences in disclosure, working with very young children, and how to best apply forensic interviewing techniques in developing countries.

Newlin, C., Steele, L. C., Chamberlin, A., Anderson, J., Kenniston, J., Russell, A., Stewart, H., & Vaughan-Eden, V. (2015, September). Child forensic interviewing: Best practices. *OJJDP Juvenile Justice Bulletin*.
https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/248749.pdf

Type of study: Not a study – reports on an expert census process
Subject of study: Consolidation of current knowledge on the generally accepted best practices of those conducting forensic interviews of children in cases of alleged abuse or exposure to violence
Location of study: United States

Summary: This bulletin consolidates the current knowledge of professionals on best practices for interviewing children in cases of alleged abuse. Representatives of several major forensic interview training programs—the American Professional Society on the Abuse of Children, the CornerHouse Interagency Child Abuse Evaluation and Training Center, the Gundersen National Child Protection Training Center, the National Children's Advocacy Center, and the National Institute of Child Health and Human Development—reviewed their programs' differences and similarities. The authors discuss the purpose of the child forensic interview, provide historical context, review overall considerations, and outline each stage (rapport-building, substantive or closure) of the interview in more detail. Key discussion points include the following: 1) No two children will relate their experiences in the same way or with the same level of detail and clarity. Individual characteristics, interviewer behavior, family

relationships, community influences, and cultural and societal attitudes determine whether, when, and how they disclose abuse; 2) The literature clearly explains the dangers of repeated questioning and duplicative interviews; however, some children require more time to become comfortable with the process and the interviewer; 3) Encouraging children to give detailed responses early in the interview enhances their responses later on; 4) Forensic interviewers should use open-ended questions and should allow for silence or hesitation without moving to more focused prompts too quickly. Although such questions may encourage greater detail, they may also elicit potentially erroneous responses if the child feels compelled to reach beyond their stored memory. Interviewer tips are also provided.

Saywitz, K. J., Wells, C. R., Larson, R. P., & Hobbs, S. D. (2019). Effects of interviewer support on children's memory and suggestibility: Systematic review and meta-analyses of experimental research. *Trauma, Violence, & Abuse*, *20*(1), 22–39. https://doi.org/10.1177/1524838016683457

Type of study: Literature review and meta-analyses
Subject of study: Reviews findings from multiple studies of the impact of interviewer supportiveness on the accuracy of children's reports
Location of study: Not specified – Studies were published in English in peer-reviewed journals. No location-based exclusion criteria are mentioned.

Summary:
The accuracy of children's reports of abuse has been hotly debated in the press, academia, and the courtroom. Yet, children's accuracy depends, in part, on the context in which the children are interviewed. Guidelines often recommend creating a supportive psychosocial context to promote open, honest responding; however, there is also concern that support promotes social desirability and acquiescence to suggestion, leading children to report more of what they perceive adults want to hear than the truth. The question remains as to whether there is a sufficient body of scientific research to determine whether interviewer supportiveness (e.g., a provision of warmth, smiling, friendliness, eye contact, interest, open-body posture, positive feedback, using the interviewee's first name) improves interview outcomes while minimizing children's stress or whether it increases suggestibility and impairs accuracy. Using a systematic search strategy and meta-analyses, this study identifies and reviews findings from experimental studies of the effects of interviewer supportiveness on the accuracy of children's reports. Although the number of studies

in the evidence base is small (n = 15), the studies are of relatively good quality. Both the literature review and the meta-analyses results suggest noncontingent interviewer support bolsters children's accuracy. Children are more resistant and less acquiescent to suggestive questions when interviewers are supportive as compared to nonsupportive or neutral. Effects are in the moderate range. Interviewer support is also associated with fewer errors on nonsuggestive questions.

The bulk of the evidence suggests that interviewers can be supportive without being suggestive and that supportive interviewing aids children's accuracy and productivity, provided it is not contingent on the content of children's responses. Generalizability from this evidence base to real-world cases is limited by the fact that this literature is heavily focused on young children recounting nontraumatic events over short delays, and relatively mild manipulations of nonsupport conditions. Gaps in the literature include that few studies examine age differences in support effects, attempt to assess what role children's perceptions (perceived support) play, or identify the critical elements of supportive and nonsupportive conditions contribute to support effects.

4 | Victim Support & Advocacy

Cascardi, M., Brown, C., Shpiegel, S. & Alvarez, A. (2015). Where have we been and where are we going? A conceptual framework for child advocacy. *Sage Open*. https://doi.org/10.1177/2158244015576763

Type of article: Review article
Subject of article: Reviews the development of child advocacy as an interdisciplinary field of study and provides a conceptual framework for future research efforts
Location: Not applicable

Summary: This article charts the development of child advocacy as a field of study to understand its focus on protection needs. It identifies tensions in child advocacy regarding children's protection, rights, and values, and describes strategies for reconciliation; and it offers a conceptual framework of child advocacy to inform research and education. Historically, child advocacy has justifiably focused on protection needs. Values and assumptions about children's best interests have also governed child advocacy, in part because evidence to inform decisions was lacking, and in part because of its history as an activist movement. Against this historical backdrop, the article describes contemporary trends in child advocacy that reconcile children's protection with their inherent rights to personhood, relying on the principles and articles of the United Nations Convention on the Rights of the Child, most notably children's rights to participation and self-expression. The article also demonstrates how values and ideology are being integrated with empiricism and objective analysis to inform policy and practice in child advocacy. The future of child advocacy depends on continued synthesis of rights and protection, as well as values and rigorous analysis. From this perspective, the authors propose a conceptual framework for research and education in child advocacy.

Herbert, J. L., & Bromfield, L. (2016). Evidence for the efficacy of the child advocacy center model: A systematic review. *Trauma, Violence, & Abuse, 17*(3), 341–357. https://doi.org/10.1177/1524838015585319

Type of article: Systematic review
Subject of article: Reviews the research base for the CAC model
Location: Not applicable – no location criteria used in the search process

Summary: The Children's Advocacy Center (CAC) model has been presented as the solution to many of the problems inherent in responses by authorities to child sexual abuse. The lack of referral to therapeutic services and support, procedurally flawed and potentially traumatic investigation practices, and conflict between the different statutory agencies involved are all thought to contribute to low conviction rates for abuse and poor outcomes for children. The CAC model aims to address these problems through a combination of multidisciplinary teams, joint investigations, and services, all provided in a single child-friendly environment. Using a systematic search strategy, this research aimed to identify and review all studies that have evaluated the effectiveness of the approach as a whole, in order to understand what study designs were being used to evaluate effectiveness of CACs and to determine the evidence that exists for the efficacy of the CAC model, while recognizing that a separate evidence base exists for parts of the approach (e.g., victim advocacy and therapeutic responses). The review found that while the criminal justice outcomes of the model have been well-studied, there was a lack of research on the effect of the model on child and family outcomes. Out of 27 articles utilized in this review, 19 were focused on criminal justice outcomes (testing the effect of the approach on improving disclosures, arrests, decisions to prosecute, convictions, and reducing revictimization). Another body of evidence focused on service user satisfaction, particularly on how children and nonoffending caregivers felt about the investigation and aspects of service delivery at the CAC (n = 9). Much less evidence existed for outcomes related to child trauma, in terms of their recovery both from abuse and from the systemic trauma from the investigation (n = 3). A small number of studies also addressed family functioning (n = 2). In total, only half of the studies involved comparison against a control group. None of the studies examining the impact of CACs on child and family outcomes involved a non-CAC comparison group. Overall, the review suggests that the CAC model appears to increase the availability of types of practices (e.g., forensic interviews, medical examinations, referral to counselling, treatment for sexually transmitted infections [STIs]) that are assumed to lead to positive outcomes but that research into these subsequent outcomes is limited. Although some modest outcomes were clear, the lack of empirical research and overreliance on measuring program outputs, rather than outcomes, suggests that some clarification of the goals of the CAC model is needed and that there is a clear need for more rigorous empirical research of the CAC model, particularly on the impact of the services on child trauma symptoms, both in terms of therapeutic interventions, and to demonstrate reduced child trauma resulting from coordinated/co-located services.

Letson, M, Davis, C., Sherfield, J., Beer, O., Phillips, R. & Wolf, K. (in press). Identifying compassion satisfaction, burn-out, & traumatic stress in children's advocacy centers. *Child Abuse & Neglect*. https://doi.org/10.1016/j.chiabu.2019.104240

Type of article: Research – cross-sectional survey
Subject of article: Surveys child abuse professionals working in CAC settings across the United States to examine compassion satisfaction, burnout, and secondary traumatic stress (STS); identifies work and worker characteristics that may impact compassion satisfaction, burnout, and STS; understands professional and personal impacts of occupational stress; and explores coping responses
Location: United States

Summary: Due to the lack of research specific to CAC professionals, very little is known about how best to create a CAC work environment that facilitates reduction and prevention of compassion fatigue and burnout. Furthermore, the multiple unique roles and responsibilities of the CAC multidisciplinary team (MDT) necessitate a nuanced understanding of the differential impact of compassion fatigue, STS, and burnout across team members. The objectives of this study were to use the *Professional Quality of Life (ProQOL)* tool to measure compassion satisfaction, burnout, and STS among child abuse professionals working in a CAC setting and to identify work and worker characteristics that may contribute to or alleviate the experience of compassion fatigue, burnout, and STS. This study also sought to understand the professional and personal impact of work-related stress on CAC professionals while exploring how these professionals coped with work-related stress. Subjects were child abuse professionals working in CAC settings recruited through the National Children's Alliance (NCA) and Ray E. Helfer Society Listservs. A total of 885 participants fully completed the survey (mean age = 42.07 years; 85% female). The study sample was geographically diverse and represented all MDT member roles.

Overall, mean scores were average for compassion satisfaction, high average for burnout, and higher than the ninetieth percentile for STS. All three scales differed significantly by MDT professional role and employment length. Child welfare workers had significantly higher burnout scores than all other professions, including those with multiple professional roles, except law enforcement and prosecutors. They also had significantly lower compassion satisfaction scores than most others, even after

controlling for demographics, employment length, on-call status, and caseload. After controlling for all other factors, being in any child abuse profession for 11–19 years resulted in significantly lower compassion satisfaction scores, significantly higher burnout, and significantly higher STS scores compared to those in any child abuse profession for over 20 years. Furthermore, any child abuse professional that provided on-call services had significantly higher burnout than those who did not provide on-call services; this is a particularly key finding given the frequent use of on-call services in CACs. Although the majority of the experiences identified were universal, variation in certain findings was also present across the professional roles represented. The unique aspects of various professional roles, and the subsequent effects of performing these roles, highlight the importance of multiple method approaches for future studies focusing on these phenomena. These results contribute to the field's understanding of MDT professions who might be at higher risk for burnout and STS and help inform future interventions to support the MDT. Limitations include the unknown representativeness of the sample.

Nathanson, R., & Saywitz, K. J. (2015). Preparing children for court: Effects of a model court education program on children's anticipatory anxiety. *Behavioral Sciences and the Law, 33*, 459–475. https://doi.org/10.1002/bsl.2191

Type of article: One-group pretest-posttest study
Subject of article: Examines the effect of pretrial education programs on anticipatory anxiety of children and adolescents awaiting criminal or dependency court appearances
Location: Las Vegas, NV

Summary: This study examined whether a pretrial preparation program, consisting of legal knowledge education, stress inoculation training, and a mock trial, is associated with decreased anticipatory anxiety of child witnesses. The group studied included 193 youth ages 4–17 years who were awaiting impending legal proceedings and attended Kids' Court School (KCS) one to two weeks before their court appearances. The group-based program includes three components: (1) court education about pretrial and trial processes and the roles and functions of courtroom participants, (2) stress reduction training, and (3) a mock trial in a moot courtroom with practice answering questions and using stress reduction strategies to promote generalization. Utilizing *The Court-Related Stress Scale-Revised (CRSS-R)*, participants completed a measure of anticipatory court-related anxiety before and after the intervention.

Children rated the overall court-related experience (total score) as significantly less stressful after attending KCS. As predicted, children's anticipatory court-related anxiety decreased significantly after participation in KCS. Results also found that there was a significant interaction of age with time (pretest and posttest). The very youngest children demonstrated the smallest effect sizes. There was also a nonsignificant trend towards very young children expressing less pre-preparation stress than older children. Further research with preschoolers is clearly needed to conduct preparation that prepares children to cope with the challenges they will face in the courtroom without inadvertently raising their anxiety by discussing possibilities they had not yet imagined. Results demonstrate the promise of a brief, unbiased, standardized program for reducing system-induced stress on child witnesses, while maintaining the integrity of the legal process. Further research investigating individual differences, such as developmental disability, mental health symptomatology, attachment status, and temperament, could be instrumental in maximizing the benefits of a pretrial preparation program.

Vanderzee, K., Pemberton, J., Conners-Burrow, N., & Kramer, T. (2016). Who is advocating for children under six? Uncovering unmet needs in child advocacy centers. *Children and Youth Services Review, 61,* 303–310. https://doi.org/10.1016/j.childyouth.2016.01.003

Type of article: Research – mixed-methods study using administrative data from state records and qualitative interviews with CAC advocates
Subject of article: Interviews advocates at CACs who were interviewed regarding their perceptions of their work with young children, their unmet needs in working with very young children, and how it differs from their work with older children and their families
Location: Arkansas

Summary: Evidence suggests that children under the age of 6 years are affected by trauma, yet there are few studies available to determine how well their needs are addressed in the mental health system. Children's Advocacy Centers (CACs) offer a promising avenue for expanding the system of care for very young children exposed to sexual and/or physical abuse. This study used a mixed-methods approach to examine the type and extent of CAC services for very young children in one state. Results from a state-level administrative data system revealed that most children were visiting the CAC related to an allegation of sexual abuse. In-person interviews with

CAC advocates were coded for the following domains: process, community messages, referral process for mental health services, treatment attitudes, perceived effects of trauma (which included two sub codes: parent perceptions and advocate perceptions), mental health training, and emotional toll. Results suggest that advocates have variable perceptions regarding the effects of trauma on young children, and they do not consistently receive training in the mental health needs of traumatized children under 6. Study results both confirm the need for an expanded system of service delivery for the youngest and most vulnerable child maltreatment victim and suggest significant effort is needed to increase the knowledge and training provided to CAC advocates related to the effects of trauma and subsequent mental health needs among very young children.

Young, T. H., Williams, J., & Nelson-Gardell, D. (2014). Family victim advocates: The importance of critical job duties. *Psicologia: Teoria e Pesquisa*, *30*(4), 393–400. http://www.scielo.br/scielo.php?pid=S0102-37722014000400004&script=sci_arttext

Type of article: Research - cross-sectional online survey
Subject of article: Surveys CAC directors and family victim advocates employed in Children's Advocacy Centers about the specific services provided by family victim advocates and how they rated the importance of their job duties.
Location: United States

Summary: Children's Advocacy Centers (CACs) across the United States intervened in more than 250,000 child abuse cases in 2011. Understanding the work of family victim advocates is imperative to helping children and families in child abuse cases. This study surveyed advocates and program directors from CACs across the United States to compare their perceptions of the critical job duties of family victim advocates, based upon the job duties for family victim advocates identified by National Children's Alliance. Recruitment for the web-based survey was done through emailed invitations from regional CAC directors to the CAC directors in their regions. Each job duty was rated on a scale from 4 (very important) to 0 (unimportant). Data analysis revealed that CAC directors rated the importance of these duties significantly higher than family victim advocates. Results suggest that CAC directors may need to provide more oversight and training to advocates in order to convey understanding about which services are more important and why. Being able to discern the importance of job duties is critical when making decisions related to service provision, especially when time and agency personnel are limited. Limitations include

the low response rate for the survey and the use of contacted advocates in some CACs.

5 | Medical Evaluation

Adams, J. A., Farst, K. J., & Kellogg, N. D. (2018). Interpretation of medical findings in suspected child sexual abuse: An update for 2018. *Journal of Pediatric and Adolescent Gynecology*, *31*(3), 225–231. https://doi.org/10.1016/j.jpag.2017.12.011

Type of article: Review article summarizing new data and recommendations
Subject of article: Updates to the 2016 guidelines for the medical assessment and care of children who might have been sexually abused
Location: Not applicable

Summary: Most sexually abused children will not have signs of genital or anal injury, especially when examined nonacutely. A recent study reported that only 2.2% (26 of 1160) of sexually abused girls examined nonacutely had diagnostic physical findings, whereas among those examined acutely, the prevalence of injuries was 21.4% (73 of 340). It is important for healthcare professionals who examine children who might have been sexually abused to be able to recognize and interpret any physical signs or laboratory results that might be found. This review summarizes new data, recommendations, and updates to the 2016 guidelines. The main changes are in the sections discussing examination documentation, testing for sexually transmitted infections (STIs), and the interpretation of medical and laboratory findings. A recent survey of physicians with experience in child sexual abuse evaluation indicates that there appears to be 80-100% agreement with all but one of the current interpretations. The finding of a deep notch in the posterior hymen is still an inconclusive finding, with no expert consensus as to the degree of significance with respect to abuse. There is also new evidence that viewers of video recordings, as opposed to still photos of examination findings, showed significantly greater agreement with the examining clinician as to the diagnosis of a hymen transection. These results suggest that videography, as opposed to still photographs, might be a preferred method for documenting findings in cases of child sexual abuse. When screening for STIs in prepubertal and adolescent girls who present with suspected sexual abuse, nucleic acid amplification tests (NAAT) on "dirty" urine samples have proved superior to vaginal cultures. This method will likely also be more sensitive in diagnosing *T. vaginalis*, because newer tests are now available. Confirmation testing using an alternate target NAAT remains important for cases in which the result could have forensic significance. The table listing an approach to the interpretation of medical and laboratory findings in child sexual abuse has also been revised slightly,

mainly by clarifying the description of findings, separating physical findings into acute and nonacute types, and listing laboratory findings separately.

Crawford-Jakubiak, J. E., Alderman, E. M., Leventhal, J. M., & Committee on Child Abuse and Neglect. (2017). Care of the adolescent after an acute sexual assault. *Pediatrics*, *139*(3), Article e20164243. https://doi.org/10.1542/peds.2016-4243

Type of article: Not a study – clinical report providing guidance for the clinician in rendering pediatric care
Subject of article: Provides guidance on the acute assessment and care of adolescent victims who have experienced a recent sexual assault, including follow-up of the acute assault, as well as prevention of sexual assault
Location: Not applicable – from the American Academy of Pediatrics

Summary: Sexual violence is a broad term that encompasses a wide range of sexual victimizations. Since the American Academy of Pediatrics published its last policy statement on sexual assault in 2008, additional information and data have emerged about the effects of sexual violence on adolescents and the treatment and management of the adolescent who has been a victim of sexual assault. This report provides new information to update physicians and focuses on the acute assessment and care of adolescent victims who have experienced a recent sexual assault. (This report does not address sexual abuse of young children or abuse that might be disclosed long after it occurred.) Follow-up of the acute assault, as well as prevention of sexual assault, are also discussed.

Key guidelines in the report include 1) routinely asking adolescents about sexual violence, dating violence, and sexual assault; 2) being aware of the current reporting requirements related to sexual assault; 3) being knowledgeable about the resources available in their own communities, as well as when and where to refer for forensic and other services; 4) being familiar with the CDC guidelines for care of survivors of sexual assault, or referring to an appropriate provider; 5) providing appropriate sexually transmitted infection (STI) screening, HIV Post-exposure Prophylaxis (PEP) treatment, and follow-up according to CDC guidelines; 6) offering emergency contraception when appropriate; 7) considering the possibility that "date rape" drugs may have been used in the context of an assault; 8) being prepared to offer emotional support as well as referrals for more comprehensive mental healthcare in

their communities; and 9) working with schools, law enforcement, and local communities to support evidence-based sexual violence prevention activities.

Kellogg, N. D., Melville, J. D., Lukefahr, J. L., Nienow, S. M., & Russell, E. L. (2018). Genital and extragenital gonorrhea and chlamydia in children and adolescents evaluated for sexual abuse. *Pediatric Emergency Care*, *34*(11), 761–766. https://doi.org/10.1097/PEC.0000000000001014

Type of article: Retrospective medical record review
Subject of article: Reviews diagnosis of genital and extragenital *Neisseria gonorrhoeae* (NG) and *Chlamydia trachomatis* (CT) in children and adolescents assessed for sexual abuse/assault and the concordance of patient history and examination factors relating to sexual abuse or contact
Location: Location not specified – listed as a children's hospital emergency department and an affiliated outpatient sexual abuse assessment center

Summary: This study describes the use of a nucleic acid amplification test in detecting genital and extragenital NG and CT in children and adolescents assessed for sexual abuse/assault. The charts of children aged 0 – 17 years, consecutively evaluated for sexual victimization in emergency department and outpatient settings were reviewed. Data extracted included age, sex, type of sexual contact, anogenital findings, previous sexual contact, toxicology results, and sites tested for NG and CT. Of the 1319 patients who were tested, 579 were tested at more than one site, and 120 had at least one infected site. CT was identified in 104 patients, and NG was found in 33. In bivariate analysis, a positive test was associated with female sex, age older than 11 years, previous sexual contact, acute or healed genital injury, drug/alcohol intoxication, and examination within 72 hours of sexual contact. Fifty-one patients had positive anal tests, and 24 had positive oral tests. More than 75% of patients with positive extragenital tests had additional positive tests or anogenital injury. Most with a positive anal (59%) or oral (77%) test did not report that the assailant's genitals came into contact with that site. Positive tests for NG and CT in patients evaluated for sexual victimization may represent infection from sexual contact, contiguous spread of infection, or the presence of infected assailant secretions. Relying on patient reports of symptoms, or types of sexual contact, to determine need for testing may cause NG and CT infections in patients evaluated for sexual victimization to be missed.

Killough, E., Spector, L., Moffatt, M., Wiebe, J., Nielsen-Parker, M., & Anderst, J. (2016). Diagnostic agreement when comparing still and video imaging for the medical evaluation of child sexual abuse. *Child Abuse & Neglect*, *52*, 102–109. https://doi.org/10.1016/j.chiabu.2015.12.007

Type of article: Prospective quasi-experimental study
Subject of article: Studies the impact of imaging modality on the diagnostic agreement of participants regarding presence/absence of findings indicating penetrative trauma on nonacute postpubertal genital exams
Location: Kansas City, MO

Summary: Still photo imaging is often used in medical evaluations of child sexual abuse (CSA) but video imaging may be superior. The authors aimed to compare still images to videos with respect to diagnostic agreement regarding hymenal deep notches and transections in postpubertal females. Additionally, they evaluated the role of experience and expertise on agreement. The authors hypothesized that videos would result in improved diagnostic agreement of multiple evaluators as compared to still photos. Participants were medical personnel who regularly perform CSA exams. Diagnostic agreement was evaluated utilizing a retrospective selection of videos and still photos obtained directly from the videos. Videos and still photos were embedded into an online survey as 16 cases. 116 participants completed the study. Participant diagnosis was more likely to agree with study center diagnosis when using video ($p < 0.01$). Use of video resulted in statistically significant changes in diagnosis in four of eight cases. In two cases, the diagnosis of the majority of participants changed from no hymenal transection to transection present. No difference in agreement was found based on experience or expertise. Use of video versus still images resulted in increased agreement with original examiner and changes in diagnostic impressions in review of CSA exams. Further study is warranted, as video imaging may have significant impacts on diagnosis.

Smith, T. D., Raman, S. R., Madigan, S., Waldman, J., & Shouldice, M. (2018). Anogenital findings in 3569 pediatric examinations for sexual abuse/assault. *Journal of Pediatric and Adolescent Gynecology*, *31*(2), 79–83. https://doi.org/10.1016/j.jpag.2017.10.006

Type of article: Cross-sectional study – retrospective chart review

Subject of article: Anogenital findings among children and adolescents evaluated for suspected sexual abuse/assault
Location: Toronto, Ontario, Canada

Summary: Accurate interpretation of anogenital examination findings in the context of suspected child and adolescent sexual abuse/assault is essential, because misinterpretation has significant child protection and criminal justice implications. A consensus approach to the interpretation of anogenital examination findings is widely used to support accurate diagnosis; however, a large-scale study using this standardized approach is lacking. This study (a) determined the proportion of anogenital examinations for sexual abuse concerns with findings diagnostic of trauma and/or sexual contact; (b) determined whether frequency of diagnostic findings varies according to age, gender, and timing of examination; and (c) characterized diagnostic findings. Retrospective records of children aged 0–18 years evaluated for sexual abuse/assault were reviewed. Case details of 3569 patients were extracted and anogenital examination findings were reinterpreted using a published consensus approach. Anogenital examination findings diagnostic of trauma and/or sexual contact were present in 173 of 3569 patients (4.8%). The prevalence of diagnostic findings was significantly higher in adolescents than in children younger than 12 years of age (13.9%, 114/823 vs. 2.2%, 59/2657), in female patients than male patients (5.7%, 164/2866 vs. 1.5%, 9/614), and in examinations within 72 hours for children younger than 12 years (14.2%, 91/643 vs. 4.5%, 45/997). Acute injuries were the most common type of diagnostic finding.

As diagnostic findings were present in a small proportion of children and adolescents examined for suspected sexual abuse/assault, it is essential that practitioners who interpret examination findings be adequately trained and familiar with the current consensus approach and are aware of case characteristics associated with higher likelihood of findings. Limitations include changes to the consensus approach over time and the retrospective chart review nature of the study.

6 | Mental Health

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., Revillion Cox, J., & Amaya-Jackson, L. (2017). Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 46*(3), 303–330. https://doi.org/10.1080/15374416.2016.1220309

Type of article: Literature review
Subject of article: Examines the evidence for the treatment of symptoms related to child trauma exposure, focusing on studies that assessed participants for both trauma exposure (experienced or witnessed) and mental health symptom impact (e.g., elevation on some indicator of mental health problems)
Location: Not applicable – no location specific review criteria

Summary: Child and adolescent trauma exposure is prevalent, with trauma exposure-related symptoms, including posttraumatic stress, depressive, and anxiety symptoms often causing substantial impairment. This article updates the evidence base on psychosocial treatments for child and adolescent trauma exposure completed by Silverman et al. (2008). For this review, the authors focus on 37 studies conducted during the seven years since the last review. Treatments are grouped by overall treatment family (e.g., cognitive-behavioral therapy [CBT]), treatment modality (e.g., individual vs. group), and treatment participants (e.g., child only vs. child and parent). All studies were evaluated for methodological rigor according to *Journal of Clinical Child & Adolescent Psychology* evidence-based treatment evaluation criteria (Southam-Gerow & Prinstein, 2014), with cumulative designations for level of support for each treatment family. The strongest evidence base was found for individual CBT with parent involvement, individual CBT, and group CBT. These three treatment categories were deemed *Level 1 – Well-established*, meaning that at least two randomized controlled trials had shown them to be effective. Group CBT with parent involvement and Eye Movement Desensitization and Reprocessing (EMDR) were deemed Level 2 – *Probably efficacious*, while individual integrated therapy for complex trauma and group mind-body skills were deemed as Level 3 – *Possibly efficacious*. Individual client-centered play therapy, individual mind-body skills, and individual psychoanalysis were all deemed Level 4 – *Experimental*, due a lack of research evidence. Finally, group creative expressive + CBT was deemed Level 5 –

Questionable efficacy, due to studies showing it produces no beneficial effect. The results provide continued evidence for CBT as the recommended first-line trauma treatment approach.
Almost all of the individual interventions within the well-established treatment families, the highest evidentiary category, included some combination of these six elements: (a) psychoeducation about trauma prevalence, impact, and the intervention; (b) training in emotion regulation strategies (e.g., relaxation, identification of emotion, cognitive coping); (c) imaginal exposure; (d) in vivo exposure; (e) cognitive processing; and/or (f) problem solving. However, the specific emphasis of the individual interventions varied. Findings from the review also suggest that within the broad treatment category of CBT, providers, organizations, and policymakers likely have substantial room to incorporate provider and client choice about which particular treatment to use within trauma-focused CBTs.

The review suggests that including parents and other caregivers in treatment is still empirically supported; however, two of the three well-established treatment families in this review included minimal or no parent involvement (at least for children 7 and older), with relatively similar outcomes. This finding offers some hope for situations in which parent involvement is challenging (e.g., school-based services). The analyses also provide some guidance regarding when treatment should include parents, including when children are young (ages 3–6), when children have behavioral problems, when parents were perpetrators themselves, and when parents have their own mental health problems and/or unhelpful trauma-related beliefs. Findings from the studies reviewed also suggest that explicit exposure (imaginal, in vivo, or both) may not be necessary for treatment to be successful. Both parent involvement and inclusion of explicit exposure need further study before a definitive determination can be made. Limitations of the review include small sample sizes, particularly for culturally diverse groups, analytic issues with the studies—such as not using intent to treat analyses—and reporting effect sizes.

Fong, H. F., Bennett, C. E., Mondestin, V., Scribano, P. V., Mollen, C., & Wood, J. N. (2016). Caregiver perceptions about mental health services after child sexual abuse. *Child Abuse & Neglect, 51,* 284–294. https://doi.org/10.1016/j.chiabu.2015.09.009

Type of article: Research – cross-sectional mixed methods study

Subject of article: Examines caregiver perceptions about mental health services and explores factors that affected whether their children linked to services after child sexual abuse
Location: Philadelphia, Pennsylvania

Summary: The objective of this study was to describe caregiver perceptions about mental health services (MHS) after child sexual abuse (CSA) and to explore factors that affected whether their children linked to services. The authors conducted semi-structured, in-person interviews with nonoffending caregivers of suspected CSA victims (< 13 years old) seen at a Children's Advocacy Center in Philadelphia. Guided by the Health Belief Model framework, interviews assessed perceptions about CSA severity, the child's susceptibility for adverse outcomes, the benefits of MHS, and the facilitators and barriers to MHS. Caregivers expressed strong reactions to CSA and multiple concerns about adverse child outcomes. Most caregivers reported that MHS were generally necessary for children after CSA. Caregivers who had not linked to MHS, however, believed MHS were not necessary for their children—most commonly because they were not exhibiting behavioral symptoms. Caregivers described multiple access barriers to MHS, but caregivers who had not linked reported that they could have overcome these barriers if they believed MHS were necessary for their children. Caregivers who had not linked to services also expressed concerns about MHS being retraumatizing and stigmatizing. Interventions to increase MHS linkage should focus on improving communication with caregivers about the specific benefits of MHS for their children and proactively addressing caregiver concerns about MHS. Limitations include the small sample size, which was predominantly Black and female, and the varying degrees of service utilization in the linked group, from participation in an intake session to completion of therapy.

Ormhaug, S. M., & Jensen, T. K. (2016). Investigating treatment characteristics and first-session relationship variables as predictors of dropout in the treatment of traumatized youth. *Psychotherapy Research, 28*(2), 235–249. https://doi.org/10.1080/10503307.2016.1189617

Type of article: Research – randomized controlled trial
Subject of article: Examines treatment and first-session process variables as predictors of treatment dropout among traumatized youth
Location: Norway

Summary: Attrition is a common problem in youth trauma treatment, but there is currently little knowledge of why so many youths drop out. In this study, treatment variables (caregiver attendance in the first session and exposure- vs. non-exposure-based treatment) and first-session process variables (the therapeutic alliance and youths' perceptions of parental treatment approval) were investigated as predictors of dropout. Participants (N = 156, mean age = 15.1 years) were randomly assigned to trauma-focused cognitive-behavioral therapy or therapy as usual in a community trial. Measures included the *Child Posttraumatic Symptom Scale (CPSS)*, the *Child and Adolescent-Perceived Parental Approval of Therapy Scale (CAPPATS)*, and the *Therapeutic Alliance Scale for Children (TASC-R)*, along with administrative data. Dropout (n = 39, 25.0%) was predicted by a lack of caregiver attendance, lower rates of youth-perceived parental treatment approval, and weaker therapist-rated youth alliance. Results showed that neither type of treatment, youth-rated alliance nor caregiver-rated alliance predicted dropout. The findings indicate that, in addition to caregivers' actual participation in the first session, youths' perception of their parents' approval of treatment seems to influence treatment attendance. This finding implies that therapists should engage caregivers in therapy immediately and address possible discordance in treatment goals and tasks. Furthermore, consistent with findings from adult studies, exposure-based treatments do not appear to increase dropout rates. Limitations include missing data, analytic issues related to the nesting of clients within therapists, and the lack of data on the caregivers' own reported approval of the treatment.

Simon, V. A., Barnett, D., Smith, E., Mucka, L., & Willis, D. (2017). Caregivers' abuse stigmatization and their views of mental health treatment following child sexual abuse. *Child Abuse & Neglect, 70,* 331–341.
https://doi.org/10.1016/j.chiabu.2017.06.024

Type of article: Descriptive – cross-sectional, one group study
Subject of article: Examines the relationship between nonoffending caregivers' abuse stigmatization and their motivation for, and perceived obstacles to, mental health service utilization
Location: Urban, Midwestern United States

Summary: Many families do not utilize mental health services after the discovery of child sexual abuse (CSA), even when trauma-focused treatments are offered at low or no cost. Nonoffending caregivers frequently serve as gatekeepers to youths'

treatment, and their reactions to CSA may figure into decisions about treatment engagement. The current study examined both caregivers' abuse stigmatization (i.e., self-blame and shame about their children's CSA) and associations with two factors predictive of treatment engagement (motivation, obstacles). Participants were recruited from a Children's Advocacy Center where they received forensic interviews and were offered services following CSA discovery. Participating caregiver–child pairs included 52 nonoffending caregivers (83% biological parents) and their children (69% girls; Mean age = 10.94 years [SD = 2.62]). Measures included the *Parent Motivation Inventory (PMI)* and the *Obstacles to Engagement Scale (OES)*.

Caregiver abuse stigmatization was associated with higher motivation for treatment but also more obstacles to treatment. Further, abuse stigmatization moderated associations between children's posttraumatic stress disorder (PTSD) symptoms and perceived obstacles to treatment. Among caregivers experiencing high abuse stigmatization, greater child PTSD symptoms were associated with more obstacles to treatment. Among caregivers experiencing low stigmatization, child PTSD was either associated with fewer treatment obstacles or was unrelated to treatment obstacles. For caregivers who felt stigmatized and had symptomatic children, the most salient obstacles did not appear to be the practical barriers that CACs often address through low/no-cost treatment, transportation assistance, or in-home services. Rather, they were concerns about whether therapy was relevant to them, the process and consequences of personal disclosures, and the other stressors in their lives. Acknowledging and addressing feelings of shame and attributions of self-blame could help caregivers cope with their own distress and better support their children.

A unilateral approach treatment referral for families with newly discovered cases of CSA may be less than optimal for insuring youth receive needed services. Caregivers' responses to their children's CSA have significant implications for parenting and child adjustment, and additional research is needed to understand which caregivers are most vulnerable to abuse stigmatization following the discovery of their children's CSA. This study highlights the need to screen caregivers for abuse stigmatization in order to bridge the gap to mental health services, especially for more symptomatic youth.

Zajac, K., Ralston, M. E., & Smith, D. W. (2015). Maternal support following childhood sexual abuse: Associations with children's adjustment postdisclosure and at 9-month

follow-up. *Child Abuse & Neglect, 44,* 66–75. https://doi.org/10.1016/j.chiabu.2015.02.011

Type of article: Research – longitudinal cohort study
Subject of article: Examines both child and mother-rated maternal support as predictors of children's adjustment soon after abuse disclosure and nine months later
Location: United States

Summary: Maternal support has been widely cited as an important predictor of children's adjustment following disclosure of sexual abuse. However, few studies have examined these effects longitudinally. The current study examines the relationships between a multidimensional assessment of maternal support rated by both mothers and children, and children's adjustment in various domains (internalizing, externalizing, anger, depression, and posttraumatic stress disorder symptoms) concurrently and longitudinally. Participants were 118 mother–child dyads recruited from a Children's Advocacy Center where children were determined through a forensic evaluation to be victims of sexual abuse. Child and mother ratings of maternal support and child adjustment were collected shortly after the forensic evaluation and at 9-month follow-up. Measures included the *Maternal Self-Report Support Questionnaire (MSSQ)*, the *Maternal Support Questionnaire-Child Report (MSQ-CR)*, *Child Behavior Checklist (CBCL)*, and the *Trauma Symptom Checklist for Children (TSCC)*.

Results were consistent with findings from past studies that maternal support is significantly related to children's postdisclosure adjustment and extends these findings longitudinally. Child ratings of maternal support were primarily related to child adjustment outcomes at time 1 and were only significantly related to child-rated outcomes (e.g., PTSD, depression, and anger). These findings suggest that children's perceptions of maternal support are relatively specific to the time point at which they are obtained and to their self-assessment of adjustment problems, rather than those rated by their mothers. Mothers' ratings of maternal support followed a similar pattern, with the strongest associations seen at time 1 and with mother ratings of child adjustment. An important contribution of the current study is the use of a multidimensional abuse-specific measure of maternal support that can be rated by both mothers and children. Assessment of multiple aspects of maternal support has proven to be important, as various maternal behaviors were shown to be differentially related to child outcomes. The study also suggests the importance of using both child and mother ratings of maternal support in both clinical practice and future

research. Limitations include the high attrition rate between time 1 and time 2, the low recruitment rate for eligible participants, and concerns about the maternal support measurement tools.

7 | Case Review

Hahlweg, P., Didi, S., Kriston, L., Härter, M., Nestoriuc, Y., & Scholl, I. (2017). Process quality of decision making in multidisciplinary cancer team meetings: A structured observational study. *BMC Cancer*, *17*, Article 772. https://doi.org/10.1186/s12885-017-3768-5

Type of article: Cross-sectional observational study
Subject of article: Studies the quality of decision-making processes used in multidisciplinary team meetings and their relationship to treatment recommendations
Location: Hamburg, Germany

Summary: The quality of decision making in multidisciplinary team meetings (MDTMs) depends on the quality of information presented and the quality of team processes. Few studies have examined these factors using a standardized approach. The aim of this study was to objectively document the processes involved in decision making in MDTMs, document the outcomes in terms of whether a treatment recommendation was given (none vs. singular vs. multiple), and identify factors related to type of treatment recommendation. A standardized tool was used to assess the quality of the presented information and team processes in 29 MDTMs and 249 cases. Results showed that, while cancer-specific medical information was judged to be of high quality, psychosocial information and information regarding patient views were considered to be of low quality, or not presented at all. Treatment recommendations were thus impeded by physicians having insufficient knowledge about the patient, patient's family status, their treatment preferences, and psychological distress. As far as treatment recommendations are concerned, none were given in 25% of the cases, one was given in 64%, and more than one was given in 10% (with 1% missing data). Giving no treatment recommendation was associated with duration of case discussion, duration of the MDTM session, quality of case history, quality of radiological information, and specialization of the MDTM. Higher levels of medical and treatment uncertainty during discussions were found to be associated with a higher probability for more than one treatment recommendation. The quality of different aspects of information was observed to differ greatly. In general, the study did not find MDTMs to be in line with the principles of patient-centered care. The recommendation outcome varied substantially between different specializations of MDTMs. The quality of certain information was associated with the

recommendation outcome. The authors suggest a patient advocate (e.g., nursing staff) be present at MDTMs to increase input of the patient's perspective into the MDTMs. Uncertainty during discussions was related to more than one recommendation being considered. Time constraints (e.g., duration of session and duration of case discussion) were found to play an important role. Some of those aspects seem modifiable, which offers possibilities for the reorganization of MDTMs.

Herbert, J. L., & Bromfield, L. (2019). Multi-disciplinary teams responding to child abuse: Common features and assumptions. *Children and Youth Services Review*, *106*, Article 104467. https://doi.org/10.1016/j.childyouth.2019.104467

Type of article: Review article
Subject of article: Presents a collective program logic model for multi-disciplinary teams responding to child abuse
Location: Not applicable

Summary: The physical and sexual abuse of children is a complex social issue that often requires a multidisciplinary response—an alliance between police, child welfare authorities, mental health practitioners, medical examiners, and advocates for children and their nonabusive caregivers. Previously published reviews have identified deficits in the rationale for multidisciplinary approaches to child abuse, particularly between the intention of systems to address the well-being of children postdisclosure, and their design, which overwhelmingly focuses on the needs of the criminal justice system. This article aims to present a program logic (see Figure 1 below) that reflects the collective rationale in use among multidisciplinary teams responding to child abuse. The program logic was developed from the results of a series of systematic literature searches on multidisciplinary teams. The findings of each of the reviews were examined to identify and categorize across studies the factors that enable (a) the delivery of the program, (b) activities that constitute the program, (c) program mechanisms (how the activities are expected to change things), and (d) expected outcomes—each of which are described in detail in the paper. The logic highlights that the rationale for multidisciplinary teams relies heavily on referral to external services and programs to improve the well-being of children and families affected by abuse. This article adds to the conceptual development, planning, and evaluation of multidisciplinary teams by elucidating common assumptions about the connection between mechanisms and outcomes across approaches. It also suggests that underlying the activities of approaches (e.g., multidisciplinary interviews, case

reviews, system advocacy) are a series of mechanisms of change (e.g., knowledge and information sharing, collaboration and case planning) that are assumed to influence intended outcomes over the short-, medium-, and long-term. Articulating the assumptions underlying this common approach will assist program developers with designing interventions that are assumed to influence intended outcomes over the short, medium-, and long-term; are appropriately targeted; and result in meaningful improvements to multidisciplinary approaches. It also suggests critical areas for further research to improve understanding of the effect of multiagency components.

Figure 1:

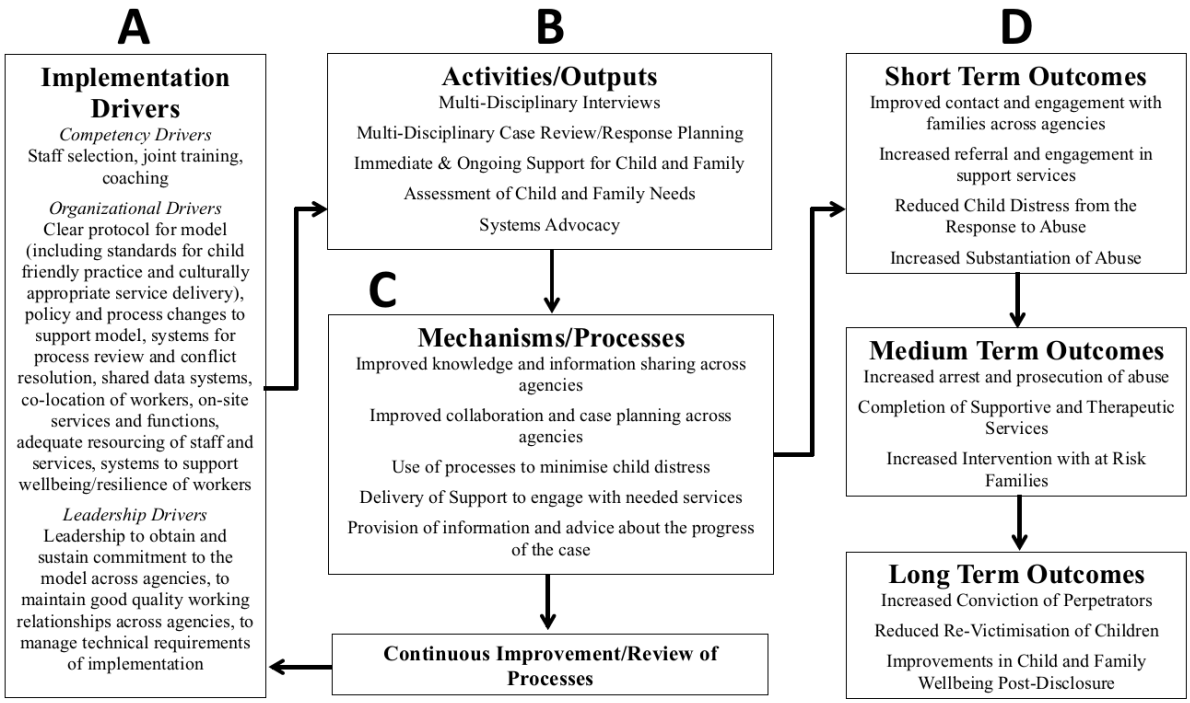


Fig. 1. A program logic of multi-disciplinary teams responding to physical and sexual child abuse.

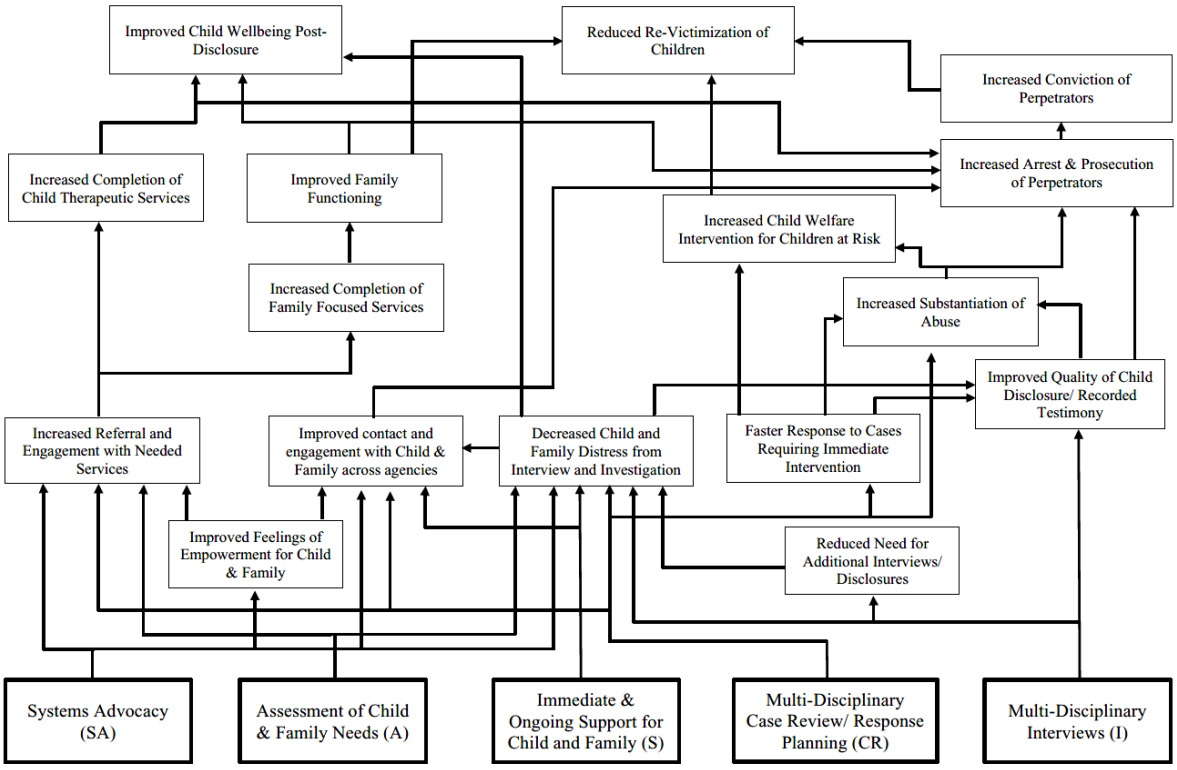


Fig. 2. Outcomes logic for multi-disciplinary teams.

Raine, R., Wallace, I., Nic a' Bháird, C., Xanthopoulou, P., Lanceley, A., Clarke, A., Prentice, A., Ardron, D., Harris, M., Gibbs, J. S. R., Ferlie, E., King, M., Blazeby, J. M., Michie, S., Livingston, G., & Barber, J. (2014). Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: A prospective observational study. *Health Services and Delivery Research, 2*(37), 1–172. https://doi.org/10.3310/hsdr02370

Type of article: Prospective observational study and expert consensus coding
Subject of article: Identifies the characteristics of multidisciplinary team meetings that are associated with decision implementation
Location: The London and north Thames areas of England

Summary: Multidisciplinary team (MDT) meetings have been endorsed by the United Kingdom's Department of Health as the core model for managing chronic diseases. However, the evidence for their effectiveness is mixed and the degree to which they have been absorbed into clinical practice varies widely across conditions and settings. This study aimed to identify the key characteristics of chronic disease MDT

meetings that are associated with decision implementation, establish a measure of effectiveness, and derive a set of feasible modifications to MDT meetings to improve decision making. Data were collected by the following methods: (a) observation of MDT meetings, (b) completion of the Team Climate Inventory (TCI) by MDT members, (c) interviews with MDT members and patients, and (d) review of patients' medical records to examine the influence of patient-related factors (disease, age, sex, deprivation indicator, whether or not their preferences and other clinical/health behaviors were mentioned) and MDT features (team climate and skill mix) on the implementation of MDT treatment plans. Results showed that the likelihood of MDT treatment plan implementation was reduced by 25% for each additional professional group represented. Implementation was more likely in MDTs with clear goals and processes and a good team climate. Implementation varied by patient deprivation and by disease category (with the lowest odds of implementation in mental health teams). The study ascertained 16 key themes within five domains where there was substantial diversity in beliefs and practices across MDT meetings. These include purpose and function of MDTs (decision making, information sharing, peer support, and education); structure of MDTs; chairing arrangements and documentation approaches; content of discussion (referring to scientific evidence or research and discussion of psychosocial issues); and role of patient. The study identified 21 indications of good practice for improving the effectiveness of MDT meetings, such as recommendations relating to the purpose of the meetings (e.g., that agreeing treatment plans should take precedence over other objectives); meeting processes (e.g., that MDT decision implementation should be audited annually); content of the discussion (e.g., that information on comorbidities and past medical history should be routinely available); and the role of the patient (e.g., concerning the most appropriate time to discuss treatment options). Expert stakeholders from a range of chronic disease specialties agree these indicators are both desirable and feasible. These are important because MDT meetings are resource-intensive, and they should deliver value to the National Health Service and patients. Priorities for future work include research to examine whether or not the 21 indications of good practice identified in this study will lead to better decision making. Other areas for further research include exploring the value of multidisciplinarity (i.e., the number of disciplines represented) in MDT meetings and the reasons for low implementation in community mental health teams. There is also scope to examine the underlying determinants of the inequalities demonstrated in this study, such as exploring patient preferences in more depth. Finally, future work could examine the association between MDT decision implementation and improvements in patient outcomes.

Raman, S., Maiese, M., Vasquez, V., Gordon, P., & Jones, J. M. (2017). Review of serious events in cases of (suspected) child abuse and/or neglect: A RoSE by any other name? *Child Abuse & Neglect, 70*, 283–291. https://doi.org/10.1016/j.chiabu.2017.06.020

Type of article: Descriptive
Subject of article: Development of a serious case review process, based on a review of the existing processes and literature, and initial piloting of the process
Location: Large metropolitan health region in Australia

Summary: Presenting child abuse and neglect (CAN) cases to health services may be complex; when things go seriously wrong such as a child death or near death, cases are reviewed and health service professionals are subject to intense scrutiny. While there are a variety of mechanisms to review critical incidents in health services, no formal process exists in Australia for the review of cases in which child protection is the primary concern. The study aimed to develop a systematic process to review serious events in cases of suspected CAN across two health districts in Sydney, so that shared learnings could fuel system change. Drawing upon mapping, case review, and literature findings, and using quality improvement methodology, a model named Review of Serious Events (RoSE) was developed in suspected cases of CAN. The authors reviewed the Serious Case Reviews (SCRs), Child Death Review processes (CDRTs or CFRTs), Root Cause Analyses (RCA), the London Protocol, the Systems Model for case review, and the PROCESS > SCREEN models, in order to contextualize the development and rationale for the model. The RoSE model has the key features of being child-focused: seeking to examine care over a period of time, using child protection staff as lead reviewers, involving health professionals/services in the review who have been involved with the child, and implementing systems change at local levels. The RoSE model was trialed through 2014–2015. Eight cases were reviewed using RoSE and were similar to those reviewed prior to having a model. Participant feedback from RoSE group processes was overwhelmingly positive. Outputs were transparent and accessible to key stakeholders, though there was mixed progress with implementation. Challenges identified included(a) the time it took for the lead reviewers to collate information, conduct the meeting, and produce the report; (b) the resistance from (some) clinical services to changing practice; and (c) the logistics of finding the right time and place to hold the group meeting and engage all relevant participants. The study found that the RoSE model is a serious case review process that is strongly child-focused, both investigative and reflective, led by child protection

experts, and that can be adapted to other settings and systems.

8 | Case Tracking

Jud, A., Fegert, J. M., & Finkelhor, D. (2016). On the incidence and prevalence of child maltreatment: A research agenda. *Child and Adolescent Psychiatry and Mental Health*, *10*, Article 17. https://doi.org/10.1186/s13034-016-0105-8

Type of article: Commentary
Subject of article: Reviews key child maltreatment epidemiological research and directions for future research using both population surveys and agency data
Location: Not applicable

Summary: Research on child maltreatment epidemiology has primarily been focused on population surveys with adult respondents, which has limited implications for specific policies in child protection. Far less attention has been paid to analyzing reported incidents of alleged child maltreatment and corresponding agency responses. This type of research is, however, indispensable to know how well a child protection system works and if the most vulnerable are identified and served. Policy makers also need information about which officials or agencies (e.g., schools, police, healthcare providers, etc.) in their jurisdictions have knowledge of the problem, and what they are doing or not doing when they encounter it. Based on this information, they can make concrete plans about how to allocate resources, change practices, train officials, and reorganize systems to better respond.

Comparing data from agency records and population surveys shows that both data sets align on the finding of higher rates for female than male victims of child sexual abuse and equal gender distribution for other types of maltreatment. In agency data, incidents of child sexual abuse are generally the least prevalent form of child maltreatment with percentages often around 3–9%. The understudied phenomenon of child neglect, on the other hand, is by far the most prevalent form in agency data. Findings from agency data are also in agreement with surveys insofar as children are often not only subjected to one type of maltreatment, but multiple types either at the same time or by being victimized at different times in different contexts.

The National Child Abuse and Neglect Data System (NCANDS) provides the longest-running data set to analyze trends. Finkelhor et al. (2013) have noted that rates of child sexual abuse and child physical maltreatment have both markedly dropped (-

64% and -55%, respectively) since the early 1990s. The promising trend in agency reported cases of child sexual abuse has been corroborated by a concurring decrease shown in several prevalence studies. The evidence from population surveys shows trends similar to the agency data on declines for physical maltreatment. However, hospital data show no decline in maltreatment-related injuries or fatalities. For neglect, the most prevalent form of child maltreatment, there is some smaller decline in the period since 2006 in agency cases. Few studies have tried to estimate the costs of child maltreatment for a nation or region.

Major recommendations for future research include the following:

1) the development of shared definitions between research and practice, (e.g. through establishing a minimum data set that identifies a common set of variables for the tracking of child maltreatment), and
2) a reduction in the work burden imposed by agency surveys on frontline staff, who are already struggling with overwhelming caseloads, through brief, concise and user-friendly surveys and the improvements of data abstraction approaches.

Leach, C., Baksheev, G. N., & Powell, M. (2015). Child sexual abuse research: Challenges of case tracking through administrative databases. *Psychiatry, Psychology and Law*, *22*(6), 912–919. https://doi.org/10.1080/13218719.2015.1019333

Type of article: Review article
Subject of article: Reviews common challenges when using administrative databases for research questions and recommends ways to enhance data quality
Location: Not applicable

Summary: Child sexual abuse (CSA) has a serious impact on victims, their families, and the broader community. As such, there is a critical need for sound research evidence to inform specialist responses. Increasingly, researchers are utilizing administrative databases to track outcomes of individual cases across health, justice, and other government agencies. There are unique advantages to this approach, including the ability to access a rich source of information at a population-wide level. However, the potential limitations of utilizing administrative databases have not been fully explored. Because these databases were created originally for administrative rather than research purposes, there are significant problems with using this data at face value for research projects, including the potential for data to be captured

inconsistency due to variation across multiple users of the database. Additionally, data can be unreliable if researchers do not fully understand the purpose and use of the system. Given these factors, researchers need to be attentive to the quality and suitability of the collected data.

There are many advantages to using administrative data records for the study of child sexual abuse (CSA), such as overcoming attrition and sampling bias, and allowing researchers to identify all cases in contact with an agency. Utilizing officially recorded data also sidesteps limitations from recall bias and socially desirable responding, particularly for sensitive issues such as CSA. In addition, there are many pragmatic advantages of this methodology, such as the ability to obtain large sample sizes, explore a broad range of variables, and obtain decades worth of information with minimal impact on research and agency resources. Notwithstanding these important advantages, there are limitations to using administrative data records. For example, administrative data records constrain data pools to include only children who have come to the attention of government services, which is likely to represent only a proportion of sexually abused children. In addition, variables are restricted to those data points collected by the agency and may not include all those of interest to researchers, such as parental stress, available social supports, parent-child interactions, or socioeconomic status.

There are several potential problems researchers may encounter when accessing an administrative database for the purpose of collating research data. These include identifying relevant cases to include in the sample, collecting reliable and consistent data from variables that may not have been recorded in such a manner, being limited in the range of information that is available, difficulty in tracking cases between agencies that do not share common identifiers, and dealing with missing data.

Given that the use of administrative databases is a unique and increasingly viable method of sourcing data, it is critical that researchers are attentive to a number of key aspects when utilizing such data. The most critical aspect is for researchers to appreciate that this is a time-consuming task. Although the use of administrative databases may be an efficient way to gather longitudinal data, it also requires a significant investment of time to ensure that the most accurate data are obtained. Recommendations for assisting researchers in addressing the reliability of data and establishing methods to deal with missing data include (a) understanding the agency's data recording policy and practice, (b) examining interrater reliability, and (c) dealing thoughtfully and carefully with missing data. In addition, policy makers can

assist by supporting the establishment of centralized data systems that are capable of drawing information on vulnerable children from across government agencies and frontline health systems.

Walsh, W. A., Jones, L. M., & Swiecicki, C. C. (2014). Using child advocacy center tracking data to examine criminal disposition times. *Journal of Child Sexual Abuse*, *23*(2), 198–216. https://doi.org/10.1080/10538712.2014.868386

Type of article: Secondary data analyses
Subject of article: Explores the utility of using CAC data from a computer-based case-tracking system to enhance research about criminal justice involvement in child maltreatment
Location: Norfolk, Virginia

Summary: Information from CACs could be an important resource for answering questions about criminal justice outcomes for child abuse cases given the difficulty of obtaining criminal justice data on these cases. In this study, the authors use data from a CAC to examine the feasibility of using NCAtrak (a national computerized, web-based case-tracking system) to examine criminal disposition time frames in child abuse cases. This study examined the length of time it takes to criminally resolve child abuse cases (time from prosecution review to final criminal disposition). This is a key court outcome measure but has received limited attention in the child abuse field. Three types of child abuse cases were examined: physical abuse cases, sexual abuse cases with adult perpetrators, and sexual abuse cases with juvenile perpetrators.

The NCAtrak data indicated that the time frame for the cases varied widely, beginning with wide variation in how quickly cases were sent to prosecution for review. Just over a quarter of cases (27%) were sent within 1 week of initial report of child abuse to the CAC, 23% of cases took from 1 week to 1 month, 32% of cases took from 1 month to 3 months, and 18% of cases took more than 3 months. There was no significant difference in time between child abuse report and prosecution review by the type of child abuse case. The American Bar Association time frames and many state standards recommend that 99% of felony cases be disposed within 6 months and that all felony cases be disposed within 1 year. Yet this study found only a minority of child abuse cases resolved within the 6-month time frame. About one-third (37%) of child physical abuse cases, 42% of child sexual abuse cases, and 56% of child sexual abuse cases with juvenile offenders were resolved within this time frame. Furthermore, a significant minority of cases did not achieve the goal of resolution

within 1 year. About one in four child physical and sexual abuse cases with adult offenders took more than one year to reach a final disposition. About 11% of child sexual abuse cases with juvenile offenders took more than one year to reach a criminal disposition. Although this exploratory study only involved data from one CAC, it demonstrates that computer case-tracking programs at CACs, such as NCAtrak, can be used to expand criminal justice research on child abuse.

9 | Organizational Capacity

Claiborne, N., Auerbach, C., Zeitlin, W., & Lawrence, C. K. (2015). Organizational climate factors of successful and not successful implementations of workforce innovations in voluntary child welfare agencies. *Human Service Organizations: Management, Leadership & Governance*, *39*(1), 69–80. https://doi.org/10.1080/23303131.2014.984096

Type of article: Research – Pre-post longitudinal study
Subject of article: Examines the relationship of organization climate to innovation implementation for child welfare workers
Location: United States – Northeastern state

Summary: This study advances research on implementing innovations in child welfare organizations, confirming the association between a positive organizational climate and successful change initiative implementation. Employees including managers, child welfare workers, educators, and support staff from six nongovernmental agencies (three that completed the implementation of a change initiative and three that did not) were surveyed using the *Psychological Climate Survey*.

Four dimensions of organizational climate were examined:

(1) *Role Dimension* includes the ambiguity, conflict, and overload subscales. Ambiguity is operationalized as (a) unclear authority for decision-making, (b) unclear goals and objectives, and (c) unclear job responsibilities and expectations. Conflict is operationalized as (a) rules and regulations that interfere with the quality of worker performance, (b) tasks that are contrary to workers' better judgment, (c) too many people directing a worker, and (d) responsibility assigned to workers for things over which they have no control. Overload is operationalized as (a) more work than workers can do, (b) work quantity that interferes with doing a good job, and (c) constant pressure on workers.
(2) *Job Dimension* includes the importance, autonomy and challenge subscales. Importance is operationalized as (a) people outside the organization affected by how workers do their job, (b) a job that is important to the workers' team functioning, and (c) work that makes a meaningful contribution and is highly

important. Autonomy is operationalized as (a) the freedom to decide how the job is done, (b) assigned control so that the worker has authority to make decisions in the work area, (c) worker autonomy in how best to do the job, and (d) freedom to complete assignments without over-supervision. Challenge is operationalized as (a) a job that requires a wide range of skills and effort to do it well, (b) that challenges workers' abilities, and (c) that requires workers to use their full knowledge and skills.

3) *Organization Dimension* includes the innovation, justice and support sub-scales. Innovation is operationalized as the encouragement of workers to develop ideas and try new ways of doing the job, improve on their boss's methods, and find new ways around old problems. Justice is operationalized as (a) fairly made decisions about worker jobs with concerns being heard, and (b) collection of accurate and complete information before decisions are made. Support is operationalized as organizational concern for the wellbeing, opinions, and general satisfaction of workers.

4) *Supervisor Dimension* includes the trust and support, goal emphasis, and work facilitation sub-scales. Trust and support is operationalized as (a) respectful treatment of workers by the supervisor, (b) time and space for the supervisor to listen to problems, and (c) care for workers' satisfaction and opinions. Goal emphasis is operationalized as (a) high standards of performance that are established and emphasized by the supervisor and (b) emphasis on the importance of measurable goals for performance and improvement. Work facilitation is operationalized as (a) supervisor demonstration of how to improve performance, (d) modeling hard work, and (c) helping workers solve job-related problems to complete work on time.

The study found that the organizational climate dimensions of Role, Job, and Organization were significantly related to innovation implementation, indicating that agencies that fully implemented a change initiative had a more positive organizational climate. The Supervisor dimension was not significantly related to innovation implementation, indicating no association with whether or not the change initiative was implemented. When examining administrators versus nonadministrators, the Organization dimension was significant only for administrators, indicating that administrators had a more positive climate perception than workers.

Organizational environments of innovation, fairness, and support are important factors in initiating change in agencies and may also have significant impacts on

employee turnover and client outcomes. Perceptions of a work environment being less supportive and unfair arouse employee dissatisfaction, leading to high turnover rates among child welfare employees. Factors related to high turnover include discontent with contingent rewards, high caseloads, paperwork demands, quality of supervision, and pay. Further, high turnover interrupts the relationship between workers and the children and families, which can have negative outcomes. These include lengthening the time for children to attain permanency, interrupting home visits to assess child safety, and possibly re-traumatizing children who have already experienced significant disruptions in forming trusting relationships.

In summary, administrators and child welfare workers from agencies that successfully implemented their change initiative reported having a significantly more positive organizational climate, although there were differences across the four dimensions and for administrators versus nonadministrators. Limitations include the attrition rate, concerns about generalizability to public child welfare agencies, and that, give the type of study conducted, the relationship found between organizational climate and innovation implementation is not causal.

Edmondson, A. C., & Lei, Z. (2014). Psychological safety: The history, renaissance, and future of an interpersonal construct. *Annual Review of Organizational Psychology and Organizational Behavior*, *1*(1), 23–43. https://doi.org/10.1146/annurev-orgpsych-031413-091305

Type of article: Review
Subject of article: Examines psychological safety, the factors that contribute to it, and its implications for individuals, teams, and organizations
Location: Not applicable

Summary: Psychological safety describes people's perceptions of the consequences of taking interpersonal risks in a particular context such as a workplace. First explored by pioneering organizational scholars in the 1960s, psychological safety experienced a renaissance starting in the 1990s and continues to the present. Organizational research has identified psychological safety as a critical factor in understanding phenomena such as voice, teamwork, team learning, and organizational learning. A growing body of conceptual and empirical work has focused on understanding the nature of psychological safety, identifying factors that contribute to it, and examining

its implications for individuals, teams, and organizations. This article reviews the literature for these three levels and suggests directions for future research.

Individual-level research has examined the relationships between individual experiences of psychological safety and outcomes including job engagement, organizational commitment, quality internal auditing, learning from failure, and creative work involvement. Some studies examine employee adherence to expected (or in-role) behaviors, conceptualizing employees as reactive respondents to managerial actions, rewards, or other organizational factors. Others give employees a more active, agentic role, examining relationships between psychological safety and discretionary improvement behaviors including speaking up.

Group-level research includes studies of direct, mediating, and moderating roles for psychological safety in team learning, innovation, and performance. Findings suggest that psychological safety is essentially a team- or group-level phenomenon. Studies have found statistically significant variance in psychological safety between groups within organizations; that is, people working closely together tend to have similar perceptions of psychological safety, which vary across groups within the same organization. Some of this variance can be attributed to local manager or supervisor behaviors, which convey varying messages about the consequences of taking the interpersonal risks associated with behaviors such as admitting error, asking for help, or speaking up with ideas.

Organizational-level research identifies relationships between psychological safety, commitment-based human resources (HR) practices, social capital, high-quality relationships, climate for initiative, and firm performance, each measured at the organizational level of analysis. The main outcomes of interest are organizational performance and organizational learning. In some studies, psychological safety serves as a mediator, and in others, as a moderator of relationships between organizational antecedents and outcomes.

The study had several key findings. First, across all of the studies reviewed, psychological safety has consistently been shown to play a role in enabling performance. Second, psychological safety is associated with learning across the levels of analysis (individual, group, and organization). Finally, the study showed that individuals who experience greater psychological safety are more likely to speak up at work. Future research directions include pursuing a dynamic view of psychological safety, testing potential boundary conditions for the effects of psychological safety,

examining cross-cultural differences, and developing reliable and valid measures of psychological safety, as well as more sophisticated analyses to determine causality.

Williams-Gray, B. (2016). Building capacity in nonprofit human service agencies through organizational assessment during the accreditation process. *The Journal of Nonprofit Education and Leadership*, *6*(2), 99–114. https://doi.org/10.18666/JNEL-2016-V6-I2-6499

Type of article: Research – Pre-post longitudinal study
Subject of article: Examines whether performing an organizational self-assessment as part of an accreditation process had any effect on capacity building as perceived by the participating organizations
Location: United States

Summary: The purpose of this study was to explore the effects of organizational self-assessment as a tool to enhance organizational capacity in nonprofit human service agencies when it is performed as part of an accreditation process. Senior leadership at 88 organizations completed the 56-item self-administered *Assessment of Organizational Capacity (AOC)* pretest designed to measure capacity at the beginning of the Council on Accreditation's accreditation process, and then repeated the same self-assessment posttest at the end of the accreditation process. The elements of organizational capacity examined are mission and goal, governance and leadership, financial resource management, human resources, information technology, community linkages, cultural competence, and performance quality improvement and outcomes. The findings reveal that 59% of the organizations demonstrated an increase in capacity from the beginning to the end of the accreditation process, 9% had an identical score, and 32% had a decrease in capacity over time. There appears to be a relationship between an increase in organizational capacity and positive accreditation outcomes, but the statistical significance cannot be determined due to the small sample size.

Nineteen items in which 10% or more of respondents indicated that they needed additional capacity were further examined (see Figure 2 below). Organizations identified their greatest capacity challenges, with all 11 items on performance quality improvement identified as weaknesses. Other challenges included funding diversification, fundraising, efficiencies in technology to support organizational systems, mission clarity (the relationship of mission to strategic planning), and the

inclusion of diversity in decision making. None of the capacity questions about leadership and governance were identified as challenges.

The findings mostly support the premise that organizational self-assessment is a beneficial process in building capacity and helping to identify the specific management and administration capacities needing growth or strengthening within organizations. Limitations include the small sample size, the self-report nature of the survey, possible changes in agency informants from pretest to posttest, and possible response bias, as agencies undergoing an accreditation may not have wanted to identify weaknesses, even after being told the self-assessments had no impact on the accreditation decision.

Suggested reading for additional information on psychological safety in organizations:

Edmondson, A. C. (2018). The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth. John Wiley & Sons.

Children's Advocacy Centers have elements in common with all types of organizations, but with the CAC's interdependence with MDT members, CACs also operate in a unique team environment. Google recently conducted research to identify the dynamics of effective teams regardless of their setting. This work is very relevant to the organizational capacity of all CACs and to their efforts to support their MDTs. Google identified five key attributes of effective teams (https://rework). First among these critical ingredients is psychological safety. All CAC leaders would be well-served to gain a more complete understanding of how psychological safety is applied in an organizational or team environment, especially when the same term is also widely used, in another context, in Trauma-Informed Practice literature. Amy Edmondson's book, *The Fearless Organization*, does a good job of laying out the key issues involved in creating a psychologically safe work environment and does so in very practical terms. This book serves as a good overall text for those seeking to further build their organizational capacity to excel.

Figure 2:

Capacity Elements and Challenges Identified in Pretest Organizational Assessment SOCE

Capacity elements	Capacity challenges (SOCE)
Mission and goals	1) Our organization has clearly measurable goals/objectives/outcomes in a written strategic plan.
Financial resource management	2) Our organization has developed contingency plans for responding to changes in funding.
	3) Our organization has developed a multiyear revenue strategy that addresses sources of funding and identifies areas in which revenues and expenses may not be balanced.
	4) Our fundraising program has the staff and resources needed to meet funding goals.
Information technology	5) We have sufficient information management resources to support the collecting, analyzing, and sharing of information across our organization.
	6) Our organization has invested in technology/automated systems and staff to support information management goals.
	7) Information management supports quality service delivery at our organization.
Cultural competence	8) Our organization actively seeks involvement and feedback from community stakeholders and diverse perspectives.
Performance quality improvement and outcomes	9) Our organization has agreed upon the measures used in assessing progress toward achieving outcomes.
	10) Data collection instruments and procedures are in place.
	11) Our organization has sufficient measures and tracks progress toward outcomes.
	12) Our organization regularly assesses program effectiveness by reviewing outcome data.
	13) Our organization actively assesses program effectiveness based upon actual performance data/information and established benchmarks.
	14) Our organization assesses current performance on outcomes against established benchmarks/targets.
	15) We have an organizationwide continuous quality improvement program.
	16) Performance information is reported at established time frames to the board and management staff.
	17) Managers and staff use performance data/information to identify opportunities for programs/service delivery improvements and improve the quality of their work with clients.
	18) Performance data/information is used to identify effective practices and interventions within our organization.
	19) Evidence-based practices are continually studied and applied to improve programs/services.

10 | Child-Focused Setting

Bosch, S. J., & Lorusso, L. N. (2019). Promoting patient and family engagement through healthcare facility design: A systematic literature review. *Journal of Environmental Psychology*, 62, 74–83. https://doi.org/10.1016/j.jenvp.2019.02.002

Type of article: Systematic review
Subject of article: Examines whether the physical design of healthcare facilities affects patient and family engagement in care
Location: Not applicable – no location-based criteria in review

Summary: This study summarizes and synthesizes published literature regarding whether the physical design of healthcare facilities affects patient and family engagement in care. It explores potential environmental affordances provided by structures that may promote better engagement and a more positive experience, ultimately leading to the "quadruple aim" of enhancing the healthcare experience through better culture, better care, better health, and lowered costs.

From the review, the authors identified four environmental affordances which seem to support patient- and family-engaged care: physical comfort (comprised of both spatial [e.g., room size, adjacencies] and sensory comfort [e.g., acoustical, thermal]); providing patients with a sense of control (e.g., ability to control ambient conditions, such as lighting or temperature); access to social support (e.g., family members feel welcome in the facilities where care is provided), and access to positive distractions (e.g., "environmental feature or element that elicits positive feelings, holds attention and interest without taxing or stressing the individual and may therefore block or reduce worrisome thoughts," pg. 81). The authors found a modest amount of evidence indicating that the physical environment in which healthcare is provided may affect variables related to patient- and family-engaged care, such as family presence, length of family visits, and frequency of patient–family interactions. Designs that are comfortable and foster control of one's physical and social environment, access to social support, and positive distractions may enhance the patient and family experience and promote engagement in care delivery.

Dudley, N., Ackerman, A., Brown, K. M., Snow, S. K., American Academy of Pediatrics Committee on Pediatric Emergency Medicine, & Emergency Nurses Association Pediatric Committee. (2015). Patient- and family-centered care of children in the emergency department. *Pediatrics*, *135*(1), e255–e272. https://doi.org/10.1542/peds.2014-3424

Type of article: Technical report
Subject of article: Reviews the present state of practice and research regarding patient- and family-centered care for children in the emergency department setting
Location: Not applicable

Summary: Patient- and family-centered care (PFCC) is an approach to the planning, delivery, and evaluation of healthcare that is grounded in a mutually beneficial partnership among patients, families, and healthcare professionals. Providing PFCC to children in the emergency department (ED) setting presents many opportunities and challenges. This revised technical report reviews existing policy statements, reports, and literature in order to describe the present state of practice and research regarding PFCC for children in the ED setting. PFCC embraces the following concepts: (1) care is provided for a person, not a condition; (2) the patient is best understood in the context of their family, culture, values, and goals; and (3) honoring this context will result in better healthcare, safety, and patient satisfaction.

There are significant challenges and complexities to providing PFCC for children in the ED, including overcrowding and acuity in the emergency department; the lack of a previous relationship between the patient/family and ED healthcare professionals; the acute nature of many events prompting an ED visit; cultural and societal influences on varied family structures, adolescent development, and care needs—which may lead to an ED visit without family; and reluctance on the part of healthcare professionals to allow family member presence (FMP) during invasive procedures. Despite these challenges, achieving excellence in the provision of PFCC is possible in the ED. Embracing the philosophy of PFCC across disciplines (such as nursing, interpreter services, child life and social services, chaplaincy, or mental health services) can promote patient safety, comfort, and satisfaction despite the challenges of the ED environment.

The authors discuss how all aspects of emergency care can reflect the practice of PFCC, including clinical operations and patient flow, policies and practice, physical plant, and education of staff and trainees, and review multiple tangible ways to

increase PFCC. Examples include the following: 1) a bedside registration system to ensure parent and child remain together; 2) assistance, such as valet parking, for a single parent who arrives with an ill child in the ED; 3) changing the "visitor" badge to read "family," to reinforce the commitment to moving beyond thinking of family as visitors and truly welcoming them as partners in the care of the child; 4) timely access to professional interpreter services when a language or communication barrier exists, as research demonstrates disparities in quality of care for families whose primary language is not English; 5) family-centered rounds, as well as the use of photographs to identify care team and their roles, which may improve recognition, acceptance of trainees, and satisfaction with care; and 6) altering the physical plant to better accommodate family members, including well siblings, and provide restrooms, diaper-changing space, safe and dedicated pediatric waiting areas, and simple refreshments.

There is evidence to support both the satisfaction of families with the PFCC approach and improved job satisfaction and reduced burnout for healthcare professionals. Prior research demonstrates that implementing a PFCC approach in adult patient care settings has led to improvements in patient safety, fewer medical errors, and lower cost of care. The authors promote future research to study these long- and short-term outcomes associated with implementing PFCC in the ED with children. The authors further recommend the education of ED healthcare professionals to include the teaching of principles of PFCC with active participation by patients and families in formal medical education.

Trzpuc, S. J., Wendt, K. A., Heitzman, S. C., Skemp, S., Thomas, D., & Dahl, R. (2016). Does space matter? An exploratory study for a child–adolescent mental health inpatient unit. *HERD: Health Environments Research & Design Journal*, *10*(1), 23–44. https://doi.org/10.1177/1937586716634017

Type of article: Mixed-methods study using surveys and interviews
Subject of article: Explores the influence of several design strategies intended to induce calm feelings for patients, staff, and families
Location: Minneapolis, Minnesota

Summary: This study explores design elements and spaces as a contributing influence on behavior and well-being for patients, staff, and families in a child–adolescent mental health unit that was embarking on a renovation and relocation

project. Evidence-based strategies were employed for the design of the new unit to enhance the experience for patients, staff, and families and to support changes in operational and procedural strategies. A mixed-methods approach was utilized to explore the influence of several design strategies intended to induce calm feelings for patients, staff, and families. A comprehensive literature review informed the design process and study design. Methods included patient image surveys, online staff surveys, and face-to-face staff interviews.

The project included modifying the physical inpatient unit as well as unique spaces outside of inpatient rooms, such as a therapeutic pool and creation of secure outdoor play area. A variety of design strategies were used for this project, including color and curved architectural elements, offering patient environmental control options, balancing privacy and socialization areas, providing spaces for physical activity and movement, and integrating nature-based elements throughout the unit. Results of the patient survey show that the most commonly selected calming design elements and spaces had elements with characteristics of choice and control over an attribute (e.g., music panels in patient rooms, colored lights in hallways and rooms, etc.). The highest ranked features among the staff included the sensory room and pool. Staff members were also positively influenced by the colors and artwork throughout the unit as well as the upgraded security and safety features. Findings also show the space has a positive influence on families, demonstrated by its welcoming character and features that help to facilitate better interaction with patients.

Overall, findings from this project show that the renovated unit is preferred by both patients and staff. Unit design interventions were identified as helpful to patients, although some were identified as more helpful than others. Findings from staff interviews show the unit design features may have potentially more clinical efficacy on patients' mental health outcomes and should be explored in further research. Also, by designing patient rooms in a way that is user-friendly, and by allowing patients to have many options, positive behavioral outcomes have resulted on the units. In addition, increased physical activities, both indoors and outdoors, were identified as helpful for influencing patients' positive outcomes. Further research can inform designers, architects, and healthcare organizations in providing safer and more effective environments for mental healthcare professionals and patients.

Section II: Other topic areas

Child abuse prevention 68
Child physical abuse 82
Commercial sexual exploitation of children (CSEC) 96

Child Abuse Prevention

Daro, D. (2019). A shift in perspective: A universal approach to child protection. *The Future of Children*, *29*(1), 17–40. https://doi.org/10.1353/foc.2019.0002

Type of article: Review article and commentary
Subject of article: Reviews the historical context for how parental shortcomings have been addressed and proposes a universal approach for all parents with need.
Location: Not applicable

Summary: In the United States, two approaches have developed to exercise collective influence on how parents raise their children. One is mandatory public intervention in families who have placed their children at risk, exemplified by the child welfare system. The other is voluntary offers of assistance, including child abuse prevention services that place responsibility on parents to determine whether they'll accept the advice they receive and change their behavior. This article traces a shift in emphasis from a Progressive Era policy that offered common supports to all new parents, to a more bifurcated prevention system that emphasizes public investments primarily for those parents and children at highest risk. Moreover, for the past 50 years, voluntary and mandatory parental assistance have operated independently, with minimal shared agenda setting and planning. This is contrasted with the healthcare system, where early assessment and diagnosis mean that people receive a continuum of care, based on their level of need. For example, when a patient is diagnosed with precancerous cells, they are not immediately offered chemotherapy or told to go away until the disease becomes Stage IV cancer. Rather, they are offered an intervention appropriate to their condition. Early medical treatment isn't viewed as intrusive; it's seen as an important first step in protecting health and avoiding more complex and costly therapy.

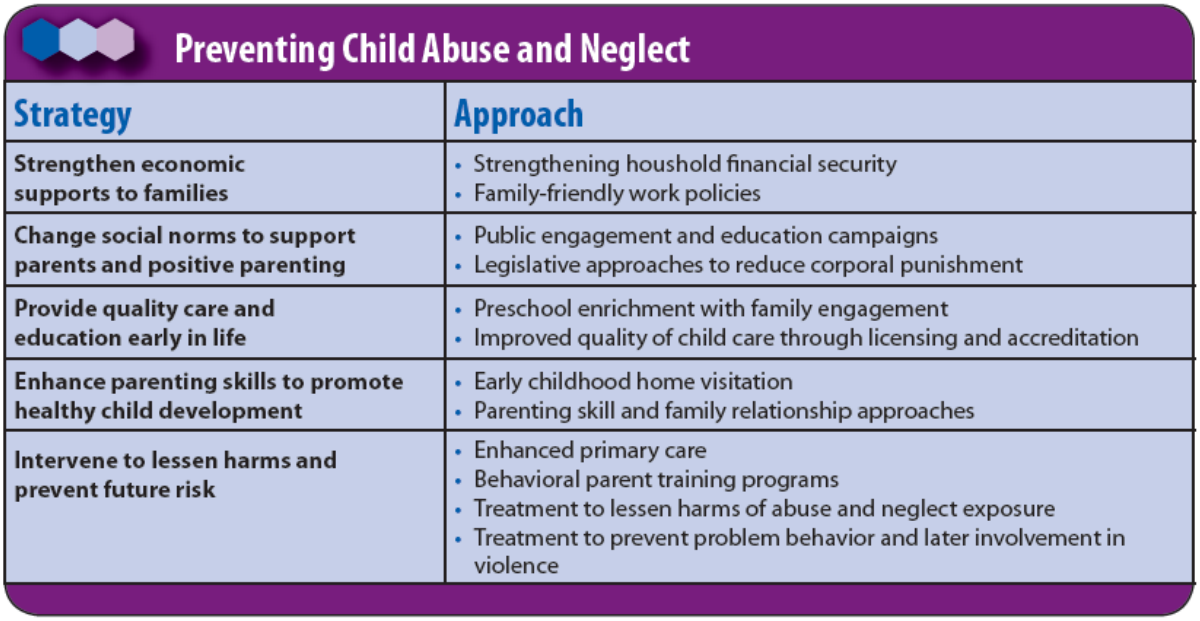
Unfortunately, the policy response to parental shortcomings isn't comparable. There's no adequate early assessment when people become parents, and child welfare agencies typically offer assistance only after a child is harmed. Highlighting inefficiencies found in both the parent support and intervention systems, the author suggests that the time is right for a universal approach that reaches out to all new parents, offering each family a level of assistance commensurate with their needs. State child welfare agencies can work with those implementing evidence-based

prevention services, and with state public health and welfare agencies, to create a broad network of services. Such a partnership can minimize the longstanding gap between mandated and voluntary parental assistance, and can build an integrated, more effective child protection system. For this partnership to be truly innovative, it will need to move toward a community-owned universal assessment strategy that's offered to all new parents. The delivery system to accomplish this objective should promote public recognition that raising children presents challenges for all parents, strengthen cross-system staff and agency collaboration, and build a database categorizing the types and levels of support. The ultimate goal is that seeking out and accepting formal public services to help meet parenting demands is as acceptable as using preventive healthcare.

Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf

Type of article: Review article
Subject of article: Presents a select group of strategies based on the best available evidence to help prevent child abuse and neglect
Location: Not applicable

Summary: This technical package represents a select group of strategies based on the best available evidence to help prevent child abuse and neglect. These strategies include strengthening economic supports to families, changing social norms to support parents and positive parenting, providing quality care and education early in life, enhancing parenting skills to promote healthy child development, and intervening to lessen harms and prevent future risk. This package includes strategies with a focus on preventing child abuse and neglect from happening in the first place, and approaches to lessen the immediate and long-term harms of child abuse and neglect. These strategies and approaches range from a focus on individuals, families, and relationships to broader community and societal change. This range is needed to better address the interplay between individual-family behavior and broader neighborhood, community, and cultural contexts.



Preventing Child Abuse and Neglect

Strategy	Approach
Strengthen economic supports to families	• Strengthening houshold financial security • Family-friendly work policies
Change social norms to support parents and positive parenting	• Public engagement and education campaigns • Legislative approaches to reduce corporal punishment
Provide quality care and education early in life	• Preschool enrichment with family engagement • Improved quality of child care through licensing and accreditation
Enhance parenting skills to promote healthy child development	• Early childhood home visitation • Parenting skill and family relationship approaches
Intervene to lessen harms and prevent future risk	• Enhanced primary care • Behavioral parent training programs • Treatment to lessen harms of abuse and neglect exposure • Treatment to prevent problem behavior and later involvement in violence

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome. Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the strategy or the preventive direction or actions to achieve the goal of preventing child abuse and neglect. The second component is the approach. The approach includes the specific ways to advance the strategy. This can be accomplished through programs, policies, and practices. The third component includes the evidence for each of the approaches in preventing child abuse and neglect or its associated risk factors. This package is intended as a resource to guide and inform prevention decision-making in communities and states. Commitment, cooperation, and leadership from numerous sectors—including public health, education, justice, healthcare, social services, business/labor, and government—can bring about successful implementation of this package.

Frieden, T. R. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health*, *100*(4), 590–595. https://doi.org/10.2105/AJPH.2009.185652

Type of article: Commentary
Subject of article: Presents the health impact pyramid, a 5-tier alternative conceptual framework for public health action
Location: Not applicable

Summary: The traditional depiction of the potential impact of healthcare interventions is a 4-tier pyramid, with the bottom level representing population-wide interventions that have the greatest impact, and ascending levels with decreasing impact that represent primary, secondary, and tertiary care. All of these models, however, focus most of their attention on various aspects of clinical health services and their delivery and, to a lesser extent, health system infrastructure. Although these are of critical importance, public health involves far more than healthcare. The fundamental composition, organization, and operation of society form the underpinnings of the determinants of health, yet they are often overlooked in the development frameworks to describe health system structures. As a result, existing frameworks accurately describe neither the constituent elements nor the role of public health.

A 5-tier pyramid best describes the impact of different types of public health interventions and provides a framework to improve health. At the base of this pyramid, which indicates interventions with the greatest potential impact, are efforts to address socioeconomic determinants of health. In ascending order are the following tiers: (a) interventions that change the context to make individuals' default decisions healthy, (b) clinical interventions that require limited contact but confer long-term protection, (c) ongoing direct clinical care, and (d) health education and counseling.

Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. The health impact pyramid postulates that addressing socioeconomic factors (tier 1, or the base of the pyramid) has the greatest potential to improve health. Interventions that change the context for individual behavior (tier 2) are generally the most effective

public health actions. One-time clinical interventions (tier 3), such as immunizations, can be more effectively applied than those requiring ongoing care; and clinical interventions (tier 4) are generally, although not inevitably, more effective than counseling and education (tier 5). Implementing interventions at each of the levels can achieve the maximum possible sustained public health benefit.

Diagram:

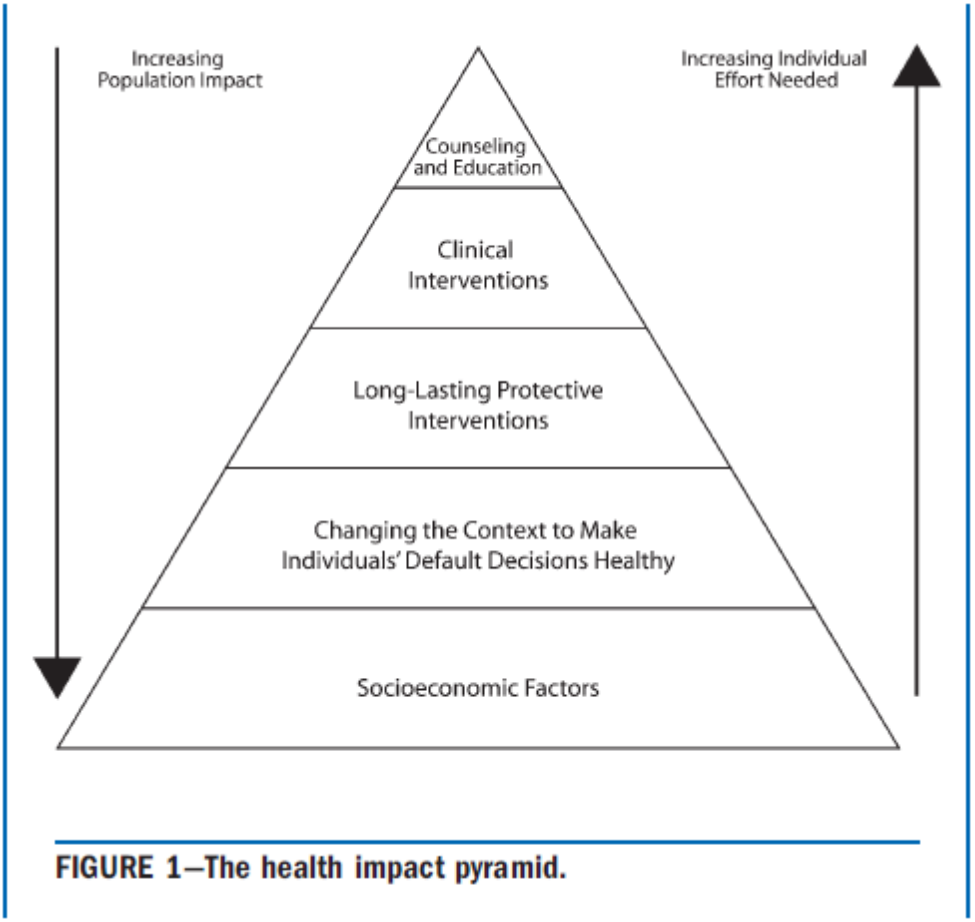


FIGURE 1—The health impact pyramid.

Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analyses. *Journal of Family Psychology*, (4), 453. http://dx.doi.org/10.1037/fam0000191

Type of article: Meta-analysis
Subject of article: To examine the impact of spanking on child outcomes and address several methodological concerns in prior studies

Location: Not applicable

Summary: Whether spanking is helpful or harmful to children continues to be the source of considerable debate among both researchers and the public. Previous meta-analyses included a different set of articles and came to varied and conflicting conclusions, namely that physical punishment is largely ineffective and harmful, that physical punishment is effective under certain circumstances, and that physical punishment is linked with children's cognitive, emotional, and behavioral problems but only modestly. This article addresses two persistent issues in the research in order to study design difference: (a) whether effect sizes for spanking are distinct from those for physical abuse, and (b) whether effect sizes for spanking are robust. Meta-analyses focused specifically on spanking were conducted on a total of 111 unique effect sizes representing 160,927 children. Thirteen of 17 mean effect sizes were significantly different from zero and all indicated a significant link between spanking and increased risk for detrimental child outcomes, including more aggression, more antisocial behavior, more externalizing problems, more internalizing problems, more mental health problems, and more negative relationships with parents. Spanking was also significantly associated with lower moral internalization, lower cognitive ability, and lower self-esteem. The largest effect size was for physical abuse; the more children are spanked, the greater the risk that they will be physically abused by their parents. Several adult outcomes were significantly associated with a history of spanking from parents: adult antisocial behavior, adult mental health problems, and adult support for physical punishment. Taken together, these meta-analyses support the conclusion that parents' use of spanking is associated with detrimental child outcomes. Effect sizes did not substantially differ between spanking and physical abuse or by study design characteristics.

The meta-analyses presented here found no evidence that spanking is associated with improved child behavior and rather found spanking to be associated with increased risk of 13 detrimental outcomes. These analyses did not find any support for the contentions that spanking is only associated with detrimental outcomes when it is combined with abusive methods or that spanking is only associated with such outcomes in methodologically weak studies. Across study designs, countries, and age groups, spanking has been linked with detrimental outcomes for children, a fact supported by several key methodologically strong studies that isolate the ability of spanking to predict child out-comes over time. Although the magnitude of the observed associations may be small, when extrapolated to the population in which 80% of children are being spanked, such small effects can translate into large societal

impacts. Parents who use spanking, practitioners who recommend it, and policymakers who allow it might reconsider doing so given that there is no evidence that spanking does any good for children, and all evidence points to the risk of it doing harm. Limitations include the inability to determine causality from these analyses.

Klevens, J., Barnett, S. B. L., Florence, C., & Moore, D. (2015). Exploring policies for the reduction of child physical abuse and neglect. *Child Abuse & Neglect*, *40*, 1–11. https://doi.org/10.1016/j.chiabu.2014.07.013

Type of article: Research – Quasi-experimental
Subject of article: Explores the effects of state policies on child maltreatment rates
Location: United States

Summary: Policies can be powerful tools for prevention given their potential to affect conditions that can improve population-level health. Given the dearth of empirical research on policies' impacts on child maltreatment, this article (a) identifies 37 state policies that might have impacts on the social determinants of child maltreatment, (b) identifies available data sources documenting the implementation of 31 policies, and (c) utilizes the available data to explore effects of 11 policies (selected because they had little missing data) on child maltreatment rates. These include the following policies:

1) two policies aimed at reducing poverty (state minimum wage % above federal minimum wage and state tax burden for families of three at federal poverty line);
2) two temporary assistance to needy families policies (maximum monthly earnings and still be eligible, maximum monthly benefits for family of three);
3) two policies aimed at increasing access to child care (income cutoff for child care subsidies for family of three [% of state median income] and wait list for child care assistance [no/yes]);
4) three policies aimed at increasing access to high quality pre-K (enrollment in pre-K for 4-year-olds [%], enrollment in pre-K for 3-year-olds [%], and expenditure per child in pre-K); and,
5) three policies aimed at increasing access to healthcare (eligibility for Medicaid/SCHIP for children 1–5 years old [% of federal poverty limit], continuity of eligibility for Medicaid/SCHIP [no/yes], and presumptive eligibility for Medicaid/SCHIP [no/yes]).

Multilevel regression analyses between within-state trends of child maltreatment investigation rates and these 11 policies—controlling for states' childhood poverty, adults without a high school diploma, unemployment, child burden, and race/ethnicity—identified that only two policies that were significantly associated with decreased child maltreatment rates: 1) lack of waitlists to access child care assistance and 2) policies that ensure continuity of child healthcare by providing Medicaid and SCHIP enrollees continuous coverage for, most commonly, 12 months rather than on a month-to-month basis. Future research might focus on a reduced number of states that have good quality administrative data or population-based survey data on child maltreatment or reasonable proxies for child maltreatment and where data on the actual implementation of specific policies of interest can be documented. Limitations include that these findings are correlational and are limited by the quality and availability of the state level data.

Mendelson, T., & Letourneau, E. J. (2015). Parent-focused prevention of child sexual abuse. *Prevention Science*, *16*(6), 844–852. https://doi.org/10.1007/s11121-015-0553-z

Type of article: Review article
Subject of article: Summarizes current strategies for reducing child sexual abuse (CSA) and their limitations, proposes a rationale for parent-focused CSA prevention, and discusses considerations pertinent to developing a parent-focused approach
Location: Not applicable

Summary: Child sexual abuse (CSA) is a serious public health issue. Current after-the-fact approaches to treat victims and punish offenders are not adequate to address a problem of this magnitude. Development and rigorous evaluation of CSA prevention strategies are critical. The authors propose that CSA prevention efforts should target parents of young children. Parents have been neglected as a focus of CSA prevention; they merit attention given their potential to improve children's safety via effective communication and monitoring.

CSA prevention approaches can be broadly categorized as perpetrator- or victim-focused, and they target various ecological levels. Examples include justice system restrictions, advocacy and media campaigns, youth-serving organizations, school-based programs, treatment of offenders, and treatment of victims. A key limitation of CSA prevention efforts to date is lack of a systematic prevention research focus.

Programs have generally been developed without careful evaluation of risk or protective factors, and have occasionally been taken to scale without rigorous evaluation. Reasons for this pattern include the urgency that often accompanies policy decisions in the wake of publicized CSA cases, limited funds for CSA prevention research, and insufficient integration of offender- and victim-focused efforts. As a result, programs are often not implemented or funded based on efficacy or integrated so as to maximize positive impact.

Parent-focused strategies have been notably absent from prevention of CSA victimization and perpetration. There are compelling reasons why parents may be an effective target, including the considerable influence of parents on youth behaviors, the effectiveness of parent-focused prevention of child maltreatment, and parents' frequent social proximity to CSA exposure. Despite challenges in designing, delivering, and evaluating CSA prevention programs for parents, there is great promise for interventions in this area to be feasible and effective, with potential for scale-up and dissemination. Parent-focused CSA prevention can be integrated with school-, community-, and societal-focused initiatives to augment their impact. It is time that resources are devoted toward developing and studying this important area.

Merrick, M. T., Ford, D. C., Ports, K. A., Guinn, A. S., Chen, J., Klevens, J., Mercy, J. A. (2019). Vital signs: Estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention – 25 states, 2015-2017. *MMWR. Morbidity and mortality weekly report*, *68*(44), 999–1005. doi:10.15585/mmwr.mm6844e1

Type of article: Cross-sectional survey
Subject of article: Examines the potential impact of preventing adverse childhood experiences in reducing negative health and well-being outcomes and socioeconomic impacts in adults.
Location: 25 states in the United States

Summary: Adverse childhood experiences, such as violence victimization, substance misuse in the household, or witnessing intimate partner violence, have been linked to leading causes of adult morbidity and mortality. Therefore, reducing adverse childhood experiences is critical to avoiding multiple negative health and socioeconomic outcomes in adulthood. Methods: Behavioral Risk Factor Surveillance System data were collected from 25 states that included state-added adverse

childhood experience items during 2015–2017. Outcomes examined were self-reported status for coronary heart disease, stroke, asthma, chronic obstructive pulmonary disease, cancer (excluding skin cancer), kidney disease, diabetes, depression, overweight or obesity, current smoking, heavy drinking, less than high school completion, unemployment, and lack of health insurance. Logistic regression modeling adjusting for age group, race/ethnicity, and sex was used to calculate population attributable fractions representing the potential reduction in outcomes associated with preventing adverse childhood experiences.

The study found that nearly one in six adults in the study population (15.6%) reported four or more types of adverse childhood experiences. Sex, race/ethnicity, and age group were independently associated with adverse childhood experience exposure. Women, American Indian/Alaska Natives, Blacks, and the Other racial/ethnic group were more likely to experience four or more types of adverse childhood experiences than were men and Whites. Younger adults reported exposure to more adverse childhood experience types than did older adults, particularly those aged ≥65 years. Adverse childhood experiences were significantly associated with poorer health outcomes, health risk behaviors, and socioeconomic challenges. Potential percentage reductions in the number of observed cases as indicated by population attributable fractions ranged from 1.7% for overweight or obesity to 23.9% for heavy drinking, 27.0% for chronic obstructive pulmonary disease, and 44.1% for depression.

States can use comprehensive public health approaches derived from the best available evidence to prevent childhood adversity before it begins. Efforts that create safe, stable, nurturing relationships and environments that prevent adverse childhood experiences could also potentially prevent adult chronic conditions, depression, health risk behaviors, and negative socioeconomic outcomes. By creating the conditions for healthy communities and focusing on primary prevention, it is possible to reduce risk for adverse childhood experiences while also mitigating consequences for those already affected by these experiences.

Michalopoulos, C., Faucetta, K., Hill, C. J., Portilla, X. A., Burrell, L., Lee, H., Duggan, A., & Knox, V. (2019). Impacts on family outcomes of evidence-based early childhood home visiting: Results from the mother and infant home visiting program evaluation (OPRE Report 2019-07). Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

https://www.acf.hhs.gov/sites/default/files/opre/mihope_impact_report_final20_508.pdf

Type of article: Evaluation report
Subject of article: Presents the early effects on family and child outcomes from early childhood home visiting programs
Location: United States – 88 local home visiting programs in 12 states

Summary: The Mother and Infant Home Visiting Program Evaluation (MIHOPE) was designed to learn whether families benefit from Maternal, Infant, and Early Childhood Home Visiting (MIECHV)-funded early childhood home visiting programs, and if so, how. The study includes the four evidence-based models that 10 or more states chose in their initial MIECHV plans in fiscal year 2010-2011 were as follows: Early Head Start — Home-based option, Healthy Families America, Nurse–Family Partnership, and Parents as Teachers. MIHOPE is the first study to include these four evidence-based models. To provide rigorous evidence on the MIECHV-funded programs' effects, the study randomly assigned about 4,200 families to receive either MIECHV-funded home visiting or information on community services.

Several key findings were identified. First, the study found positive effects that were generally similar to, but somewhat smaller than, the average effects found in past studies. Of 12 outcomes the study focused on, four had estimated effects that are statistically significant. No outcome area stands out as one where home visiting programs had large effects. Second, differences in effects among the evidence-based models are generally consistent with the models' focuses. For example, Parents as Teachers produced the largest increase in parental supportiveness and Nurse–Family Partnership produced the largest reduction in emergency department visits for children, although the differences are sensitive to the statistical methods used. Third, effects on family outcomes do not vary much by family characteristics, suggesting that home visiting is not having larger effects for different types of families. The effects may vary in ways that were not examined in this report.

This report examines MIECHV-funded home visiting programs from 2012 through 2017, and local programs have continued to evolve. In addition, this report presents effects starting from when children are only 15 months old, which may be too early to see effects on long-term child development given the young age. There is evidence from past studies that the benefits of home visiting persist; therefore, it may be too early to make a final judgment about the programs studied in MIHOPE. For that

reason, the authors are planning to collect follow-up data over the longer term with participating families.

Peterson, C., Florence, C., & Klevens, J. (2018). The economic burden of child maltreatment in the United States, 2015. *Child Abuse & Neglect*, *86*, 178-183.

Type of article: Cost estimate
Subject of article: Estimates the lifetime per-victim cost and the associated population economic burden of child maltreatment
Location: United States

Summary: Child maltreatment incurs a high lifetime cost per victim and creates a substantial US population economic burden. This study aimed to use the most recent data and recommended methods to update previous (2008) estimates of (a) the per-victim lifetime cost, and (b) the annual US population economic burden of child maltreatment. Three ways to update the previous estimates were identified: 1) apply value per statistical life methodology to value child maltreatment mortality, 2) apply monetized quality-adjusted life years methodology to value child maltreatment morbidity, and 3) apply updated estimates of the exposed population. As with the previous estimates, the updated estimates used the societal cost perspective and lifetime horizon, but also accounted for victim and community intangible costs. Updated methods increased the estimated nonfatal child maltreatment per-victim lifetime cost from $210,012 (2010 USD) to $830,928 (2015 USD) and increased the fatal per-victim cost from $1.3 to $16.6 million. The estimated US population economic burden of child maltreatment based on 2015 substantiated incident cases (482,000 nonfatal and 1670 fatal victims) was $428 billion, representing lifetime costs incurred annually. Using estimated incidence of investigated annual incident cases (2,368,000 nonfatal and 1670 fatal victims), the estimated economic burden was $2 trillion. Accounting for victim and community intangible costs increased the estimated cost of child maltreatment considerably compared to previous estimates. The economic burden of child maltreatment is substantial and might offset the cost of evidence-based interventions that reduce child maltreatment incidence.

Walsh, K., Zwi, K., Woolfenden, S., & Shlonsky, A. (2015). School-based education programs for the prevention of child sexual abuse. *Cochrane Database of Systematic reviews, 28*(1), 33–55. https://doi.org/10.1177/1049731515619705

Type of article: Systematic review
Subject of article: To assess evidence of the effectiveness of school-based education programs for the prevention of child sexual abuse
Location: Not applicable

Summary: School-based education programs for the prevention of child sexual abuse have been implemented on a large scale in some countries. This study reviewed the evidence for the effectiveness of these programs in the following areas: (a) children's skills in protective behaviors, (b) children's knowledge of child sexual abuse prevention concepts, (c) children's retention of protective behaviors over time, (d) children's retention of knowledge over time, (e) parental or child anxiety or fear as a result of program participation, and (f) disclosures of past or current child sexual abuse during or after programs.

This review included 24 studies, conducted with a total of 5802 participants in primary (elementary) and secondary (high) schools in the United States, Canada, China, Germany, Spain, Taiwan, and Turkey. The duration of interventions ranged from a single 45-minute session to eight 20-minute sessions on consecutive days. Although a wide range of programs were used, there were many common elements, including the teaching of safety rules, body ownership, and private parts of the body; distinguishing types of touches and types of secrets; and advising who to tell. Program delivery formats included film, video or DVD, theatrical plays, and multimedia presentations. Other resources used included songs, puppets, comics, and coloring books. Teaching methods used in delivery included rehearsal, practice, role-play, discussion, and feedback.

This review found evidence that school-based sexual abuse prevention programs were effective in increasing participants' skills in protective behaviors and knowledge of sexual abuse prevention concepts (measured via questionnaires or vignettes). Knowledge gains (measured via questionnaires) were not significantly eroded one to six months after the intervention for either intervention or control groups. In terms of harm, there was no evidence that programs increased or decreased children's anxiety or fear. No studies measured parental anxiety or fear. Children exposed to a child sexual abuse prevention program had greater odds of disclosing their abuse than children who had not been exposed; however, the authors were more uncertain about this effect when the analysis was adjusted to account for the grouping of participants in classes or schools. Studies have not yet adequately measured the long-term benefits of programs in terms of reducing the incidence or prevalence (or

both) of child sexual abuse in program participants. Limitations include that the quality of the evidence for all outcomes included in the meta-analyses (combining of data) was moderate. Study quality was compromised in about half of the included studies, due to suboptimal data collection methods for study outcomes and inappropriate data analysis.

Child Physical Abuse

Bloemen, E. M., Rosen, T., Cline Schiroo, J. A., Clark, S., Mulcare, M. R., Stern, M. E., Mysliwiec, R., Flomenbaum, N. E., Lachs, M. S., & Hargarten, S. (2016). Photographing injuries in the acute care setting: development and evaluation of a standardized protocol for research, forensics, and clinical practice. *Academic Emergency Medicine, 23*(5), 653–659. https://doi.org/10.1111/acem.12955

Type of article: Multiphase process to design, implement, and evaluate a photography protocol, including literature review and pilot testing
Subject of article: Development and preliminary evaluation of a comprehensive protocol to standardize the photography of injury types in all major body regions
Location: United States – Emergency department (ED) of a large, urban, academic medical center

Summary: Photographing injuries in the acute setting allows for improved documentation as well as assessment by clinicians and others who have not personally examined a patient. This tool is important, particularly for telemedicine, tracking of wound healing, evaluation of potential abuse, and injury research. Despite this, protocols to ensure standardization of photography in clinical practice, forensics, or research have not been published. In preparation for a study of injury patterns in elder abuse and geriatric falls, the authors' goal was to develop and evaluate a protocol for standardized photography of injuries that may be broadly applied. The authors conducted a literature review for techniques and standards in medical, forensic, and legal photography, and then developed a novel protocol describing types of photographs and body positioning for eight body regions, including instructional diagrams. The protocol was revised iteratively in consultation with experts in medical photography; forensics; and elder, child, and domestic abuse. The resulting protocol requires a minimum of four photos of each injury at multiple distances with and without a ruler/color guide.

To evaluate the protocol's efficacy, multiple research assistants without previous photography experience photographed injuries from a convenience sample of elderly patients presenting to a single large, urban, academic emergency department (ED). A selection of these patients' images was then evaluated in a blinded fashion by four nontreating emergency medicine physicians, and the interrater reliability

between these physicians was calculated. Photographs of 25 injuries (10 bruises, seven lacerations, and eight abrasions) were used to assess characterization of the injury. Physicians' characterizations of the injuries were reliable for the size of the injury, side of the body, precise location of the injury, and type of abrasion. The exact shape of the injury and the primary color of bruises were not as reliably characterized, as would be expected due to the more subjective nature of these characterizations (e.g., an oval versus a circle shape or a bruise being primarily blue rather than purple).

A photography protocol will ensure that this important mechanism for documentation is optimized. The most immediately relevant application of this protocol is likely in the forensic evaluation of child abuse, intimate partner violence, and elder abuse. Emergency physicians are responsible for documenting injuries in these vulnerable patients, yet they typically receive very little training in the acquisition of a photo image, forensic evaluation, and documentation and may feel uncomfortable performing these tasks without tools and protocols to help guide this process. Additionally, standardizing this process through a protocol will improve the quality of photos and their utility in any future legal process. Before initiating ED-based photography of injuries for clinical purposes, physicians should consult their hospital's legal department regarding issues surrounding patient consent and privacy, which may vary according to hospital policy or by jurisdiction. Limitations include the geriatric and largely Caucasian sample, which limits generalizability, as well as possible bias in the selection of the photographs for piloting.

Boehnke, M., Mirsky, D., Stence, N., Stanley, R. M., Lindberg, D. M., & ExSTRA Investigators. (2018). Occult head injury is common in children with concern for physical abuse. *Pediatric Radiology, 48*(8), 1123–1129. https://doi.org/10.1007/s00247-018-4128-6

Type of article: Research – retrospective, secondary analysis of existing patient data
Subject of article: Determines the prevalence of occult head injury in a large patient cohort with suspected physical abuse
Location: 20 locations in the United States

Summary: Studies evaluating small patient cohorts have found a high, but variable, rate of occult head injury in children < 2 years old with concern for physical abuse. The American College of Radiology (ACR) recommends clinicians have a low

threshold to obtain neuroimaging in these patients. The study aim was to determine the prevalence of occult head injury in a large patient cohort with suspected physical abuse using similar selection criteria from previous studies. Additionally, the authors evaluated proposed risk factors for associations with occult head injury. This was a retrospective, secondary analysis of data collected by an observational study of 20 U.S. child abuse teams that evaluated children who underwent subspecialty evaluation for concern of abuse. The study evaluated children < 2 years old and excluded those with abnormal mental status, bulging fontanelle, seizure, respiratory arrest, underlying neurological condition, focal neurological deficit, or scalp injury.

Of the 1,143 subjects that met the inclusion criteria, 62.5% (714) had undergone neuroimaging with either head computed tomography or magnetic resonance imaging. The authors found an occult head injury prevalence of 19.7% (141). Subjects with emesis, macrocephaly, or loss of consciousness had higher odds of occult head injury. Results show a high prevalence of occult head injury in patients < 2 years old with suspected physical abuse. These data support the ACR recommendation that clinicians should have a low threshold to perform neuroimaging in patients < 2 years of age with suspected abuse. Limitations include the retrospective study design, the significant fraction of children without imaging, and the unclear clinical or forensic significance of the injuries identified.

Christian, C. W., & Committee on Child Abuse and Neglect. (2015). The evaluation of suspected child physical abuse. *Pediatrics, 135*(5), e1337-e1354. https://doi.org/10.1542/peds.2015-0356

Type of article: Clinical report
Subject of article: Guidance for clinicians on the evaluation of suspected child physical abuse
Location: Not applicable

Summary: Child physical abuse is an important cause of pediatric morbidity and mortality and is associated with major physical and mental health problems that can extend into adulthood. Pediatricians are in a unique position to identify and prevent child abuse, and this clinical report provides guidance to the practitioner regarding indicators and evaluation of suspected physical abuse of children. The role of the physician may include (a) identifying abused children with suspicious injuries who present for care, (b) reporting suspected abuse to the child protection agency for investigation, (c) supporting families who are affected by child abuse, (d)

coordinating with other professionals and community agencies to provide immediate and long-term treatment to victimized children, (e) providing court testimony when necessary, (f) providing preventive care and anticipatory guidance in the office, and (g) advocating for policies and programs that support families and protect vulnerable children.

Child abuse is a highly complex phenomenon in which parent, child, and environmental characteristics interact to place a child at risk. Because of their small size and vulnerability, infants and toddlers are at highest risk of fatal and severe physical abuse. Risk factors for infant abuse include maternal smoking, the presence of more than two siblings, low infant birth weight, and being born to an unmarried mother. Children with disabilities are at high risk for physical, sexual, and emotional abuse. Young, abused children who live in households with unrelated adults are at exceptionally high risk of fatal abuse, and children previously reported to child protective services (CPS) are at significantly higher risk of both abusive and preventable accidental death compared with peers with similar sociodemographic characteristics. Strong evidence exists for the association between poverty and child physical abuse, and children who live in poverty are overrepresented in both the child protective and foster care systems. However, specific family and community preventive factors can mitigate some of these risks, including parental resilience, parent knowledge of child development and parenting, concrete support in times of need, social connections, and a child's ability to form positive relationships. The presence of safe, stable, and nurturing relationships and environments prevents maltreatment and is essential for a healthy childhood.

Identifying suspected abuse and reporting reasonable suspicions to CPS can be one of the most challenging and difficult responsibilities for the pediatrician. Yet early identification and intervention to protect abused children have the potential to stop the abuse, secure the child's safety, and mitigate toxic stress in victims. Proper management of minor but suspicious injuries provides an opportunity for early recognition and intervention to protect vulnerable children. Physicians sometimes underappreciate the significance of sentinel injuries or attribute them to non-inflicted trauma, self-inflicted trauma, or medical disease. A careful and well-documented history is an important element of the medical evaluation. Examples of concerning histories include those that give no, vague, or conflicting explanations for significant injuries, deny trauma in a child with obvious injury, or provide explanations that do not fit the injury or that are inconsistent with the child's capabilities. An injury pattern is rarely pathognomonic for abuse or accident without careful consideration of the

explanation provided, a thorough physical examination, and radiographic or laboratory analysis.

The following pediatrician actions and guidelines can be used to protect children who are victims of physical abuse:

1) Pediatricians can be alert for injuries that raise suspicion of abuse but may be overlooked by unsuspecting physicians, including:
    a. ANY injury to a nonmobile infant, including bruises, oral injuries, or fractures;
    b. injuries in unusual locations, such as over the torso, ears, or neck;
    c. patterned injuries;
    d. injuries to multiple organ systems;
    e. multiple injuries in different stages of healing; or
    f. significant injuries that are unexplained.
2) Consider the possibility of trauma in young infants who present with nonspecific symptoms of possible head trauma, including unexplained vomiting, lethargy, irritability, apnea, or seizures, and consider head imaging in their evaluation.
3) A skeletal survey for any child under 2 years old with suspicious injuries can identify occult injuries that may exist in abused children and is very useful in the evaluation of suspected abuse.
4) Brain imaging may identify injury in abused infants, even in those who are not overtly symptomatic.
5) Examining siblings and household contacts of abused children often reveals injuries to those children; those under 2 years old benefit from a skeletal survey.
6) Consultation with colleagues, child abuse pediatricians, and other pediatric specialists to assist in the evaluation of difficult cases is very helpful.
7) Pediatricians are mandated reporters of suspected abuse, and reports to CPS are required by law when the physician has a reasonable suspicion of abuse. Transferring a child's care to another physician or hospital does not relieve the pediatrician of their reporting responsibilities.
8) Pediatricians may need to hospitalize children with suspicious injuries for medical evaluation, treatment, and/or protection.
9) Thorough documentation in medical records and effective communication with nonmedical investigators in child protection may improve outcomes of investigations and protect vulnerable children.

Lindberg, D. M., Beaty, B., Juarez-Colunga, E., Wood, J. N., & Runyan, D. K. (2015). Testing for abuse in children with sentinel injuries. *Pediatrics, 136*(5), 831–838. https://doi.org/10.1542/peds.2015-1487

Type of article: Research – retrospective, secondary analysis of existing patient data
Subject of article: Determines which putative sentinel injuries are most associated with physical abuse in young children
Location: 43 not-for-profit tertiary care pediatric hospitals in the United States

Summary: Child physical abuse is commonly missed, putting abused children at risk for repeated injury and death. Several so-called sentinel injuries have been suggested to be associated with high rates of abuse, and to imply the need for routine testing for other, occult traumatic injuries. Putative sentinel injuries in children < 2 year of age include the following:

1) In children less than 6 months of age: bruising, burns, or oropharyngeal injury.
2) In children under 12 months of age: femur/humerus fracture, radius/ulna/tibia/fibula fracture, isolated skull fracture, or intracranial hemorrhage.
3) In children less than 24 months of age: rib fracture(s), abdominal trauma, genital injury, or subconjunctival hemorrhage.

The study objective was to determine rates of abuse evaluation and diagnosis at leading children's hospitals for children who were evaluated with these putative sentinel injuries. This is a retrospective secondary analysis of the Pediatric Health Information System (PHIS) database. 30,355 children with putative sentinel injuries were identified and rates of abuse diagnosis and of testing commonly used to identify occult injuries were measured.

Among all visits for children less than 24 months old to PHIS hospitals, the rate of abuse diagnosis was 0.17%. The large majority of subjects (89.8%) had only one putative sentinel injury identified. Two putative sentinel injuries were identified in 7.6% of subjects, and 2.6% had three to six injuries identified. Rates of abuse diagnosis for children with at least one putative sentinel injury ranged from 3.5% for children less than 12 months old with burns, to 56.1% for children less than 24 months with rib fractures. Rates of skeletal survey and other testing that can identify occult traumatic injury were highly variable between centers and for different injuries.

For example, among infants with skull fractures, the rate of skeletal surveys between centers ranged from just over 20% of patients, to as high as 74%.

The study found that several putative sentinel injuries are associated with high rates of physical abuse. Among eligible children with rib fracture(s), abdominal trauma, or intracranial hemorrhage, rates of abuse were more than 20%. The data reveal an overall high rate of diagnosed abuse, but tremendous variability in evaluation and diagnosis of abuse across hospitals and injury categories. Together, these facts suggest that increased, routine, or protocolized testing for children with these injuries can identify other children with abuse that might otherwise be missed. Limitations include the use of administrative data and ICD-9 and CTC codes to identify abuse diagnoses and diagnostic testing, which may have inaccuracies or incomplete information. Limitations also include the use of existing datasets, which did not identify the presenting injury for any given child, nor whether a child's sentinel injury was accompanied by other obvious signs of abuse, such as a history of witnessed assault.

Maguire, S., Cowley, L., Mann, M., & Kemp, A. (2013). What does the recent literature add to the identification and investigation of fractures in child abuse: An overview of review updates 2005–2013. *Evidence-Based Child Health: A Cochrane Review Journal, 8*(5), 2044–2057. https://doi.org/10.1002/ebch.1941

Type of article: Meta-analyses
Subject of article: To determine which radiological investigations should be performed to identify fractures in suspected child abuse and which fractures are indicative of abuse
Location: Not applicable. No location-specific search criteria.

Summary: Fractures are a manifestation of physical abuse and common accidental injuries. Fractures have been reported in over a third of children < 2 years who have been physically abused, 18% of whom have multiple fractures. An abusive fracture in a young child denotes a severe assault; however up to 60% of boys and 40% of girls sustain accidental fractures by their 15th birthday. All children < 2 presenting with suspected abuse should be screened for occult fractures. Distinguishing which fractures are indicative of abuse and optimizing the identification of occult fractures are the challenges. This article identifies additional studies published since previous systematic reviews to address these two issues. An all-language literature search of 14 databases was conducted for the years 2005–2013, using revised keywords. All

studies underwent standardized critical appraisal by two independent reviewers, applying quality criteria relating to the confirmation of child abuse, exclusion of abuse and quality of skeletal survey (SS) conducted. A meta-analysis, stratified by age, was conducted to determine the predictive value for abuse of specific fractures by fitting a random effects model. Twenty-three studies addressed "radiological investigations" and nine studies addressed "fractures indicative of abuse." Radiological studies reiterated that a single investigation (SS or radionuclide imaging) will miss some abusive fractures; in 8.4–37.6% of children, and the repeat SS adds new information that influences child protection procedures. Debate continues as to which are the optimal images to include in the repeat SS. At this time, it would appear that those for whom it is deemed relevant should have a full repeat SS (omitting skull) and including oblique views of the ribs. A meta-analysis of femoral and humeral fractures by age highlighted that children < 18 months are significantly more likely to have sustained their fracture as a consequence of abuse, than those aged 1–4 years. The recent literature validates the original conclusions that repeat skeletal imaging adds important information on fractures. Comparative studies of femoral, humeral, rib, and skull fractures enabled a meta-analysis by age; however, further comparative studies are needed.

Pawlik, M. C., Kemp, A., Maguire, S., Nuttall, D., Feldman, K. W., Lindberg, D. M., & ExSTRA Investigators. (2016). Children with burns referred for child abuse evaluation: Burn characteristics and co-existent injuries. *Child Abuse & Neglect,* 55, 52–61. https://doi.org/10.1016/j.chiabu.2016.03.006

Type of article: Research - retrospective, secondary analysis of existing patient data
Subject of article: Describes the characteristics of burn injuries in children referred to child abuse pediatricians in relation to the perceived likelihood of abuse
Location: Twenty locations in the United States

Summary: Intentional burns represent a serious form of physical abuse that must be identified to protect children from further harm. This study is a retrospectively planned secondary analysis of the Examining Siblings To Recognize Abuse (ExSTRA) network data. The objective was to describe the characteristics of burns injuries in children referred to child abuse pediatricians (CAPs) in relation to the perceived likelihood of abuse. Furthermore, the authors compare the extent of diagnostic investigations undertaken in children referred to CAPs for burn injuries with those referred for other reasons. Within this dataset, 7% (215/2890) of children had burns. Children with burns were older than children with other injuries (median age 20

months vs. 10 months). Physical abuse was perceived as likely in 40.9% (88) and unlikely in 59.1% (127). Scalds accounted for 52.6% (113) and contact burns for 27.6% (60). Compared to studies investigating accidental/unintentional burns, the agent, mechanism, and distribution of burns amongst the children referred to CAPS in this dataset differ from those in children with injuries judged unintentional. Several characteristics of the history and burn injury were associated with a significantly higher perceived likelihood of abuse, including children with reported inflicted injury, absent or inadequate explanation, hot water as agent, immersion scald, a bilateral/symmetric burn pattern, total body surface area ≥10%, full thickness burns, and co-existent injuries. The rates of diagnostic testing were significantly lower in children with burns than other injuries, yet the yield of skeletal survey and hepatic transaminases testing were comparable between the two groups. This would imply that children referred to CAPs for burns warrant the same level of comprehensive investigations as those referred for other reasons in order to appropriately identify abuse. Limitations include the lack of common protocol for testing or injury screening across the 20 sites, that the dataset did not address children with burns resulting from neglect, and that the secondary data used may have been incomplete or varied between sites.

Servaes, S., Brown, S. D., Choudhary, A. K., Christian, C. W., Done, S. L., Hayes, L. L., Levine, M. A., Moreno, J. A., Palusci, V. J., Shore, R. M., & Slovis, T. L. (2016). The etiology and significance of fractures in infants and young children: A critical multidisciplinary review. *Pediatric Radiology*, *46*(5), 591–600. https://doi.org/10.1007/s00247-016-3546-6

Type of article: Literature review
Subject of article: Reviews the etiology of fractures in infants and young children; the prevalence of metabolic bone disease, particularly rickets; and the appropriate medical workup of children suspected of being physically abused
Location: Not applicable

Summary: This paper addresses significant misconceptions regarding the etiology of fractures in infants and young children in cases of suspected child abuse. This consensus statement, supported by the Child Abuse Committee and endorsed by the Board of Directors of the Society for Pediatric Radiology, synthesizes the relevant scientific data distinguishing clinical, radiologic, and laboratory findings of metabolic disease from findings in abusive injury. Out of every 1,000 children < 2 years old, one to four of them are treated annually for fractures from all causes, with 10% of these on

average evaluated for possible physical abuse. Fractures from child abuse are much more common than fractures caused by underlying medical conditions such as rickets and osteogenesis imperfecta. Given the rarity of these medical conditions, it has been estimated that children < 3 years are nearly 100 times more likely to have a fracture caused by abuse than a fracture caused by a metabolic abnormality such as rickets and approximately 20 times more likely to have a fracture caused by abuse than by osteogenesis
imperfecta. In young children, 20% of fractures caused by abuse may be incorrectly attributed to other causes. The evaluation for suspected abusive fractures requires an extensive multidisciplinary assessment that includes consideration and exclusion of other possible causes. The laboratory evaluation—including serum calcium, phosphorus, alkaline phosphatase, vitamin D level, and parathyroid hormone—should be determined by the history and physical examination.

Although some controversy exists regarding human vitamin D requirements, particularly regarding potential extraskeletal effects, vitamin D levels do not denote bone disease and significant metabolic bone disease is not associated with vitamin D levels of 20 ng/ml or greater. Specifically, levels of 20–29 ng/ml, currently designated as "insufficient," are not associated with significant bone changes and do not result in skeletal fragility. Data have demonstrated no correlation between low vitamin D levels and the likelihood of either abusive or accidental fractures in children. No study has demonstrated that low serum vitamin D level without radiographic bone changes increases susceptibility to bone fractures. Also, fetal and neonatal bone health is not correlated with maternal vitamin D levels.

Fractures in rickets are noted in association with abnormal bone radiographs, which demonstrate osteopenia and metaphyseal cupping, fraying, and splaying, and in general are not those most specifically associated with child abuse (posterior rib fractures and classic metaphyseal lesions). Examples of fractures found in children with rickets include transverse long-bone fractures, metaphyseal fractures (associated with abnormal metaphyses and not classic metaphyseal lesions), and anterior-lateral rib fractures (with abnormal ribs).

Fractures of every type and location occur in abused children, and no fracture is absolutely diagnostic of abuse. Thus, a comprehensive team approach to the evaluation with appropriate imaging is crucial. Any fracture is highly suspicious of abuse in the setting of an absent, inappropriate, or changing history. Also, certain fractures and distributions of fractures are seen almost exclusively in abused children,

including multiple fractures at various stages of healing, rib fractures (particularly posterior rib fractures) in young children, the classic metaphyseal lesion, which is also known as a "buckethandle" or "corner" fracture, and fractures of the scapula, sternum, and spinous process.

Finally, the authors discuss how courts should properly assess, use, and limit medical evidence and medical opinion testimony in criminal and civil child abuse cases to accomplish optimal care and protection of the children in these cases. The court is not an appropriate forum for the presentation of new or unsubstantiated theories of causation of disease. Courts can avoid promulgating unsubstantiated and unsafe theories and opinions by relying on medical and ethical guidelines from established professional societies such as the American College of Radiology, the Society for Pediatric Radiology, and the American Academy of Pediatrics. Decisions should be based on established scientific evidence and not unproven theories. Although it is important to question the literature and to test new hypotheses with scientific rigor, the evaluation of medical findings must be done with proper scientific technique.

Sheets, L. K., Leach, M. E., Koszewski, I. J., Lessmeier, A. M., Nugent, M., & Simpson, P. (2013). Sentinel injuries in infants evaluated for child physical abuse. *Pediatrics*, *131*(4), 701–707. https://doi.org/10.1542/peds.2012-2780

Type of article: Research – case-control, retrospective study
Subject of article: Examines the prevalence of relatively minor abusive, or sentinel, injuries in infants evaluated for abuse
Location: Wisconsin

Summary: Relatively minor abusive injuries can precede severe physical abuse in infants. The study objective was to determine how often abused infants have a previous history of "sentinel" injuries, compared with infants who are not abused. A case-control, retrospective study was completed of 401 infants < 12 months old who had been evaluated for abuse in a hospital-based setting and found to have definite, intermediate concern for, or no abuse after evaluation by the hospital-based child protection team. A sentinel injury was defined as a previous injury reported in the medical history that was suspicious for abuse, because the infant could not cruise or the explanation was implausible. Of the 200 definitely abused infants, 27.5% had a previous sentinel injury, compared with 8% of the 100 infants with intermediate concern for abuse (odds ratio: 4.4, 95% confidence interval: 2.0–9.6; P < .001). None

of the 101 nonabused infants (controls) had a previous sentinel injury (P < .001). The type of sentinel injury in the definitely abused cohort was bruising (80%), intraoral injury (11%), and other injury (7%). Sentinel injuries occurred in early infancy: 66% at < 3 months of age and 95% at or before the age of 7 months.

Medical providers were reportedly aware of the sentinel injury in 41.9% of cases. This study shows that previous sentinel injuries are common in infants with severe physical abuse and rare in infants evaluated for abuse and found to not be abused. When an infant is evaluated for possible abuse, a history of a sentinel injury should heighten the concern for abuse. A history of bruising or oral injury in a precruising infant evaluated for abuse should heighten the level of suspicion because these injuries are common in abused infants and rare in infants found not to be abused. Detection of sentinel injuries, along with appropriate intervention, would improve secondary prevention of abuse.

Sugar, N. F., Taylor, J. A., & Feldman, K. W. (1999). Bruises in infants and toddlers: Those who don't cruise rarely bruise. *Archives of Pediatrics & Adolescent Medicine, 153*(4), 399–403. https://doi.org/10.1001/archpedi.153.4.399

Type of article: Research – cross-sectional survey
Subject of article: Determines the frequency and location of bruises in normal infants and toddlers, and determines the relationship of age and developmental stage to bruising.
Location: Seattle, Washington

Summary: Children commonly sustain minor injuries during the course of normal activity and play. The physician who examines infants and toddlers must routinely evaluate whether injuries, such as bruises and abrasions, are consistent with normal activity or raise concern that a child has been physically abused. This study examined children < 36 months attending well-child care visits in community primary care pediatric offices for bruising in infants and toddlers. Data was collected on patient demographics, developmental stage, presence and location of bruises, any medical condition that causes bruises, as well as known or suspected abuse. Results showed that bruises were found in 203 (20.9%) of 973 children who had no known medical cause for bruising and in whom abuse was not suspected. The presence of any bruises was clearly associated with patient age. Only 2 (0.6%) of 366 children < 6 months and 8 (1.7%) of 473 children < 9 months had any bruises. Bruising was also directly correlated with developmental stage: bruises were noted in only 11 (2.2%) of

511 children who were not yet walking with support (cruising), while 17.8% of cruisers and 51.9% of walkers had bruises ($p < .001$). Mean bruise frequency ranged from 1.3 bruises per injured child among precruisers (range, 1–2 bruises) to 2.4 per injured child among walkers (range, 1–11). The most frequent site of bruises was over the anterior tibia and knee. Bruises on the forehead and upper leg were common among walkers, but bruises on the face and trunk were rare, and bruises on the hands and buttocks were not observed at any age. There were no differences in bruise frequency by sex. African American children were observed to have bruises much less frequently than White children ($p < .007$). While it is possible that African American children have bruises less frequently than White children, it is more likely that children with more darkly pigmented skin have bruises that are more difficult to recognize than bruises on children with lighter pigmentation.

This large study of healthy children concluded that bruises are rare in normal infants and precruisers and become common among cruisers and walkers. Bruises in infants < 9 months and who are not yet beginning to ambulate should lead to consideration of abuse or illness as causative. Bruises in toddlers that are located in atypical areas, such as the trunk, hands, or buttocks, should prompt similar concerns. Limitations include parental report of ambulatory stage, visual diagnosis of bruises, and a lack of interobserver reliability.

Wootton-Gorges, S. L., Soares, B. P., Alazraki, A. L., Anupindi, S. A., Blount, J. P., Booth, T. N., Dempsey, M. E., Falcone, R. A., Jr., Hayes, L. L., Kulkarni, A. V., Partap, S., Rigsby, C. K., Ryan, M. E., Safdar, N. M., Trout, A. T., Widmann, R. F., Karmazyn, B. K., & Palasis, S. (2017). ACR appropriateness criteria® suspected physical abuse—child. *Journal of the American College of Radiology, 14*(5), S338–S349.

Type of article: Literature review and evidence-based guidelines
Subject of article: Provides guidance on the appropriateness of imaging and treatment procedures for specific clinical scenarios related to suspected physical child abuse
Location: Not applicable.

Summary: Imaging often plays a major role in the detection and documentation of physical injury. Young children, particularly in the first year of life, are the most vulnerable to physical abuse. Radiographic skeletal surveys are the initial imaging modality of choice because fractures occur in up to 55% of physically abused

children. The majority of skeletal surveys that are positive for fractures are performed in children < 1 year of age, and 80% of abused children with fractures are < 18 months of age. Thus, skeletal survey is recommended in all children < 2 years of age in whom there is suspicion of abuse. A repeat limited skeletal survey after two weeks can detect additional fractures and can provide fracture dating information. In older children, it is usually appropriate to target imaging to the area(s) of suspected injury.

The type and extent of additional imaging for pediatric patients being evaluated for suspected physical abuse depends on the age of the child, the presence of neurologic signs and symptoms, evidence of thoracic or abdominopelvic injuries, and social considerations. Unenhanced CT of the head is the initial study for suspected intracranial injury. Clinically occult abusive head trauma can occur, especially in young infants. Therefore, head CT should be performed in selected neurologically asymptomatic physical abuse patients. A head MRI may provide additional diagnostic information to a head CT in about 25% of children. An MRI of the cervical spine should be considered at the time of the head MRI, as unsuspected injury (usually ligamentous) may be present in over 33% of children with intracranial injury. Contrast-enhanced CT of the abdomen/pelvis is utilized for suspected intraabdominal or pelvic injury. Particular attention should be paid to discrepancies between the patterns of injury and the reported clinical history. Making the diagnosis of child abuse also requires differentiation from anatomical and developmental variants and possible underlying metabolic and genetic conditions.

Commercial sexual exploitation of children (CSEC)

Chester, H., Lummert, N., & Mullooly, A. (2015). Child victims of human trafficking: Outcomes and service adaptation within the U.S. Unaccompanied Refugee Minor programs. http://www.usccb.org/about/anti-trafficking-program/upload/URM-Child-Trafficking-Study-2015-Final.pdf

Type of article: Descriptive
Subject of article: Describes the features of the Unaccompanied Refugee Minor (URM) program and the outcomes for a sample of children served by the program
Location: United States

Summary: Foreign-born child victims of trafficking in the United States without the care of a parent or legal guardian are eligible to enter the Unaccompanied Refugee Minor (URM) program, a specialized system of community-based and licensed foster-care programs developed and funded specifically for certain foreign-born children. This paper reports on 110 child victims of trafficking served by the URM and presents the features of the URM program model that most effectively meet the specialized needs of foreign-born child victims of human trafficking. Also shared are key findings from the study related to individual outcomes for child victims of trafficking, the services and resources provided to child victims of trafficking, and the policies and practices of URM programs for the recruitment, training, and support of foster families and program staff. Demographic, case history, and individual service provision and outcome data were collected from administrative data sources; staff interviews and foster parent surveys were also conducted.

The mean age of the children at the time they entered the URM program was 16.5 years, ranging between 12 and close to 18. The children served represented fifteen countries of origin. Among the children in this sample whose exploitation details are known, 42% were victims of labor exploitation, 36% were victims of sexual exploitation, and 22% were exploited for their labor and also suffered sexual assault or were sexually exploited. The authors observed no correlation between type of exploitation and a child's age, although some clear differences exist along gender lines. Fewer of the male victims were exploited in sex trafficking schemes or reported sexual exploitation/assault occurring as part of their labor exploitation. Overall, almost half of the children in this study were exploited by someone with whom they

or their family had a prior relationship. Half the children in the known sample were exploited for more than a year.

Proxies were used to measure and analyze the stability and well-being of the children. To measure stability, the number of placement changes were recorded and analyzed. Authors found no statistical differences in the number of placement changes based on the kind of exploitation children suffered and no correlation between the length of time in the trafficking situation and later placement changes. Girls experienced significantly more moves than boys. Whether or not children formed meaningful connections with adults was used as a proxy for well-being. Forty percent of children had no documented connection to an adult. Other proxies for well-being were absence without leave (AWOL) incidents or instances when caregivers did not know where the child was. Within the sample, very few children went AWOL from their placements.

Programs staff also identified the following notable service considerations: (a) exploring connections with a child's biological family, (b) including the potential for reunification; (c) meeting therapeutic and behavioral needs through recreational activities and other nonconventional methods; and (d) helping children feel safe in addition to keeping them safe.

The URM program, with its specific adaptations and accommodations to meet the specialized needs of foreign-born child victims, can serve as a national and international model for the care and integration of both foreign-born and national/citizen child victims of human trafficking and commercial sexual exploitation. Advanced training on serving foreign-born child victims of trafficking would be helpful to all potential care providers. Limitations include that the sample includes only children identified, determined eligible by the federal government as victims of trafficking, and referred for URM placement, and thus may not represent the entire foreign-born child trafficking victim population in the United States. Additionally, some analyses were not possible due to the small sample size.

Cohen, J., Mannarino, A. P., & Kinnish, K. (2017). Trauma-Focused Cognitive Behavioral Therapy for commercially sexually exploited youth. *Journal of Child & Adolescent Trauma, 10,* 175–185. https://doi.org/10.1007/s40653-015-0073-9

Type of article: Descriptive paper with a composite case example

Subject of article: Explores the trauma experiences, responses, and treatment challenges of commercially exploited youth and how Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) can be utilized with this population
Location: Not applicable

Summary: Commercially sexually exploited children and adolescents present numerous clinical challenges that have led some mental health providers to question whether current evidence-based treatments are adequate to address the needs of this population. For example, clinicians frequently express concerns about how to engage these youth in treatment when the youth do not view the exploitation as traumatic, or when youth want to return to their exploiter; as well as how to deal with repeated running away or other potentially dangerous behaviors during therapy, and engage caregivers who are overwhelmed with the youth's multiple problems. This paper (a) addresses commonalities between the trauma experiences, responses, and treatment challenges of commercially exploited youth and those of youth with complex trauma; (b) highlights the importance of careful assessment to guide case conceptualization and treatment planning for commercially exploited youth; and (c) describes strategies for implementing Trauma-Focused Cognitive Behavioral Therapy for complex trauma specific to these youth.

Commercially exploited youth and youth with complex trauma generally share the following overlapping characteristics: (a) multiple interpersonal trauma experiences typically perpetrated by a caregiver with attachment disruption and decreased sense of safety; (b) high levels of PTSD symptoms (particularly avoidance), often associated with traumatic bonding and/or minimization or denial of trauma impact; (c) elevated levels of externalizing behavior problems and associated risky behaviors (e.g., running away, substance abuse, truancy, etc.); and (d) elevated levels of other domains of complex trauma impact (e.g., affective dysregulation; negative self-concept; interpersonal disturbances; and biological, dissociative, and behavioral problems).

The first step in effective treatment is accurate diagnosis. In addition to taking the usual psychiatric history, the clinician should attempt to obtain a complete trauma history—including the duration and frequency of trauma experiences throughout the youth's development—using an instrument such as the *Traumatic Experiences Screening Instrument (TESI)*. Assessing trauma responses using a standardized instrument such as the *UCLA PTSD Reaction Index* (Steinberg et al. 2004) also provides important information.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a well-established, evidence-based treatment for traumatized children ages 3–18 years old and their nonoffending parents or caregivers. Applications of the TF-CBT model for commercially exploited youth include the following:

1) The Enhancing Safety component is provided first and is reiterated throughout treatment as detailed below.
2) The TF-CBT phases are adjusted to dedicate proportionally more time to coping skills acquisition early in treatment, in recognition that youth with complex trauma have significant dysregulation. Note: Up to half of the total number of treatment sessions may be dedicated to this phase.
3) The total duration of treatment may be extended up to 25 sessions.

Additional complex trauma TF-CBT applications relevant for commercially exploited youth include recognizing the therapist as a potential trauma reminder and identifying unifying trauma "themes." Including caregivers and enhancing their ability to provide effective support, structure, and empathy to commercially exploited youth is also important. Finally, providing specific, targeted behavioral strategies to prevent and preempt risky behaviors (e.g., running away) is also an important application for this population.

An initial randomized controlled treatment trial in Africa for commercially exploited youth supports the effectiveness of TF-CBT for this population and the case example illustrates how TF-CBT complex trauma applications may be successful. More empirical treatment outcome research on TF-CBT with commercially exploited youth in the U.S. and internationally is needed.

Dank, M., Yu, L., & Yahner, J. (2016). Access to safety: Health outcomes, substance use and abuse, and service provision for LGBTQ youth, YMSM, and YWSW who engage in survival sex. Urban Institute. https://www.urban.org/sites/default/files/publication/77601/2000605-Access-to-Safety.pdf

Type of article: Research – cross-sectional, multimethod study
Subject of article: Describes and quantifies the sexual and physical health outcomes among lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth, young men who have sex with men (YMSM), and young women who have sex with

women (YWSW) engaged in survival sex in New York City; assess how many are using and abusing alcohol and drugs; and details youths' access to and interactions with treatment and service providers.
Location: New York City, New York

Summary: Researchers conducted a three-year study of lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth; young men who have sex with men (YMSM); and young women who have sex with women (YWSW) who have engaged in survival sex in New York City. Trained youth leaders conducted in-depth interviews with 283 youth who engaged in survival sex in New York City and self-identified as LGBTQ, YMSM, or YWSW. Earlier reports from this study have focused on the experiences and needs of youth engaging in survival sex and youths' interactions with the criminal justice and child welfare systems. In this third report of the series, the authors focus on youths' sexual, physical, and mental health problems; substance use behaviors; and treatment and service provider experiences. Data was collected from youth respondents about their exposure to sexually transmitted diseases (STDs) and other health issues, extent of substance abuse, and treatment and service provider experiences.

Key findings include that most youth reported using barrier and nonbarrier protection (most frequently condoms) against sexually transmitted infections (STIs) and pregnancy. Those youth who did not use protection cited financial and personal reasons, including getting paid more to not use a condom, not feeling the need to use protection with their partner or friend, trusting regular clients, and being forced to not use a condom.

Medical providers are often the first professionals that young people see when they have a medical issue or a question pertaining to sex or relationships, and they usually can insure patient/doctor confidentiality. Given these facts, medical providers are in a unique position to develop a trusted relationship with youth that allows them to feel comfortable discussing their engagement in survival sex. Healthcare providers can then provide youth with referrals and connect them to other agencies that might help with nonmedical needs, in addition to advocating on youths' behalf to receive certain services. Service providers often work together to meet client needs by forming formal and informal partnerships.

Of the 283 youth studied, 93% had visited one or more service providers. Of those, 99% accepted help from that provider, and 94% said they would seek such assistance

again. Although most of the youth had positive things to say about the youth programs and services offered to them, some recounted negative experiences, especially feeling discriminated against based on their sexual orientation and/or gender identity and expression, and particularly in urgent care and emergency room settings. Over a third (36%) of the youth who sought services stated their needs were fully met, but nearly two-thirds (64%) had unmet needs. The most common services youth wished had been offered by their provider were vocational/education assistance (15%), permanent housing assistance (13%), and short-term crisis or emergency shelter (7%).

In general, there is a lack of services once a youth reaches age 18 and 21. In New York City, there is a lack of funding for beds, medical and mental healthcare, job skills training, and educational opportunities for youth between the ages 21 and 24.

Recommendations include (a) to increase the number of medical vans that meet youth where they are, and establish more youth-focused medical care at clinics and emergency rooms; (b) to raise awareness of pre-exposure prophylaxis medication and make it more widely available and accessible to youth to help reduce the HIV infection rate; (c) to establish and fund more holistic and LGBTQ-sensitive mental health counseling and care for youth and staff; (d) to expand training to mental healthcare professionals and other youth provider staff on signs of PTSD and complex trauma and increase resources available to treat LGBTQ youth, YMSM, and YWSW suffering from PTSD; (e) to increase language capacity and provide cultural competency training to staff who work with foreign- born and/or non-English-speaking LGBTQ youth; (f) to establish a centralized, formal youth services referral database; and (g) to listen to the voices of youth regarding their recommendations for services and access to programs and safety.

Edinburgh, L., Pape-Blabolil, J., Harpin, S. B., & Saewyc, E. (2015). Assessing exploitation experiences of girls and boys seen at a child advocacy center. *Child Abuse & Neglect, 46,* 47–59. https://doi.org/10.1016/j.chiabu.2015.04.016

Type of article: Research — cross-sectional, retrospective study used existing data
Subject of article: Documents the contexts and experiences of sexual exploitation among youth presenting at a CAC; identifies the presenting physical findings, risk behaviors, and trauma symptoms of sexually exploited boys and girls, including when sexual exploitation was facilitated by a trafficker; and evaluates how the questions

asked during standard forensic interviews elicit useful or less helpful responses when the type of abuse is sexual exploitation with multiple perpetrators
Location: United States – urban Midwestern hospital-based Children's Advocacy Center

Summary: This study describes the abuse experiences of sexually exploited runaway adolescents seen at a CAC (N = 62) and sought to identify risk behaviors, attributes of resiliency, laboratory results for sexually transmitted infection (STI) screens, and genital injuries from colposcopic exams. Retrospective mixed-methods data included in-depth forensic interviews, along with self-report survey responses, physical exams, and chart data. Forensic interviews were analyzed using interpretive description analytical methods along domains of experience and meaning of sexual exploitation events. Univariate descriptive statistics characterized trauma responses and health risks.

These victims reported wide-ranging symptoms of emotional distress. Most admitted cutting or burning themselves, 3 in 4 reported suicidal ideations, and half had attempted suicide in the past year (57% of boys versus 47% of girls). Among those who completed the *UCLA PTSD screening tool*, 78% experienced PTSD symptoms severe enough to meet DSM IV criteria for PTSD. Most youth reported ever using alcohol or marijuana, and 1 in 4 had ever used methamphetamine. All of the boys and nearly half of the girls met the criteria for problem substance use.

Youth were most often sexually exploited after running away or being kicked out of their home. Contrary to common depictions, youth may be solicited relatively quickly as runaways, yet exploitation is not always linked to having a pimp. The first sexual exploitation events for many victims occurred as part of seemingly random encounters with procurers. Older adolescent or adult women recruited some youth working for a pimp. However, half the youth did not report a trafficker involved in setting up their exchange of sex for money, substances, or other types of consideration. After being recruited, there were three main types of exploitation described by the youth interviewed: (a) "small" transactions with faceless, nameless purchasers; (b) exploitation by a pimp/trafficker; and (c) self-managed transactions without a pimp.

Avoidant coping does not appear effective, as most patients exhibited significant symptoms of trauma. The standard principles of forensic interviewing still apply, and it is important to establish rapport and review the ground rules for the interview to

assure a common understanding of the expectations regarding accurate reporting and interpretation of information. It is especially important to ensure that any question asked is well thought-out, as there may be unintended consequences for the victim based on their response. Before interviewing sexually exploited youth, the multidisciplinary team at the CAC will need to think through how they will question teens about illegal events where the teen is also pulled into illegal behavior such as theft, selling, and using drugs. It is essential that providers recognize that the teen may have been involved in illegal activities during the time they were abused, but it is key to treat youth as victims of the exploitation they experienced. Awareness of variations in youths' sexual exploitation experiences may help researchers and clinicians understand potential differences in sequelae, design effective treatment plans, and develop community prevention programs. Limitations include the use of retrospective chart reviews, where inconsistencies can create missing data (e.g., different questions were asked during forensic interviews), the small sample size, and the limited number of boys involved in the study.

Gibbs, D. A., Walters, J. L. H., Lutnick, A., Miller, S., & Kluckman, M. (2015). Services to domestic minor victims of sex trafficking: Opportunities for engagement and support. *Children and Youth Services Review*, *54*, 1-7. https://doi.org/10.1016/j.childyouth.2015.04.003

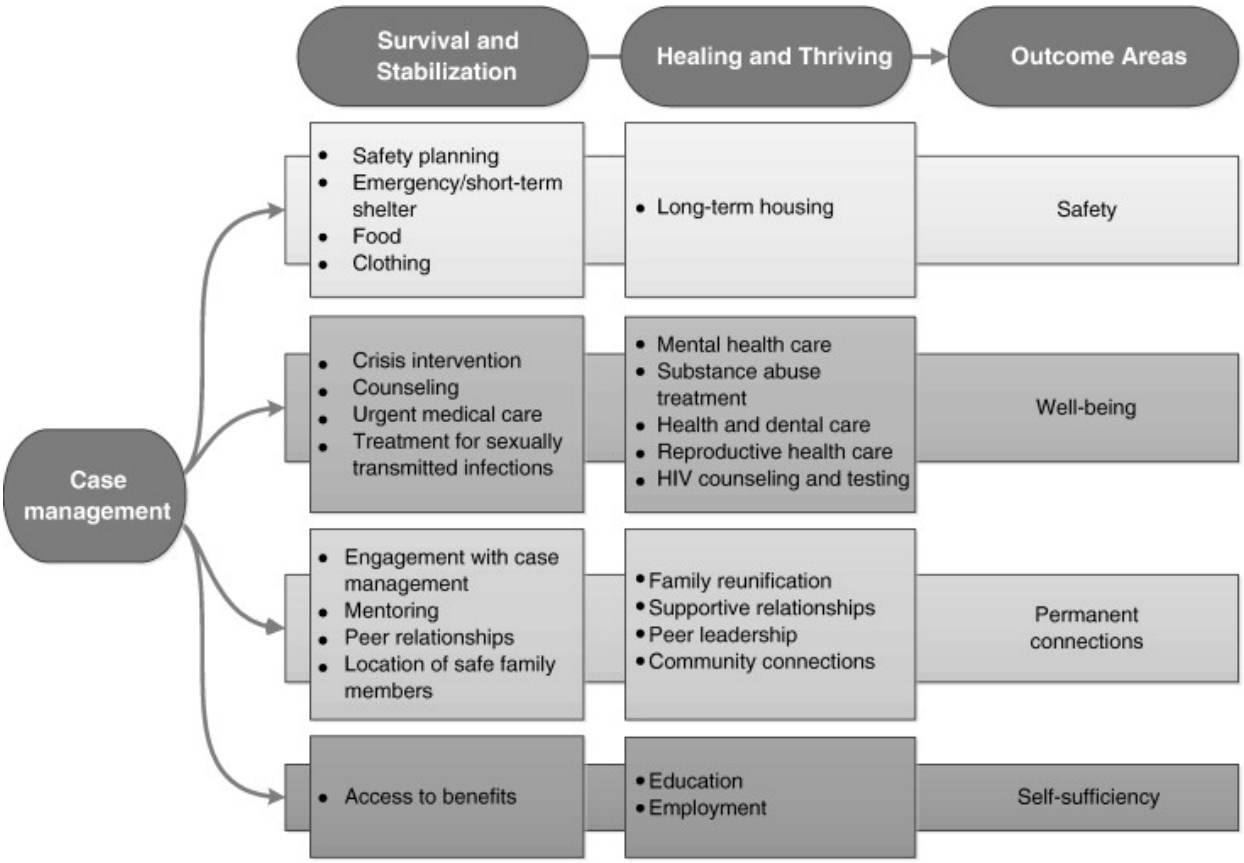
Type of article: Descriptive study using qualitative interviews and program data
Subject of article: Describes the characteristics and service needs of the clients at three programs serving domestic minor victims of human trafficking
Location: San Francisco, CA; Chicago, IL; New York City, NY

Summary: Human trafficking of young people is a social problem of growing concern. Within the United States, the existence of trafficking is well-established, yet not well-understood. This paper describes an evaluation of programs that serve minor domestic victims of human trafficking. These programs provided case management and comprehensive services, either directly or through community collaboration. Evaluation data included data on client characteristics, service needs, and services delivered; key informant interviews with program staff and partner agencies; and case narrative interviews in which program staff provided in-depth descriptions of clients' histories. All clients served were known or believed to be sex trafficked.

The three programs served 201 young people during the 2.5-year evaluation period, of which 55% were confirmed as sex trafficked (range 29%–94%). Approximately three-quarters of all young people served across the three programs were females, with a median age of 17 (range 12–18 years). Race and ethnicity varied among programs; overall, 65% of young people were African American (range 54%–86%), and 22% were Hispanic (range 4%–34%). Across all programs, young people reported high rates of service system involvement and prior maltreatment. More than one third (38%) of clients were reported to have a child welfare case worker at the time of program intake (range 34%–45%). The majority of clients needed crisis intervention, safety planning, educational support, mental health services, and employment services.

Although they were diverse in terms of demographics and circumstances, two common patterns were of homeless young people exchanging in sex to meet survival needs, and being emotionally engaged with their trafficker. Key findings include (a) the diversity of trafficked minors, (b) the challenge of initial and continued engagement with service delivery, (c) the structural and resource barriers to long-term support for young people, and (d) the potential contribution of programs specifically addressing trafficked minors. A framework linking services to young people's circumstances and outcome areas is proposed (see Figure 3 below). Limitations include the small number of organizations and clients in the study.

Figure 3:



Greenbaum J, Crawford-Jakubiak J, & Committee on Child Abuse and Neglect. (2015). Child sex trafficking and commercial sexual exploitation: Healthcare needs of victims. *Pediatrics, 135*(3), 566–574. https://doi.org/10.1542/peds.2014-4138

Type of article: Clinical report
Subject of article: Provides clinical guidance on the risk factors for commercial sexual exploitation of children (CSEC); victim identification and evaluation; and referrals, resources, and multidisciplinary intervention
Location: Not applicable

Summary: Child sex trafficking and CSEC are major public health problems in the United States and throughout the world. Despite large numbers of American and foreign youth affected and a plethora of serious physical and mental health problems associated with CSEC, there is limited information available to pediatricians regarding the nature and scope of human trafficking and how pediatricians and other healthcare providers may help protect children. Knowledge of risk factors,

recruitment practices, possible indicators of CSEC, and common medical and behavioral health problems experienced by victims will help pediatricians recognize potential victims and respond appropriately.

Male and female victims of sex trafficking and CSEC may present for medical care for a variety of reasons related to trauma, infection, reproductive issues, and mental health problems. They require a comprehensive evaluation and, often, numerous referrals. The pediatrician has the opportunity to work collaboratively as part of a team of professionals from a number of disciplines to address these needs. Victims of CSEC rarely self-identify and although some victims have no risk factors or obvious indicators, youth at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with child protective services (CPS) or the juvenile justice system, multiple sexually transmitted infections (STIs), pregnancy, or substance use or abuse.

Evaluations of CSEC victims may be challenging. A comprehensive history related to injuries/abuse, reproductive issues, substance use, and mental health symptomatology obtained with a nonjudgmental, open attitude may provide important revelations. However, this cannot be performed without attention to the youth's safety and potential distress during the interview. Medical evaluation of a CSEC victim involves addressing acute medical/surgical issues, evaluating possible chronic untreated conditions, documenting acute/remote injuries, testing and treating STIs, and often, obtaining a sexual assault evidence kit.

Providers may advocate for victims by educating child-serving professionals and families regarding CSEC and child trafficking, and by giving anticipatory guidance to parents and children regarding internet safety and common recruitment scenarios. They may also advocate changing state laws so that minors involved in commercial sexual exploitation are treated as victims rather than as juvenile offenders. Pediatricians are mandated reporters of suspected child abuse and neglect. In states where CSEC/sex trafficking is considered a form of abuse, the pediatrician must make a formal report of suspected exploitation to law enforcement and to CPS as well, if indicated.

As healthcare providers, educators, and leaders in child advocacy, pediatricians play an essential role in addressing the public health issues faced by child victims of CSEC. Their roles can include working to increase recognition of CSEC, providing direct care and anticipatory guidance related to CSEC, engaging in collaborative efforts

with medical and nonmedical colleagues to provide for the complex needs of youth, and educating child-serving professionals and the public.

Lavoie, J., Dickerson, K. L., Redlich, A. D., & Quas, J. A. (2019). Overcoming disclosure reluctance in youth victims of sex trafficking: New directions for research, policy, and practice. *Psychology, Public Policy, and Law, 25*(4), 225–238. https://doi.org/10.1037/law0000205

Type of article: Review article
Subject of article: Reviews what is known about how best to obtain clear and accurate disclosures from victims of commercial sexual exploitation of children (CSEC) about their exploitation
Location: Not applicable

Summary: An alarming number of youths worldwide are victims of commercial sexual exploitation, particularly sex trafficking, and youth are at greatest risk for trafficking as adolescents. Given the developmental processes and motivations across the adolescent period, combined with personal history, victims of CSEC are highly likely to be reluctant to disclose their exploitation to police—who often encounter victims as suspects of delinquency and crime, and who then interrogate these victims as suspects. Unlike the best-practice interviewing strategies available to elicit disclosures in other vulnerable victim populations—including, most notably, children suspected of having been sexually abused—little scientific and policy attention has been devoted to understanding how to question CSEC victims in a way that reduces their disclosure reluctance and increases their provision of legally relevant information.

In the current review, which focuses primarily on adolescent victims of sex trafficking, the authors review the developmental processes underlying reluctance to disclose, such as age-normative reductions in adolescents' willingness to tell adults about some risky experiences, identity exploration, and an increasing desire for autonomy. These processes each which have implications for disclosure patterns in adolescent victims of sex trafficking. In addition, the victims' prior experiences, such as abuse, maltreatment, and experiences while being trafficked also significantly impact how they perceive and interact with adults—including legal professionals—and, therefore, what they are likely to disclose. Finally, the victims' own guilt and shame, as well as their perceived reliance on the trafficker for daily needs, may also impact disclosure reluctance.

Youth suspected of having been sex trafficked or at risk for sex trafficking come to the attention of the authorities via several different paths, though rarely initially via the victim's own disclosure. The most common way is because the victims are suspected of delinquency or crime. When this occurs, the police may question the victims using interviewing tactics common to interrogations of criminal suspects. Such tactics can undermine disclosure accuracy and credibility and foster mistrust and hostility. The tactics also make it extremely difficult to build rapport, be supportive, and conduct an interview in a manner that promotes, rather than inhibits, victims' comfort and cooperation. A comprehensive analysis of the extent to which victims are questioned like suspects, and the consequences of doing so, is needed, as is an analysis of questioning approaches and their effects on victim disclosures, both in jurisdictions with and without specialized trafficking units.

Only two studies have directly examined forensic interviewing of victims of sex trafficking, and both have limitations. Well-established, empirically supported forensic interviewing protocols already exist that outline best-practice questioning strategies to elicit accurate and complete disclosures from child victims of sexual abuse. A relatively straightforward recommendation for future research might be simply to test whether these same strategies are useful when questioning suspected victims of sexual trafficking. However, the unique risk factors in the lives and relationships of victims of sex trafficking, combined with their typical encounters with the police, make their needs in forensic settings understandably complex. Important directions for future research include (a) systematic research documenting current approaches to forensic interviewing of victims of sex trafficking; (b) identification, using rigorous and creative experimental designs, of the mechanisms underlying adolescents' willingness (or not) to disclose personal experiences to adults; (c) tests of the effects of variants of rapport and support on adolescents' disclosures, comfort, and cooperation; and (d) examining the effects of different questioning approaches (e.g., high proportion of closed-ended questions, interrogative tone) on adolescents' perceived credibility in trafficking cases.

Two key practical recommendations can be made based on existing knowledge. The first is a clear need for legal professional training on adolescent development, and how developmental processes play out in interactions with adolescent victims of sex trafficking. The second is greater attention to understanding the types of sexual abuse that adolescents are more versus less likely to endure, as these experiences

shape in profound ways their reactions to questioning—by any authority figure—about the abuse, their role, and its consequences.

Salami, T., Gordon, M., Coverdale, J., & Nguyen, P. T. (2018). What therapies are favored in the treatment of the psychological sequelae of trauma in human trafficking victims? *Journal of Psychiatric Practice, 24*(2), 87–96. https://doi.org/10.1097/PRA.0000000000000288

Type of article: Review article
Subject of article: Promotes recommendations for psychotherapeutic interventions for treating the psychological symptoms of human trafficking, informed in part by the literature concerning the treatment of other forms of trauma, coupled with the current understanding of the psychological issues faced by human trafficking victims
Location: Not applicable

Summary: Human trafficking is a major public health concern that brings about deleterious psychological consequences and sequelae. Although a number of risk and protective factors for the health consequences of human trafficking victims have been identified, there is a dearth of information in the area of treatment. Specifically, a literature review found no articles comparing the different components of prevailing trauma treatment strategies or the potential usefulness of these strategies in the treatment of human trafficking victims. To this end, the study compared and contrasted the different therapeutic treatments typically implemented with victims of trauma (including domestic violence victims and torture victims), and discussed how the different components of these treatments may or may not be helpful for human trafficking victims.

PTSD is a common condition for many human trafficking victims. Cognitive processing therapy (CPT) and prolonged exposure therapy (PE) are the primary interventions employed in outpatient settings for trauma survivors. Although both evidence-based manualized treatment protocols that have been found to be effective in the treatment of PTSD, their primary mechanisms of action differ: the proposed mechanism of change for CPT is the use of cognitive restructuring techniques to change maladaptive hopelessness cognitions regarding one's self and the world that develop as a result of trauma experience, whereas PE is thought to mitigate distress as a result of trauma primarily through a habituation process, whereby victims of trauma are repeatedly exposed to both internal (e.g., thoughts) and external (e.g., places) stimuli that remind them of the trauma event(s).

Although studies comparing the effectiveness of cognitive-based (e.g., CPT) and exposure-based (e.g., PE) treatments show comparable levels of treatment effectiveness for treatment completers, there are some differences that may be potentially meaningful for human trafficking victims. First, although both CPT and PE are said to modify maladaptive cognitions, some studies suggest that only CPT is able to resolve issues of guilt and shame. Second, although studies examining real-world utilization of these interventions show poor retention and substantial dropout rates for both therapy types, studies generally find higher dropout rates for PE. Third, PE and Cognitive Processing Therapy-Cognitive Therapy (CPT-C, an updated version of CPT) may be helpful for patients with literacy deficits and physical disabilities because patients do not need to write a trauma account for either of these approaches.

On the basis of the prevailing research, the authors highlighted cognitive therapies as being preferred in addressing the needs of human trafficking victims. Mental health providers who work with human trafficking victims should become aware of and practiced in the use of cognitive therapeutic approaches in treating this population. Efficacy and effectiveness studies will provide better evidence of treatment effectiveness for human trafficking victims. Research designs that focus on mechanisms of action (mediation studies) and factors that may influence outcomes (moderation studies) should be employed to provide greater clarity about treatment approaches.

Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence, 33*(3), 185-195. https://doi.org/10.1007/s10896-018-9950-y

Type of article: Descriptive study using secondary clinical data
Subject of article: Describes the clinical presentation of juvenile victims of commercial sexual exploitation perpetrated by family members
Location: Predominately rural state in the United States

Summary: It is well-documented in the literature that child sex trafficking can be perpetrated by family members, though limited research has focused on describing this type of sexual exploitation. This pilot study addresses this gap by providing an analysis of familial sex trafficking, considering trafficking dynamics and rurality. Using a sample of 31 child welfare-involved children referred for behavioral health assessment and treatment, this mixed methods study explores: (a) victim and trafficker characteristics, the trafficking situation, law enforcement classifications of

trafficking, clinical profiles of victims, and system involvement of children and youth involved in familial sex trafficking; (b) gender differences in clinical outcomes in sex trafficked children; and (c) geographical differences in severity of the victimization experience. Measures include administrative and clinical data, as well as the *Child Behavior Checklist (CBCL)* and the *Trauma Symptom Checklist for Children (TSCC)*.

Major findings include that a high percentage of cases (81.8%, n = 25) involved parents who used illicit drugs as the currency to profit from trafficking of their children. In every case, the parent resided with the child during the exploitation period. The overall mean severity of abuse scores were high in the overall sample (M = 14.66, SD = 3.02), with high coercion scores (M = 3.6, SD = 0.81), indicating that threats, bribes, physical force, and weapons were used to coerce the youth in this sample into sex trafficking. Severity scores were statistically significantly higher for children living in rural communities. Over one-third of the sample (35.5%, n = 11) had a psychiatric hospitalization subsequent to the trafficking, and almost half (48.4%, n = 15) reported they had attempted suicide during their lifetime. Boys and girls had similar clinical profiles except boys had higher *CBCL* externalizing scores, and females had higher *TSCC* depression scores. Identification of sex trafficking was most frequently preceded by a report from the hospital emergency room (51.6% of the time, n = 16) to child protective services, or uncovered during a police investigation (45.1%, n = 14).

This formative study sheds light on the phenomenon of familial sex trafficking, thereby creating the context for further investigations. By further explicating the nuanced and differential experience of family trafficking, this pilot study allows for the sex trafficking of children to be understood from a child maltreatment perspective, and creates additional opportunities to consider the most appropriate ways to identify and respond to victims. Increasing service providers' awareness and capabilities to recognize and appropriately respond to the unique aspects of familial sex trafficking is necessary to provide effective therapeutic services to victims, and to hold traffickers accountable for these serious crimes. Limitations include the small sample size and the use of self-report and retrospective recall, which may introduce bias.

Zimmerman, C., & Watts, C. (2003). *World Health Organization ethical and safety recommendations for interviewing trafficked women*. Health Policy Unit, London School of Hygiene and Tropical Medicine.
https://www.who.int/mip/2003/other_documents/en/Ethical_Safety-GWH.pdf

Type of article: Guidance based on expert consensus
Subject of article: Provides a set of ten basic standards for interviewing women who are in or have left a trafficking situation
Location: Not applicable

Summary: The trafficking of women and girls into forced prostitution and other slavery-like or exploitative conditions is increasingly recognized as one of the world's fastest growing crimes and most significant human rights violations. In response to the rapid global rise in trafficking and the growing demand for information on trafficking by policymakers, donors, service providers, and the media, women who have been trafficked are increasingly being interviewed to discuss their experiences. Women are being interviewed both while they are in trafficking situations under the control of traffickers, employers, or pimps and after they have left the trafficking setting, such as while in shelters, under the care of service agencies, or once they have returned home or reestablished their lives elsewhere. In any of these situations, interviewing a woman who has been trafficked raises a number of ethical questions and safety concerns for the woman, others close to her, and for the interviewer. Having a sound understanding of the risks, ethical considerations, and the practical realities related to trafficking can help minimize the dangers and increase the likelihood that a woman will disclose relevant and accurate information.

These recommendations are intended primarily for use by researchers, members of the media, and service providers unfamiliar with the situations of trafficked women. The recommendations should be used in conjunction with existing professional standards applicable to the work being conducted and should not be taken as a comprehensive guide to working with women who have been trafficked. These recommendations provide a set of ten basic standards for interviewing women who are in or have left a trafficking situation:

1. DO NO HARM: Treat each woman and the situation as if the potential for harm is extreme until there is evidence to the contrary. Do not undertake any interview that will make a woman’s situation worse in the short term or longer term.
2. KNOW YOUR SUBJECT AND ASSESS THE RISKS: Learn the risks associated with trafficking and each woman's case before undertaking an interview.
3. PREPARE REFERRAL INFORMATION—DO NOT MAKE PROMISES THAT YOU CANNOT FULFILL: Be prepared to provide information in a woman's native

language and the local language (if different) about appropriate legal, health, shelter, social support, and security services, and be prepared to help with referral, if requested.

4. ADEQUATELY SELECT AND PREPARE INTERPRETERS AND CO-WORKERS: Weigh the risks and benefits associated with employing interpreters, co-workers, or others, and develop adequate methods for screening and training.
5. ENSURE ANONYMITY AND CONFIDENTIALITY: Protect a respondent's identity and confidentiality throughout the entire interview process—from the moment she is contacted through the time that details of her case are made public.
6. GET INFORMED CONSENT: Make certain that each respondent clearly understands the content and purpose of the interview, the intended use of the information, her right not to answer questions, her right to terminate the interview at any time, and her right to put restrictions on how the information is used.
7. LISTEN TO AND RESPECT EACH WOMAN'S ASSESSMENT OF HER SITUATION AND RISKS TO HER SAFETY: Recognize that each woman will have different concerns, and that the way she views her concerns may be different from how others might assess them.
8. DO NOT RE-TRAUMATIZE A WOMAN: Do not ask questions intended to provoke an emotionally charged response. Be prepared to respond to a woman's distress and highlight her strengths.
9. BE PREPARED FOR EMERGENCY INTERVENTION: Be prepared to respond if a woman says she is in imminent danger.
10. PUT INFORMATION COLLECTED TO GOOD USE: Use information in a way that benefits an individual woman or that advances the development of good policies and interventions for trafficked women generally.

By following these recommendations and always prioritizing the safety of women, those requesting interview-based information and those conducting interviews can make significant contributions to the public recognition of this serious violation and to the quality of care for trafficked women.

Section III: Appendices

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Appendix A: Biographies of topic area experts

The authors of this project wish to thank the following expert evaluators for their guidance in the selection and evaluation of the literature.

Corey Brodsky, MA, has served as the program manager for Chapter Development and Partnerships at the Midwest Regional CAC (MRCAC) since June 2015. In his role, Corey is primarily responsible for supporting the development of the 12 State Chapter organizations in the Midwest with a particular focus on strategic planning. He also provides support to a variety of national partnership projects, including participation in the national work group to improve the response to child sexual abuse in Indian Country and management of MRCAC's programs on missing and exploited children. Corey leads MRCAC's equity initiatives in coordination with a dedicated Equity Council and was recently appointed to the Health Equity Council at Children's Hospitals of Minnesota. Corey has an MA in international affairs from The George Washington University along with a BA in global studies and French from The University of Minnesota.

Andra Chamberlin, MA, is a trainer and child forensic interview specialist with the National Children's Advocacy Center in Huntsville, AL. Andra has worked in the child abuse field since 1989 and began conducting forensic interviews in 1996. She has conducted forensic interviews in Children's Advocacy Centers (CACs) in Alabama and Texas. Andra currently teaches the National Children's Advocacy Center's (NCAC's) Forensic Interviewing of Children and Advanced Forensic Interviewing of Children trainings, and presents on child forensic interviewing at local, regional, state, national, and international child abuse conferences. She is the developer and host of the online video series for forensic interviewers titled "Takeaway Tuesdays" and helped develop the first intermediate online forensic interview training in the United States titled "Building Forensic Interviewing Skills." In addition to her ongoing work in the field of child forensic interviewing, Andra serves as a forensic interviewer mentor with the NCAC's Mentoring and Consultation Groups for Child Forensic Interviewers. Andra was a member of a community organization which established the CAC in Midland Texas where she served as program director/lead forensic interviewer for 14 years. She also piloted the development of a forensic interview protocol for the state of Texas and taught forensic interviewing training for 11 years for the Children's Advocacy Centers of Texas. Andra has provided expert testimony for both criminal and civil court proceedings in multiple jurisdictions. She received her MA in applied

research psychology and BA in sociology from the University of Texas of the Permian Basin.

Greg Flett, MSW, has over 15 years of experience working with child-serving nonprofit organizations throughout the U.S. In his role as the senior program manager at the NCAC, Greg leads the Children and Youth Workgroup for the National Resource Center of Reaching Victims. This Office of Victims of Crime–funded project brings together experts from around the country to develop resources and training aimed at increasing the quality and accessibility of services for child victims. In his previous role as the outreach coordinator for the Northeast Regional Children's Advocacy Center, Greg provided training and technical assistance to CACs and multidisciplinary teams (MDTs). He approaches this work with a strong focus on strengthening collaboration and team effectiveness to improve outcomes for children and families impacted by abuse. Greg has served as executive director of CACs in New York and Colorado, and he has facilitated trainings with MDTs and team facilitators from across the country.

Betsy Goulet, PhD, is a clinical assistant professor in the College of Public Affairs and Administration, University of Illinois Springfield (UIS), and is a national consultant/trainer. In 1986, Dr. Goulet began working in the field of child sexual abuse, beginning with her first position as the victim advocate at a rape crisis center. Dr. Goulet was the founding director of the Sangamon County Child Advocacy Center from 1989 to 1995 and organized the Illinois Chapter of Children's Advocacy Centers, serving as that organization's first president. From 1995 until June of 2002, she was the children's policy advisor to the Illinois attorney general. In that role, she drafted several pieces of legislation, including amendments to the Children's Advocacy Center Act and the creation of the Sex Offender Management Board. From 2002 to 2007, Dr. Goulet was a membership consultant for National Children's Alliance in Washington, DC, conducting national accreditation site reviews and providing training for multidisciplinary team members and Children's Advocacy Center staff. Dr. Goulet's research with Dr. Ted Cross was published in an international book on mandated reporting. Dr. Goulet was also instrumental in the development of and advocacy for the passage of legislation to require mandated reporter training for teachers in Illinois. She is currently working on another article with Dr. Cross on simulation training for child protection investigators. Her research on ethics and organizational performance was published in the *Global Encyclopedia of Public Administration, Public Policy, and Governance*. Through a contract with the Illinois Department of Children and Family Services, Dr. Goulet developed a new

model for frontline training for child protection that emphasizes experiential learning and incorporates the use of a Residential Simulation Lab and mock courtroom on the UIS campus. This project was also supported by legislation she helped to draft that was signed into effect by the governor in 2015. At UIS, she is the director of the child advocacy studies certificate program (CAST), teaching the three courses as part of an interdepartmental program for students interested in child welfare/protection careers. On the national level, she is a consultant for the Zero Abuse Project's National Child Protection Training Center, assisting other universities in the development of their CAST programs. She also serves as the principal investigator on the SAMHSA FORECAST grant at UIS, a partnership with the University of Missouri St. Louis.

Jordan Greenbaum, MD, is a child abuse physician from Atlanta, GA. She is the medical director of the Global Health and Well-Being Initiative with the International Centre for Missing and Exploited Children, and medical director of the Institute on Healthcare and Human Trafficking at the Stephanie Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta. She co-chairs the education/training committee for HEAL Trafficking, an organization of professionals working on human trafficking issues. Her research focuses on designing and validating a screening tool to be used in healthcare settings to identify youth at risk for trafficking/sexual exploitation.

Lisa M. Jones, PhD, is a research associate professor of psychology and faculty at the Crimes against Children Research Center, University of New Hampshire. She has 20 years of experience conducting research on child victimization and evaluating national, state, and community-level prevention and intervention responses to youth victims. In her recent research, she has focused on bias and hate crime victimization, youth firearm violence exposure, child sexual abuse and sex trafficking victimization, and child online risks and victimization experiences. Dr. Jones has conducted several research studies in collaboration with Children's Advocacy Centers (CACs), including a multisite evaluation of CACs, and has conducted research examining national trends in child sexual and physical abuse. She has published over 75 papers on child victimization and regularly presents across the country and internationally on these topics.

Bart Klika, PhD, is the chief research and strategy officer at Prevent Child Abuse America. Prior to joining the team, Dr. Klika served as an assistant professor of social work at the University of Montana (UM). While at UM, Dr. Klika's research on how to

prevent occurrences of child abuse and neglect focused on the causes and consequences associated with them. During his doctoral studies, Dr. Klika served as a research consultant for the Centers for Disease Control and Prevention (CDC) examining issues related to the prevention of child abuse and neglect. Dr. Klika is a member of the American Professional Society on the Abuse of Children (APSAC) Board of Directors and is the chairman of the APSAC Prevention Committee. Recently, Dr. Klika served as the senior editor of the *APSAC Handbook on Child Maltreatment* (4th Ed.). He also serves as an associate editor of the *Journal of Interpersonal Violence*. Dr. Klika holds a PhD in social welfare from the University of Washington, in addition to an MSW from the University of Chicago, and a BA in psychology from the University of Montana.

Thomas D. Lyon, JD, PhD, is the Judge Edward J. and Ruey L. Guirado Chair in Law and Psychology at the University of Southern California Gould School of Law. His work has focused on maximizing children's productivity as witnesses while minimizing error. He is the former president of the American Psychological Association's Section on Child Maltreatment and a former member of the board of directors of the American Professional Society on the Abuse of Children. His work has been supported by the National Institutes of Health, the National Science Foundation, and the United States Department of Justice.

John Melville, MS, MD, currently serves as division chief for the Division of Child Abuse Pediatrics at the Medical University of South Carolina. Dr. Melville graduated medical school at the University of California at San Diego, completed a combined medicine and pediatrics residence in Akron, Ohio, and a completed a child abuse fellowship at the University of Texas Health Science Center at San Antonio. Prior to his medical training, Dr. Melville completed a MS in computer science at Brigham Young University. Dr. Melville's passion resides in child abuse informatics—or the application of computer technologies to the work of child abuse pediatricians. Some of his projects include Photodoc, an electronic medical record dedicated to forensic medicine; The Online Bibliography of Child Abuse Pediatrics; and the Expert Witness Database.

Shalon Nienow, MD, is the medical clinic director at the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego, and a clinical assistant professor of pediatrics at UC San Diego School of Medicine. She joined the Chadwick team following four years in Albuquerque, NM, where she was an assistant professor of pediatrics at the University of New Mexico. There she had a dual appointment,

working with the Child Abuse Response Team (CART) and serving as medical director of Para Los Niños. CART provides medical evaluations for children who are alleged victims of physical abuse or neglect, and Para Los Niños provides medical evaluations for children who are alleged victims of sexual abuse/assault. Dr. Nienow frequently serves as an expert witness in civil and criminal legal proceedings related to all aspects of child maltreatment. Dr. Nienow has conducted research in patterns of disclosure in child sexual abuse as well as methods of testing for sexually transmitted infections in children. She regularly provides trainings to various members of the multidisciplinary team. Dr. Nienow has served on the NCE planning committee for the AAP section on child abuse and neglect, was an editor for the AAP's latest publication of the visual diagnosis CD, and is on the ABP content development team for Maintenance of Certification (MOC) for the Child Abuse Sub-Board. She was recently elected to the executive committee of the American Academy of Pediatrics Counsel on Child Abuse and Neglect. Areas of professional interest include starvation and torture, abuse burn patterns, psychological maltreatment, disclosure patterns, and sexually transmitted infections.

Carole Campbell Swiecicki, PhD, is the executive director of Dee Norton Child Advocacy Center in Charleston, SC—an accredited member of NCA. She also serves on the executive committee of the NCA Board of Directors as chair of the Accreditation Committee. Dr. Swiecicki is a clinical psychologist and a clinical assistant professor in the Medical University of South Carolina Department of Psychiatry and Behavioral Sciences.

Wendy A. Walsh, PhD, is a research faculty member at the University of New Hampshire's Crimes against Children Research Center, where she has worked for the past 19 years conducting research on evaluating child abuse prevention and intervention programs and the criminal justice response to child victimization. Her research areas include Children's Advocacy Centers, internet crimes against children, victims portrayed in sexual abuse images, and improving access to children's mental health services. She recently evaluated the National TeleNursing Center, a pilot project to use telemedicine to bring quality forensic medical examinations to adolescent and adult victims of sexual assault in rural, tribal, military, and underserved areas. She is the author and co-author of numerous articles about child victimization and service use, the impact of victimization, and criminal justice outcomes.

Charles Wilson, MSSW, is the senior director of the Chadwick Center for Children and Families and the Sam and Rose Stein Endowed Chair in Child Protection at Rady Children's Hospital-San Diego where he oversees a large multiservice child and family maltreatment organization providing prevention, intervention, medical assessment, and trauma treatment services along with professional education and research. Mr. Wilson serves as director of the California Evidenced-Based Clearinghouse for Child Welfare (CEBC), under contract with the California Department of Social Services; director of the Western Regional Children's Advocacy Center funded by the Office of Juvenile Justice and Delinquency Prevention; and as project director of the Center for Child Welfare Trauma-Informed Policies, Programs, and Practices (TIPs Center) for the Substance Abuse and Mental Health Services Administration (SAMHSA). The senior director also supports institution-wide efforts to improve the operations of the hospital, co-leads the Rady Children's Hospital Centers for Developmental and Behavioral Sciences and provides administrative oversight to Rady Children's Psychiatry and Medical Social Services departments. He co-chairs the Child Welfare Committee of the SAMHSA-funded National Child Traumatic Stress Network and serves on the board of the California Chapter of National Children's Alliance. Mr. Wilson previously served as executive director of the National Children's Advocacy Center in Huntsville, Alabama as well as in a variety of roles in child welfare including 14 years as the director of child welfare in Tennessee.

Appendix B: Table of citations from earlier bibliographies

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CSEC	Not included in this edition.	Not included in this edition.
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