Public Laws and Investments Intended to Promote the Use of Medical Expertise in the Diagnosis and Treatment of Child Abuse and Neglect

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Executive Summary

Health care professionals, most notably board-certified child abuse pediatricians (CAPs), are essential partners in protecting children. These professionals, when timely and meaningfully engaged by child welfare professionals and law enforcement, provide critical expertise to respond to childhood trauma, and to guard against both under and over-diagnosis of child maltreatment.[1] A missed diagnosis of abuse puts children at risk for continued abuse and further injury; while over-diagnosis may lead to the inappropriate removal of children from their family, as well as civil or criminal court involvement for persons alleged to have abused a child.

Congress has enacted laws, including the Child Abuse Prevention and Treatment Act (CAPTA) and Victims of Child Abuse Act (VOCAA), which recognize the important and unique role of health care professionals in the accurate identification, diagnosis and treatment of child maltreatment. Some states have enacted laws that set forth, some in great detail, when and how specially-trained health care professionals are to be enlisted by child welfare professionals or law enforcement during a child abuse investigation, and throughout civil and criminal court proceedings.

Despite federal and state laws recognizing the value of health care providers with expertise in child maltreatment, there remains insufficient standardized practice or investment to ensure that children receive timely and appropriate medical evaluations and care. In addition, child welfare professionals and law enforcement often lack access to the expertise of CAPs or another health care provider with specialized training in child maltreatment, and are left to make decisions about child abuse and child safety without knowledge regarding injury epidemiology, injury mechanisms, infant and child development and medical disease that impacts children. Identifying abused children before their injuries are permanent or, in some cases, fatal, requires systems of care and evaluation that are based in best practices and informed by science.

In writing this research brief, the authors examined the statutes and/or administrative policies of eleven states (Connecticut, Florida, Illinois, Indiana, Maryland, Missouri, New Jersey, Oregon, Pennsylvania, South Carolina and Texas) and the City of Los Angeles to understand whether and how child protection statutes or administrative policies:

1. Establish an expectation that a child, who was reported as a suspected victim of child maltreatment, is referred for a medical evaluation; and whether there are any added requirements related to children with specific types of injuries or demographics (e.g., infants and toddlers);
2. Articulate the specific design of a child abuse medical evaluation and consultation program that utilizes health care providers with specialized training in child maltreatment (e.g., CAPs);
3. Identify a designated funding source for medical evaluation and consultation; and
4. Create a (state or local) child protection medical director; and if so, what this position is specifically responsible for.

This analysis had these limitations:

1. Only 12 jurisdictions were included in the primary analysis. These jurisdictions - except for Pennsylvania - were chosen because the authors were aware that a medical consultation program existed. Pennsylvania was chosen as an example of a state without a medical consultation program. Ohio was not included in the overall examination of state statute or administrative policies but is discussed in this publication as it relates to Ohio's Timely Recognition of Abusive Injuries (TRAIN) Collaborative.
2. Assessing to what degree state or local statute or written policy aligned or conflicted with on-the-ground practice was pursued by an interview with a child abuse pediatrician in each of the 13 jurisdictions. This area deserves further review and analysis.

Our review demonstrates the following:

- Among the 12 medical consultation programs we reviewed, the types of cases included in the programs is highly variable.
- The interaction between the medical consultation programs and the locally operated children's advocacy center (CAC) is highly variable and often difficult to assess, particularly as it relates to physical child abuse.
- In 9 of the 12 jurisdictions with medical consultation programs, specific injuries and/or age of a child triggers a medical evaluation. In each jurisdiction, it appears that the need for the consultation can be over-ridden by the CPS supervisor under certain conditions.
- There are very limited data about the effect of the medical consultation on outcomes (e.g., decrease in re-referrals or re-abuse, reduced trauma for the child, change in diagnosis based on expert opinion from a CAP, a decrease in unnecessary removals). This is particularly important in the current environment in which there have been several publicized articles in the lay press about alleged errors made by CAPs without discussion or comparison to errors made when CAPs are not involved and/or no medical expertise is available.[2]
- There are limited data about the costs associated with the medical consultation programs. In particular, the per child cost of obtaining this expertise and how it compares to other costs in the child welfare system. In addition, the source of this funding and whether the CAPs are employed by the state or contracted with the state is variable and not always clear. This is particularly important in the current environment in which multiple concerns have been raised about the relationships between CPS and CAPs.[3]

Based on the information collected as part of this review, listed below are the recommendations for Child Protective Services agencies, child abuse pediatricians, policy makers and others who are responsible for the safety and well-being of children:

1. Work with government agencies to fund research to identify and develop standardized quantifiable outcomes of medical consultation programs. This includes measuring these outcomes and identifying which attributes of the programs are most associated with beneficial outcomes to children and families. When evaluating medical consultation

programs, encourage comparison to the current practice standard rather than a perfect system without errors.

2. Measure the cost of different approaches to medical consultation and evaluate state-level funding mechanisms for sustainable administration of these programs.
3. Develop a tool kit for jurisdictions and/or states to assist in development of medical consultation programs, which includes evaluation metrics.
4. Monitor and strengthen federal statutes, including the Child Abuse Prevention and Treatment Act and the Victims of Child Abuse Act, to promote a child's access to and to enhance the quality of specialized medical evaluations during a child abuse investigation.
5. Evaluate models of medical directorship for child welfare agencies for states who are interested in establishing robust systems of inter-professional care.

INTRODUCTION AND BACKGROUND

Child Abuse and Neglect Fatalities Consistently Involve Very Young Children

The number of children who died from child abuse and neglect in federal fiscal year (FFY) 2017 was reported to be 1,720, [4] an 11% increase from 2013.[5] While child abuse and neglect fatalities are still rare, such an increase is notable and concerning.

Child fatalities from maltreatment often involve very young children. In FFY 2017, approximately 50% of these fatalities were in children <1 year of age.[6] Child maltreatment rates decline with the age. In 2017, children <1 year of age had a fatality rate of 21.92/100,000 compared with 5.72/ 100,000 for 1-2 years old and 0.61/ 100,000 for 10-year-olds.[7]

Through the Protect Our Kids Act which was enacted in 2013, Congress created a time-limited National Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) directing the Commission to study "trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child."[8] In its final report, the CECANF noted that the youngest children who are at highest risk of death from child maltreatment may have the least exposure to mandated reporters. [9] Indeed, health care professionals may be the only mandated reporters who very young children come in contact with.

Accurate and timely recognition of the early signs of child maltreatment is critical to decreasing morbidity and mortality. This is especially true for young children. A significant proportion of children who suffer severe morbidity and/or mortality due to physical abuse had been previously evaluated by physician(s) who did not recognize the abuse.[10] The importance of sentinel injuries - medically minor injuries, such as a bruise or mouth injury, which are associated with a high risk of escalating violence - cannot be overemphasized. In a landmark study by Sheets and colleagues, 27.5% of 200 infants diagnosed with physical abuse had a previous sentinel injury, compared with 8% of 100 infants with intermediate concern for abuse, and 0 of 101 infants without concern for abuse.[11] In this study, 66% of the sentinel injuries occurred when the infant was less than 3 months old and medical providers were reportedly aware of the injury in more than 40% of cases.

The American Academy of Pediatrics (AAP) has published evidence-based recommendations for the medical evaluation of children under 2 years of age with suspected physical abuse.[12] However, despite these evidence-based recommendations, physicians fail to consistently screen and evaluate for abuse even in high-risk situations such as in infants with sentinel injuries.[13]

In 2015, the AAP updated its clinical guidelines related to the evaluation of suspected child physical abuse. These guidelines addressed the importance of standardized management of sentinel injuries to lessen the likelihood of inappropriately attributing them to non-inflicted or self-inflicted trauma or medical disease.[14]

The first comprehensive program specifically designed to improve the recognition and response to sentinel injuries was funded in 2015 by Ohio's Attorney General Mike DeWine.[15] DeWine directed $1 million to the Ohio Children's Hospital Association (OCHA) to establish TRAIN - the Timely Recognition of Abusive Injuries (TRAIN) Collaborative.[16]

The TRAIN Collaborative was established to (1) Establish a baseline frequency of missed sentinel injuries (2) Develop and disseminate medical interventions to reduce the frequency of missed sentinel injuries and (3) Measure the impact of medical interventions on the frequency of missed sentinel injuries.

The collaborative developed a bundle of care for all infants <6 months old with a sentinel injury who are evaluated in an emergency department. This bundle includes a comprehensive physical examination including examination of the face, mouth, ears, neck, torso, genitals and buttocks, a skeletal survey, a psychosocial assessment and a consultation with a pediatrician.[17] Data from the TRAIN is in the process of being published. Importantly, the number of children identified as having sentinel injuries in emergency departments participating in TRAIN EDs has quadrupled since the start of the program. A key finding was that of all infants <6 months old who presented with a sentinel injury, 6.8% returned with a second injury within 12 months even with evaluation or intervention for the initial event. Just 38.7% of infants <6 months old in the study cohort had skeletal surveys completed even with the education being provided as part of the initiative. (Jonathan Thackeray, personal communication, 2018). In June 2018, the next phase of TRAIN was launched and focuses on primary care physicians rather than emergency departments.[18]

As discussed in more detail throughout this report, many of the states with programs for obtaining medical expertise include specific recommendations related to sentinel injuries.

Importantly, however, proper identification and evaluation of sentinel injuries is just one step in successfully protecting children. Ensuring that that clinical judgment of health care providers appropriately informs the decisions made by child welfare professionals regarding a child's safety, well-being and permanence is also critically important.

Federal Policy Promotes Access to Medical Expertise, but Significant Hurdles Remain

In 1974, The United States Congress enacted the federal Child Abuse Prevention and Treatment Act (CAPTA) recognizing the importance of using multidisciplinary teams to prevent, identify and treat child maltreatment.[19]

CAPTA also established a national clearinghouse for information relating to child abuse and neglect with an expectation that this clearinghouse would "maintain, coordinate, and disseminate information on the medical diagnosis and treatment of child abuse and neglect."[20]

The Children's Justice Act (CJA) is authorized as part of CAPTA and dictates that $20 million from the Crime Victims Fund be awarded to assist states in "developing, establishing and operating programs designed to improve the assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities."[21]

In addition to CAPTA and CJA funding, Congress enacted the Victims of Child Abuse Act (VOCAA) in 1990. VOCAA provides direct funding for CACs. Since their inception, CACs have largely responded to concerns of child sexual abuse. But in 2018, the National Children's Alliance (NCA) and United States Department of Justice (DOJ) recognized the importance of leveraging the infrastructure and collaborative practices found at CACs to advance a fuller and effective response to non-sexual abuse cases. The publication from the NCA and DOJ entitled *Child Physical Abuse: A Guide to the CAC Response* states that CACs serve "many more victims of child sexual abuse than they do victims of child physical abuse (CPA)" and yet federal data illustrates that "physical abuse is far more common, potentially indicating that CACs without a specialized response to physical abuse may be unequipped to serve a large population of child victims of abuse within their jurisdictions."[22] The Office of Juvenile Justice and Delinquency Prevention (OJJDP) recognizes the importance of medical evaluations stipulating in its 2019 Report to Congress: "Medical evaluations are a critical part of an investigation and are frequently the first step in addressing the physical and emotional trauma of a child victim."

In 2019, members of the United States Senate and House of Representatives introduced the Early Detection to Stop Infant Abuse and Prevent Fatalities Act (S. 1009 and H.R. 2076). The legislation, as introduced, sought to have the federal department of Health and Human Services (HHS) Secretary "establish a demonstration program to award grants to eligible entities in order to test effective practices to improve early detection and management of injuries indicative of potential abuse in infants under the age of 7 months to prevent future cases of child abuse and related fatalities."[23]

In summary, since the enactment of CAPTA forty years ago, Congress has recognized, but not prioritized or adequately invested in or monitored strategies intended to promote collaboration between child protective services, law enforcement and specially trained medical expertise.

FINDINGS

In Table1 we present rates of child maltreatment by type of child victim in these 13 jurisdictions and nationally. What is striking is both the variability in the rates among states and the lack of apparent correlation with the extent (e.g., local vs. statewide, physical abuse vs all types of abuse) of medical consultation services. There are several potential interpretations of this. The most likely explanation for the variability may lie in the simplest of reasons; there are marked differences both in the way different states define child maltreatment and in the way in which they interpret the child maltreatment definition. For example, Pennsylvania, the state with no medical consultation

program has the lowest victim rate of any state. This is highly unlikely to be because children are the safest, but more likely because the definition of child maltreatment in Pennsylvania is one of the most stringent in the country and the indication rates are among the lowest. Ohio which shares a border with Pennsylvania has one of the highest victim rates and has one of the lowest thresholds for defining child maltreatment.

The lack of correlation with the extent of medical consultation may lie in the fact that most cases of indicated maltreatment are neglect. Medical consultation programs focus almost exclusively on physical abuse. Therefore, even a successful medical consultation program which decreased the rate of physical abuse by 25% would only minimally change the overall rates of maltreatment.

Perhaps most importantly, what this table demonstrates is that we cannot use the victim rates to quantify how successful a medical consultation program is. Instead, we need outcomes which are not based on state definitions of maltreatment. Using medical diagnoses which are independent of state definitions is one approach. Another is to use upstream measures of successful medical evaluation such as the proportion of children under 2 years of age with allegations of physical abuse who have undergone a skeletal survey or the proportion of children with allegations of physical abuse who have been examined by a physician. Determining how to best quantify the impact of medical consultation on child outcome is and using similar measures nationally will be important in order to determine both effectives and cost-effectiveness of different programs.

In Table 2 we summarize four key aspects of responses to child maltreatment: All data are what was publicly discoverable as of November 30, 2019 or was obtained from direct conversations with the physicians providing care in these jurisdictions.

1. *Whether there is a medical evaluation and consultation program:*
2. *If there is designated funding for the program*
3. *If specific injuries or age of a child triggers a medical evaluation*
4. *If there is a medical director for the program:*

This table seems to demonstrate similarly among the programs with all having designated funding and most having specific injuries which result in medical consultation. But when one looks deeper, it is clear that when you have seen one medical consultation program, you have seen one medical consultation program. There is significant variability within each aspect of the programs. For example, while all programs have designated funding, this funding is highly variable in its total amount, amount per child, its source and what the funding pays for.

In order to compare effectiveness and cost-effectiveness of different medical consultation programs, it will be critical to evaluate the program characteristics in a much more granular way and to have the necessary data available to do this. One the reasons the broad program characteristics were chosen was because these were some of the data which could be obtained consistently for all programs. So the field needs a “taxonomy of program features” – a very clear

breakdown of the major components of medical consultation programs, as well as a summary of where they differ and are most similar. This taxonomy would help evaluations of these programs to be more consistent so that the field might discover which program components are most associated with key outcomes and which types of those components are most lined with positive outcomes.

The next section of this report presents child maltreatment related medical diagnosis and consultation profiles for each of the 13 jurisdictions.

Table 1. Rates of Child Maltreatment by Types of Child Victims

2017[24]	Number of Children Under 18 Years of Age [25]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[26]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
Connecticut	**743,826**	**32.8** (n=24,432)	**11.3** (n=8,442)	**30.4** (n=1,071)	**16.0** (n=573)	**14.9** (n=558)
Florida	**4,201,983**	**70.5** (n=296,250)	**9.5** (n=40,103)	**28.0** (n=6,314)	**14.4** (n=3,285)	**13.5** (n=3,090)
Illinois	**2,897,185**	**46.3** (n=134,004)	**9.9** (n=28,751)	**25.4** (n=3,900)	**14.7** (n=2,285)	**13.2** (n=2,070)
Indiana	**1,573,409**	**103.7** (n=163,110)	**18.6** (n=29,198)	**61.7** (n=5,092)	**24.8** (n=2,072)	**23.1** (n=1,965)
Maryland	**1,347,506**	**24.1** (n=32,433)	**5.6** (n=7,578)	**8.1** (n=586)	**6.2** (n=452)	**6.0** (n=442)
Missouri	**1,382,971**	**50.9** (n=70,419)	**3.3** (n=4,585)	**4.7** (n=346)	**4.1** (n=307)	**3.8** (n=285)
New Jersey	**1,979,018**	**37.6** (n=74,455)	**3.4** (n=6,698)	**8.2** (n=840)	**3.9** (n=400)	**3.9** (n=405)
North Carolina	**2,302,346**	**52.4** (n=120,734)	**3.2** (n=7,392)	**6.8** (n=818)	**3.8** (n=467)	**3.8** (n=462)
Ohio[27]	**2,605,235**	**41.5** (n=107,992)	**9.6** (n=24,897)	**25.7** (n=3,514)	**11.0** (n=1,526)	**10.6** (n=1,487)
Oregon	**873,619**	**51.9** (n=45,316)	**12.7** (n=11,070)	**29.9** (n=1,395)	**16.7** (n=780)	**15.9** (n=754)
Pennsylvania[28]	**2,664,515**	**16.1** (n=42,890)	**1.7** (n=4,625)	**2.6** (n=361)	**1.6** (n=220)	**1.7** (n=245)
South Carolina	**1,104,674**	**62.2** (n=68,718)	**15.5** (n=17,071)	**38.1** (n=2,195)	**21.4** (n=1,254)	**19.8** (n=1,182)
Texas	**7,366,039**	**38.5** (n=283,764)	**8.3** (n=61,506)	**27.0** (n=10,871)	**13.0** (n=5,288)	**11.8** (n=4,855)

Table 2. Key Aspects of Responses to Child Maltreatment

State or County	Medical Evaluation and Consultation Program Operating	There is Designated Funding for the Program	Specific Injuries or Age of Child Triggers Medical Evaluation	Designated Medical Director
Connecticut	Yes	Yes	No	Yes
Florida	Yes	Yes	Yes	Yes
Illinois*	Yes	Yes	Yes	No
Indiana	Yes	Yes	Yes	No
Los Angeles	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes
Missouri	Yes	Yes	Yes	No
New Jersey	Yes	Yes	Yes	No
North Carolina	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	No
Pennsylvania	No	No	No	No
South Carolina	Yes	Yes	Yes	No
Texas	Yes	Yes	Yes	No

*In Illinois, the medical consultation program is not statewide and is limited to the Chicago area

STATE PROFILES OF STATUTES AND STRATEGIES INTENDED TO IMPROVE MEDICAL DIAGNOSIS AND CONSULTATION

The next section of this report presents data for each of the 13 jurisdictions.

CONNECTICUT

Medical Evaluation and Consultation Program	**Yes**
Medical Director Identified	**Yes**
Specific Injuries or Age of Child Require Specialized Medical Evaluation	**No**
Designated Funding for Medical Evaluation and Consultation Program	**Yes**

2017[29]	**Number of Children Under 18 Years of Age [30]**	**Rate of Children, per 1,000 in the Population, Receiving an Investigation or Alternative Response[31]**	**Rate of Child Victims of All Ages per 1,000 children**	**Rate of Child Victims <1 year per 1,000 children**	**Rate of Child Victims 1 year of Age per 1,000 children**	**Rate of Child Victims 2 years of Age per 1,000 children**
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
Connecticut	**743,826**	**32.8[32]** (n=24,432)	**11.3** (n=8,442)	**30.4** (n=1,071)	**16.0** (n=573)	**14.9** (n=558)

Connecticut operates several Child Abuse Centers of Excellence framed as providing “expert consultation on cases of suspected child abuse or neglect through a variety of venues: weekly child abuse team meetings; directly seeing children and families; reviewing medical records, x-rays, pictures and other materials; or discussing cases in person or by phone” with Department of Children and Families (DCF) staff or community providers.[33]

The Child Protection Team at Connecticut Children’s Medical Center (CCMC) are “highly skilled professionals” who regularly “collaborate to provide education and support to physicians, nurses and other specialists” and with DCF staff.[34] A similar team of specially trained professionals at Yale New Haven Children's Hospital provide assessment and consultation to DCF for children who have been reported as a victim of child abuse.[35]

In 2014, in response to a troubling upward trend of very young children dying from abuse along with increased knowledge about the importance of identifying sentinel injuries, child abuse pediatricians (CAPs) who had already been serving as a resource to DCF, via case consultation, transitioned to become a real-time resource to staff fielding child abuse hotline calls.[36]

For nearly three decades, Connecticut's Department of Children and Families (DCF) "has been operating under a consent decree resulting from a class action lawsuit filed in 1989."[37] The Juan F. Federal Court Monitor quarterly provides Connecticut with comprehensive reviews of how the state is progressing in its effort to protect children and finally win approval to exit federal oversight.

The Federal Court Monitor's Exit Plan report covering the period of October 1, 2017 – March 31, 2018 (*Juan F. v. Malloy Exit Plan Status Report*) further acknowledges DCF's contractual relationship with child abuse pediatricians writing, "This service provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff to help ensure the safety and well-being of children."[38] This arrangement is cited as providing DCF with expert consultation "regarding child sexual abuse and physical abuse evaluations, which may include comprehensive and specialized medical examinations." The report continues that in state fiscal year (SFY) 2017, "the teams exceeded contract capacity by over 62%, providing over 1300 consults and conducting more than 24 formal trainings" -- with 25% of the consults related to critical incidents and "in over 50% of the consults" a decision by DCF "was modified as a result."

As part of CT's 2018 Annual Progress and Services Report (APSR) submitted to the federal Administration for Children and Families (ACF), DCF cited the state's commitment to Child Abuse Centers of Excellence. These Centers were framed by DCF as enlisting board certified child abuse pediatricians to provide "an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff to help ensure the safety and well-being of children."[39]

Connecticut employs a Director of Pediatrics within DCF.[40] In advertising the position in July 2018, DCF described the Director as a senior management staff member responsible for the "oversight of the agency's pediatric and nursing support for children involved with the Department."[41] The announcement continued, "the Director of Pediatrics is central to achieving the best possible outcomes for children throughout the state of Connecticut; and for providing leadership over key areas associated with the health needs of children in care while also developing key policy and practice guidelines."[42]

FLORIDA

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	Yes
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[43]	Number of Children Under 18 Years of Age [44]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[45]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
Florida	**4,201,983**	**70.5** (n=296,250)	**9.5** (n=40,103)	**28.0** (n=6,314)	**14.4** (n=3,285)	**13.5** (n=3,090)

Since 1978, Florida state statute has required multidisciplinary medically led child protection teams (CPTs). The Children's Medical Services Program operating, within the Department of Health, is required to "develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams."[46] An "interagency agreement" executed between two separate state-level agencies - Department of Health and Department of Children and Families (DCF) - guides the operations and oversight of the contracted community-based independent CPTs.[47]

Florida is comprised of sixty-seven counties. In 2018, Child Protective Investigators (CPIs), affiliated with DCF, were responsible for child abuse investigations in 60 counties. In the remaining counties, investigators affiliated with the local sheriff are responsible for investigations. [48] Florida reports within Child Maltreatment 2017 that "25 percent of Florida Child Protective Investigations are provided by local county sheriffs."[49] CPTs are located within one of fifteen districts identified by DCF with satellite offices and telemedicine utilized so that services are available to all 67 counties.[50]

Florida child protection directives underscore, "Each CPT's main purpose is to supplement the child protective investigation activities of DCF or designated sheriffs' offices by providing multidisciplinary assessment services to the children and families involved in child abuse and neglect investigations. CPTs may also provide assessments to Community-Based Care (CBC) providers to assist in case planning activities, when resources are available. Information from CPT

assessments are critical in developing the information domains, determining findings and establishing safety actions."[51]

These medically directed CPTs specialize in diagnostic assessment, evaluation, coordination, consultation, and other supportive services that must be able to provide "specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services" including:

- "Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of related findings.
- Medical evaluation related to abuse, abandonment, or neglect, as defined by policy or rule of the Department of Health.
- Expert medical, psychological, and related professional testimony in court cases.
- Case staffing to develop treatment plans for children whose cases have been referred to the team. A child protection team may provide consultation with respect to a child who is alleged or is shown to be abused, abandoned, or neglected, which consultation shall be provided at the request of a representative of the family safety and preservation program or at the request of any other professional involved with a child or the child's parent or parents, legal custodian or custodians, or other caregivers. In every such child protection team case staffing, consultation, or staff activity involving a child, a family safety and preservation program representative shall attend and participate." [52]

By statute, Florida's Department of Health includes a Statewide Medical Director for Child Protection. This Medical Director must be a board-certified pediatrician. Among the duties of the Medical Director is to serve on a legally required "advisory committee" that conducts an independent review of the work and resulting reports related to multiagency investigations of certain child death and other critical incidents.

By statute, each CPT is led by a medical director, who is a board-certified physician in pediatrics or family medicine and has obtained a "subspecialty certification in child abuse from the American Board of Pediatrics" or met "minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics."[53]

Referrals to the CPT are required when the report involves a child presenting with:

- "Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age;
- Bruises anywhere on a child 5 years of age or under;
- Any report alleging sexual abuse of a child;
- Any sexually transmitted disease in a prepubescent child;
- Reported malnutrition of a child and failure of a child to thrive;
- Reported medical neglect of a child;
- Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of

suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home; or

- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected."[54]

The CPT must perform a "timely review" of each report to determine if a face-to-face evaluation is warranted. This evaluation may be waived if the child has been examined by a physician who is not a member of the CPT, but that physician has consulted the CPT. It can also be waived at the discretion of the child protective investigator and supervisor, when these professionals have conducted a child safety assessment and determine that there "are no indications of injuries" which are defined in statute as requiring an evaluation.[55]

Conflicts between the CPT's "findings and recommendations" and the DCF investigator or the Sheriff's department are addressed through written operating procedures."[56] If the conflict cannot be resolved at the local level, the issue is reviewed by the Statewide Medical Director.

Florida publishes a comprehensive array of statistics related to child welfare displayed on an interactive dashboard, but none appear related to children referred to and receiving a face-to-face evaluation with a CPT.[57]

In 2019, Florida's state budget directed that $1.5 million of the $23.8 million in state and federal funding appropriated for medical services for abused/neglected children be provided to CPTs "to address the increase in workload related to mandatory medical neglect cases, psychological assessments, and trauma assessments."[58]

Distinct from funding for CPTs, Florida's budget also supports children's advocacy centers (CACs).

ILLINOIS

Medical Evaluation and Consultation Program	Yes* *not statewide
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes* *not statewide
Designated Funding for Medical Evaluation and Consultation Program	Yes *not statewide

2017[59]	Number of Children Under 18 Years of Age[60]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[61]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
Illinois	2,897,185	46.3 (n=134,004)	9.9 (n=28,751)	25.4 (n=3,900)	14.7 (n=2,285)	13.2 (n=2,070)

In 2001, the state of Illinois contributed $1 million to launch the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) with a goal of eventually providing a "statewide network of physicians skilled in and dedicated to the detection, diagnosis and legal follow-up of abuse and to make this expertise readily available to all hospitals and child protective services throughout Illinois.[62] The 2001 investment, which was championed by a Republican legislative leader and the Director of the state's Department of Children and Family Services (DCFS), was authorized toward establishing "a national standard for the medical evaluation of neglected or injured children."

In 2019, MPEEC remains a partnership among University of Chicago Medicine Comer Children's Hospital, Illinois DCFS, the Chicago Police Department and John H. Stroger, Jr. Hospital of Cook County, facilitating access to child abuse medical consultation for children under the age of three in Chicago who have been reported for serious physical abuse.[63] DCFS Procedures Manual governing the response to reports of child abuse and neglect specifies that MPEEC serves children in Chicago (and is available for second opinions in Cook County) when the child presents with allegations specific to head trauma; bone fractures, internal injuries, cuts or bruises or welts when the child presents to a MPEEC hospital.[64]

Within its 2019 Annual Progress and Services Report submitted to the federal government, Illinois DCFS wrote, "For FY18 to date there have been 213 cases, minus 2 second opinions, for a total of 221 MPEEC assessments completed so far this year."[65]

Jill Glick, MD, MPEEC's medical director and the director of Child Advocacy and Protective Services at University of Chicago Medicine Comer Children's Hospital joined with some of her colleagues, following several high-profile child deaths, to publish a letter in The Chicago Tribune in April 2019 urging expansion of MPEEC across all of Illinois. They wrote, "Building the needed medical resource and bridges among child welfare, law enforcement and medical experts will save lives." They also urged policy makers to "reinstitute a division at DCFS dedicated to serious harms and medically based allegations" and to "medicalize the child welfare system. There must be medical experts involved in the development of investigational procedures and a full-time medical director with DCFS who is a child abuse pediatrician."

The observations and advocacy put forth by Glick and her colleagues echoed those made by The Illinois Children's Justice Task Force, which is a multidisciplinary advisory group created in statute that charged with advising Illinois DCFS on improving child abuse investigations. In 2016, The Task Force, noted how there were a few "medically-directed" child abuse evaluation programs, "but not enough to ensure necessary access for all children reported for serious child abuse."[66] The Task Force then recommended:

> *"Create a statewide network of pediatric child abuse and neglect medical centers of excellence and develop telemedicine for low-density areas where immediate access is not possible, to ensure access to medical review, intervention, and oversight in severe child abuse investigations. DCFS shall create an internal leadership position with pediatric child abuse and neglect forensic medical expertise and oversee this network."*

In advocating for "unit-based multidisciplinary teams," the Task Force noted the wisdom of such a concept being enlisted in all cases but balanced that with political and fiscal realities. Instead they suggested that there be established priorities:

- Allegations of serious physical injury to children under 3 years old,
- Neglect cases where there is a medical concern for the child (e.g., medical neglect, neglect of a disabled infant, nonorganic failure to thrive, and/or malnutrition),
- Child sexual abuse for children under 18 years old, and
- Allegations involving child victims with diagnosed developmental disabilities.

DCFS procedural guidelines outline when child protection staff are required to obtain a medical exam (unless the requirement has been waived by a child protection supervisor). A medical examination is not able to be waived if the alleged child is an infant, non-verbal (regardless the age); or has a developmental delay. Among the types of allegations triggering a medical examination: head injuries, burns, bone fractures, cuts, bruises, welts, abrasions and oral injuries, medical neglect, malnutrition.[67]

A 2018 funding announcement set forth $771,852 in available funding for MPEEC.[68] The funding announcement noted there are "five types of service provision by the MPEEC hospitals" that would be supported the funding. They include:

- Onsite consultation by a child abuse pediatrician for any child presenting to a MPEEC hospital with suspected child maltreatment;
- Onsite MPEEC interdisciplinary team response to mandated cases for children, age 0-36 months, with injuries described in this agreement led by a CPT which is headed by a child abuse pediatrician;
- Offsite mandated cases for children, age 0-36 months, with injuries described in this contract that reside in Chicago (Lurie and Comer only);
- Second opinion cases, which are requested by DCFS for medical expertise (Lurie and Comer only);
- Education and consultation to DCFS, law enforcement, and non-MPEEC medical providers."

Illinois was the first state to appoint a Medical Director for DCFS appointing a board-certified pediatrician to the position in 1993 who served until her death in 2018.[69] As of November 2019, DCFS' organizational chart doesn't appear to illustrate inclusion of a Medical Director.[70]

INDIANA

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[71]	Number of Children Under 18 Years of Age [72]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[73]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
Indiana	1,573,409	103.7 (n=163,110)	18.6 (n=29,198)	61.7 (n=5,092)	24.8 (n=2,072)	23.1 (n=1,965)

In May 2008, The Indiana Department of Child Services (DCS) announced that it had entered into a "partnership" with the Indiana University (IU) School of Medicine/Riley Hospital to secure real-time medical consultation for children who were reported as victims of suspected abusive head trauma.[74] The partnership became known as the Pediatric Evaluation and Diagnostic Services (PEDS) Program.

Referrals for the PEDS program were initiated by DCS toward leveraging a "collaborative resource to accurately identify abusive head trauma versus accidental injury."[75] When the PEDS program was created, the Riley Hospital PEDS team included five child abuse pediatricians (CAPS) along with a nurse and a social worker. By 2013, the PEDS program had expanded "to include cases involving fractures and burns in children less than 3 years of age."[76]

As of November 15, 2019, Indiana's Child Welfare Policy Manual stipulated:

> *"It is mandatory to complete a PEDS referral for all children less than six (6) years of age with an allegation of suspected abuse or neglect involving the head or neck (e.g. facial bruising, scratches and red " marks" on the face/neck; mouth injuries, eye injuries, head bleeds, skull fractures and a fracture or burn involving the head/neck) and all children less than three (3) years of age with allegations of suspected abuse or neglect resulting in fractures or burns or suspected fractures or burns. All intake reports with suspected injury to the head or neck of a child, as well as, fractures and burns regardless*

> *of age will be identified in the case management system with a denotation of "PEDS allegation is included in this Report".*[77]

Indiana's profile within Child Maltreatment 2017 underscores that the state "does not screen out reports that allege abuse or neglect against a child that is under the age of 3."[78]

Through the PEDS Program, there are standardized referral forms that seek information about injuries and the medical testing (e.g., skeletal survey, head CT, blood work) completed by the referring party.[79] Also to be disclosed by the referring party is any prior history the child has had with the child welfare agency, any known previous injuries, and whether the child has any siblings and whether these siblings have received a medical evaluation.

A Case Consultation Outcome form is used for each referral and documented is if the report was substantiated as child abuse or if the child was initially placed out-of-home and if so whether such placement continues.[80] Also captured on the form is feedback as to whether the "consultation" proved helpful to the referring party.

DCS' 2015-2019 Child and Family Services Plan (CFSP) indicated that the state intended "to expand and update the PEDS program contract." The exact costs and contractual details for the PEDS Program were not able to be found.

Also, there was no documentation discovered to suggest Indiana has authorized or funded a medical director.

LOS ANGELES

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	Yes
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

Since 2006, Los Angeles County has operated Medical Hubs described as a mechanism "to provide high-quality coordinated health care for children who touch the child welfare system."[81] Among the services available through the Hubs: "medical assessments of suspected child abuse or neglect" and "comprehensive medical exams for children entering out-of-home care."[82]

In 2014, the Medical Hubs were spotlighted by a Blue-Ribbon Child Protection Commission which raised concerns that there was "inadequate access to medical and mental health services". [83] This Commission reinforced, "the Hubs do not have sufficient resources to implement these services." The Commission recommended, "All of the Hubs need immediate support to align them with their original goals." Among the original goals of the HUBs was to ensure children were connected to a "forensic evaluation" based on a referral by DCFS or law enforcement so that specially trained medical professionals can undertake an "assessment of suspected child physical abuse, sexual abuse or neglect."[84] The Hubs' mission was described as providing DCFS "with expert medical opinion to inform investigations of suspected child abuse and neglect as well as improve medical care for children in the system."[85]

In 2016, the Los Angeles County Child Death Review Team (CDRT) stressed the importance of the Medical Hubs recommending:

> *"A hotline number and/or protocol should be established for CSW's to contact a HUB Child Abuse expert 24/7 to consult when there is a concern about a child's medical condition or a medical opinion."*[86]

The CDRT wrote, "Workers rely on medical professionals' opinion of whether trauma was unintentional, inflicted, accidental or a medical condition." They also noted, however, that the child's "treating medical professional may not have the knowledge and experience of a child abuse expert" including situations in which "sentinel injuries mimicked symptoms of illness that were missed by the treating medical professional."

As of November 2019, seven Medical Hubs operate in Los Angeles County. Six are operated by the Los Angeles County Department of Health Services, and one by Children's Hospital Los Angeles.[87] Los Angeles County's Child Welfare Policy Manual describes the medical hub system as "a partnership" between the Department of Health Services, the Department of Mental Health (DMH),

and the Department of Children and Family Services (DCFS).[88] Among the populations to be served by a Medical Hub: "Children who are in need of a forensic evaluation to determine abuse and/or neglect who are under DCFS referral or case status."[89]

According to the county's Child Protection Policy Manual, a forensic evaluation may be authorized "when there are allegations of physical or sexual abuse, including during an emergency response investigation and/or when the child has been placed in protective custody."[90] Prior to such an evaluation, the child welfare worker "must consult with a medical provider who has specialized training in detecting, and treatment of, child abuse injuries and child neglect (Specialist)."[91] It is this specialist who determines if a physical examination is "appropriate". If such an examination is then it must be "performed by a specialist."[92]

The Manual sets forth that a referral for a medical evaluation "will be accepted and scheduled" in the following circumstances, "regardless of other case circumstances":

- "All children who are alleged victims of child abuse or neglect and are under the age of five (5), or are non-verbal, or have been unable/unwilling to communicate with the CSW about allegation(s).
- Any case in which the referring CSW communicated to Medical Hub intake staff that he/she feels the child should be seen.
- Any child for whom a detention decision is being made based on a current physical finding, but an examination or consultation by a trained forensic examiner has not occurred."[93]

In 2019 following the death of a 4-year-old child, the Los Angeles Board of Supervisors directed the county's Office of Child Protection (OCP) to lead a review of the child's death. Among the areas to be reviewed: "An update on the assessment of the existing use of the Medical Hubs County-wide, including efficacy of services and effective collaboration between and among the departments of Health, Mental Health, Public Health, and Children and Family Services to support the needs of children and families involved in child protective services."[94] On August 30, 2019, the Executive Director of the OCP noted that a "detailed workplan" had been formulated to improve the HUB system, including related to forensic exams. The OCP's memo to supervisors also noted that there were efforts to identify "common language" between forensic medical providers and social workers. Also, Los Angeles DHS had outreached to a national network of child abuse pediatricians "to confirm best practices".

The HUBs receive public funding, but it was difficult to determine the exact amount of such funding particularly with specificity regarding up-front medical evaluations within the context of a child abuse investigation. Expansion of the Medical Hubs, notably a $10.6 million investment and 87 positions, was among highlights cited by county officials in announcing "child protection system improvements" within the 2019-2020 budget.[95]

Los Angeles created a Medical Director in 2003 in order "to coordinate and monitor the medical and psychiatric treatment of children under DCFS care."[96]

MARYLAND

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	Yes
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[97]	Number of Children Under 18 Years of Age[98]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[99]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
Maryland	**1,347,506**	**24.1** (n=32,433)	**5.6** (n=7,578)	**8.1** (n=586)	**6.2** (n=452)	**6.0** (n=442)

In 2005, the Maryland General Assembly established a Child Abuse and Neglect Center of Excellence Initiative within the Department of Health.[100] The purpose of the initiative was to:

1. Improve the protection of children in Maryland;
2. Recruit local physicians to gain clinical expertise in the diagnosis and treatment of child abuse and neglect;
3. Develop and guide the practice of local or regional multidisciplinary teams to improve the assessment and treatment of children who are the subject of a child abuse or neglect investigation or a child in need of assistance;
4. Facilitate the appropriate prosecution of criminal child abuse and neglect; and
5. Provide expert consultation and treatment in physical child abuse and neglect and sexual abuse through teleconferencing and onsite services."

The law directed that by 2007, the governor "must include" an appropriation in the state budget for the initiative. The Secretary of Health was required to "appoint and convene an expert panel on child abuse and neglect relating to research and data collection at least once each year."

In 2008, Maryland lawmakers reworked the statute replacing the Center of Excellence language with the Child Abuse Medical Providers (CHAMP) Network of Maryland.[101] Today, Maryland's Department of Health states that the "goal" of CHAMP "is to help develop medical expertise related to child maltreatment in every Maryland jurisdiction."[102] It is seen as a "valuable resource" in "evaluating suspected abuse or neglect in children, providing consultation and training to community professionals, and engaging in prevention activities." The Maryland Department Health

contracts with the School of Medicine at the University of Maryland to administer the CHAMP Program.
The program is led by Howard Dubowitz, MD, MS, FAAP, Professor and Division Head, Child Protection Division, Department of Pediatrics University of Maryland School of Medicine.[103] Beyond Dubowitz, the CHAMP faculty include six physicians and one nurse. Physician faculty must be licensed in Maryland, be board-certified in child abuse pediatrics and have at least five years of experience conducting child abuse evaluations. CHAMP faculty:

1. "Assist local and regional jurisdictions to develop standards and protocols for the composition and operation of local or regional Child Abuse Medical Providers (Maryland CHAMP);
2. Provide training and consultation to local or regional providers in the diagnosis and treatment of child abuse and neglect;
3. Provide financial support to part-time local and regional expert clinic staff for the diagnosis and treatment of child abuse and neglect;
4. Collaborate with local or regional child advocacy centers and forensic nurse examiner programs; and
5. Help assure that medical professionals have access to information on how to cooperate with local departments of social services, child advocacy centers, and local law enforcement officers to:
    - Protect children from trauma during the process of child abuse and neglect investigations and prosecutions;
    - Minimize the number of times each is interviewed and examined; and
    - Minimize the potential for influencing a child's statement."

By statute, CHAMP's broader network of health care professionals is expected to have the expertise to "address the prevention, diagnosis and treatment of child abuse and neglect while working closely with other disciplines and organizations addressing these issues, including child advocacy centers." The earlier enacted purposes remained intact when the 2008 statutory change occurred. The only slight reworking was made to number three: "Develop and guide the practice of local or regional multidisciplinary teams to improve the **MEDICAL** assessment and treatment of children who are the subject of a child abuse or neglect investigation or a child in need of assistance."

While state statute does not set forth a requirement of when children are to be referred for medical evaluation, the Family Law statute addresses "emergency medical treatment" defined as "medical or surgical care" rendered in a health care facility or child advocacy center in order to[104]:

1. "To relieve any urgent illness, injury, severe emotional distress, or life-threatening health condition; or
2. To determine the existence, nature, or extent of any possible abuse or neglect."

Expert child abuse or neglect care" provided for the "diagnosis and treatment" of child abuse is to be provided by the following people:

- physician;
- multidisciplinary team or multidisciplinary team member;
- health care facility; or
- staff member of a health care facility who is an expert in the field of abuse and neglect.

Telemedicine is recognized, as an option, "if appropriate" toward achieving "a timely expert diagnosis of child abuse or neglect."

Maryland law authorizes the establishment of a 23-member State Council on Child Abuse and Neglect (SCCAN) with one member required to be "a pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, who shall be appointed by the Governor from a list submitted by the Maryland chapter of the American Academy of Pediatrics."[105] SCCAN serves as one of the state's (federally required) Citizen Review Panels.[106] SCCAN annually issues a report. SCCAN's most recent annual reports have addressed CHAMP and "expert medical evaluations" with the Council noting that "CHAMP providers see a very small proportion of the children reported to Child Protective Services" [107]

The Council acknowledged "multiple studies" that have determined "that poor and minority children are more likely to have accidental injuries misidentified as abuse, while non-poor and white children are more likely to have abusive injuries misidentified as accidental." This problem "may be exacerbated" when health care professionals "without child welfare expertise or child welfare workers without health care expertise are determining whether a child has been abused or neglected."

The Council's 2016 report (issued in June 2017) addressed "expert medical evaluations." The Council stipulated, "The current systems for providing healthcare services to Maryland children involved in the child welfare system (abuse/neglect investigations & foster care) are inadequate.[108]" This report reiterated that the 2015 report "laid out the argument for the need for reform of health care provisions to children involved in child welfare." The Council then wrote, "While the recommendations to date have gone unaddressed, the Council continues to advocate for a centralized system to provide expert forensic and health care coordination to children involved in child welfare."

It renewed the call for Maryland to develop a "centralized system for providing forensic and medical services to children involved in the child welfare system." Policy makers were urged to "fund each component" of such a centralized system:

- Management by a physician Health Director within the Maryland Department of Human Resources' Social Services Administration;
- Oversight and policy development by an Interagency Child Welfare Health Coordination Expert Panel;

- A system for tracking and improving health outcomes; including fatalities and near fatalities due to child maltreatment

Maryland has issued "referral guidelines" intended to help child welfare and law enforcement "decide when to seek medical consultation for suspected child abuse and neglect."[109] With regard to physical abuse, certain conditions "should be medically evaluated urgently (within 12-24 hours)":

- Bruising in an infant who cannot "cruise" (walk holding onto objects)
- Any suspicious bruising on a child who is less than three years old or developmentally delayed
- Small, localized burns (cigarette, iron) that newly or recently occurred

Other conditions should be medically evaluated within 48 hours and include:

- Suspicious bruising in a child over 3 years old and developmentally normal
- Pattern bruise marks
- Healing localized burns (cigarette, iron)

Where a referral to a "child abuse specialist" is not possible then "photographs should be obtained and reviewed by child abuse specialist." Child welfare caseworkers and law enforcement are urged to "consider evaluation by a child abuse specialist" for:

- "Follow-up of any child with an inconclusive hospital evaluation for physical abuse
- Siblings of a child who has been physically abused, according to the following guidelines:
- Siblings under the age of 3 must receive a medical evaluation by a child abuse specialist
- Strongly consider requesting skeletal survey for infants less than one year, strongly consider head CT
- Siblings 3-6 years old—strongly consider medical evaluation by either Child Abuse Pediatrician or child's primary care practitioner
- Siblings 6-10 years old—consider medical evaluation based on concerns raised by child and/or caregivers, school, etc."

Addressing child neglect, the guidelines note, "There are many circumstances when the assessment and management of child neglect can be enhanced with medical consultation by a physician specialist in child abuse and neglect." It is further noted, "In general, such consultation is not urgent as neglect reflects patterns of inadequate care or children's needs not being met over time. Nevertheless, it is helpful if the consultation is sought early during the assessment." The guidelines conclude, "In most situations, a physical examination is not needed for the consultation."

Maryland Children's Trust Fund is the funding source for CHAMP.[110] The state's CTF benefits from revenue generated when an individual purchases a birth certificate for a cost of $30, with $15 of that fee then directed to the CTF for CHAMP.[111] Statute stipulates, "To the extent possible, the

Governor shall include in the annual State budget funds for the payment of emergency medical treatment for children examined or treated under this section."[112]

In 2019, the Maryland Department of Human Services sought to recruit a State Medical Director for Children Receiving Child Welfare Services with the job description indicating that the individual would be responsible for advising on and facilitating health care coordination for children in out-of-home-placement.[113]

MISSOURI

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[114]	Number of Children Under 18 Years of Age[115]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[116]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
Missouri	1,382,971	50.9 (n=70,419)	3.3 (n=4,585)	4.7 (n=346)	4.1 (n=307)	3.8 (n=285)

Since 1989, Missouri has operated and funded the SAFE-CARE (Sexual Assault Forensic Examination-Child Abuse Resource and Education) Network providing training "to physicians and nurse practitioners in the medical evaluation of alleged victims of child sexual abuse, physical abuse, and neglect."[117] Administered by the Missouri Department of Health and Senior Services, the "primary objective" of the network is "to provide comprehensive, state-of-the-art medical evaluations to alleged child victims in their own communities."

The Department of Health and Senior Services (DHSS), MO HealthNet Division (MHD), Department of Public Safety (DPS) and Children's Division (CD) are partners in the SAFE-CARE Network." Missouri KidsFirst "manages" the SAFE-CARE network and describes the Network as a mechanism "to provide every abused child easy access to quality and compassionate medical care to ensure their own health and safety through proper diagnosis and treatment." This medical care by a SAFE-CARE provider is often scheduled at a children's advocacy center (CAC).

Missouri KidsFirst routinely works with "child abuse pediatricians to develop training to ensure that current providers maintain the standards of the SAFE-CARE network as established by the SAFE-CARE Advisory Council."[118] The network includes "pediatricians, family practice physicians, and nurse practitioners. Members encompass a wide range of experience, from urban to rural, small private practice to large children's hospitals" with each playing a "valuable role in providing a coordinated multidisciplinary response to child maltreatment in Missouri."

A 2016 statutory change mandated that when a report of child abuse or neglect involves a child three years of age or younger and “merits an investigation” then the investigation “shall include an evaluation of the child by a SAFE CARE provider.”[119] Outside a direct evaluation, the child’s “case file and photographs of the child’s injuries” are to be reviewed by a SAFE CARE provider.

If a SAFE CARE provider “makes a diagnosis” that the young child “has been subjected to physical abuse, including but not limited to symptoms indicative of abusive bruising, fractures, burns, abdominal injuries, or head trauma” then the children’s division “shall immediately submit a referral to the juvenile officer.”

Missouri’s state budget covering the period July 1, 2018 through June 30, 2019 included $250,000 for the SAFE-CARE Program with the appropriated funding to be utilized for “implementing a regionalized medical response to child abuse, providing daily review of cases of children less than four years of age under investigation by the Missouri Department of Social Services, Children’s Division and to provide medical forensics training to medical providers and multi-disciplinary team members.”[120] The state budget also included funding designated for CACs, which is where many SAFE-CARE providers evaluate children.

NEW JERSEY

2017[121]	Number of Children Under 18 Years of Age[122]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[123]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
New Jersey	**1,979,018**	**37.6** (n=74,455)	**3.4** (n=6,698)	**8.2** (n=840)	**3.9** (n=400)	**3.9** (n=405)

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	**No**
Specific Injuries or Age of Child Require Specialized Medical Evaluation	**Yes**
Designated Funding for Medical Evaluation and Consultation Program	**Yes**

Enacted in 1998 and amended in 2006, New Jersey statute sets forth an expectation that the New Jersey Commissioner of Human Services “shall establish four regional diagnostic and treatment centers for child abuse and neglect affiliated with medical teaching institutions in the State that meet the standards adopted the commissioner.”[124] These centers were expected to “have experience in addressing the medical and mental health diagnostic and treatment needs of abused and neglected children in the region in which it is located.” New Jersey now supports six state-designated regional diagnostic and treatment centers (RDTCs), two of which operate as satellites.[125] One RTDC - The CARES Institute - indicates it provides “nearly 1,400 comprehensive child abuse medical evaluations annually.”[126]

Regional Center	Counties Served[127]
Audrey Hepburn Children's House	**5** - Bergen, Hudson, Morris, Passaic, Sussex
St. Joseph's Children's Hospital (Satellite Office)	**1** -Passaic
Metropolitan Regional Diagnostic and Treatment Center (located at Children's Hospital of New Jersey at Newark Beth Israel Medical Center)	**1** - Essex
Dorothy B. Hersh Child Protection Center (located at The Children's Hospital at St. Peter's University Hospital)	**8** - Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Union, Warren
Jersey Shore University Medical Center (Satellite Office located at K. Hovnanian Children's Hospital)	**2**-Monmouth, Ocean
NJ Child Abuse Research Education & Service (NJ CARES) Institute	**7** - Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem

A 2015 request for proposal to award funding for regional centers stipulated that New Jersey recognizes[128]:

> "A need to ensure that all children with suspected abuse or neglect are examined and treated in a trauma informed setting with the experience and expertise to support children and families. Access to medical and mental health professionals who specialize in child abuse and neglect is essential to our work and assists in helping:
> - A child victim receive appropriate follow up care and treatment;
> - The child welfare agency in developing a plan to ensure the child is protected and that no further maltreatment takes place;
> - Law enforcement with prosecution; and,
> - The courts with expert guidance for decision-making."

Statute requires that these centers be multidisciplinary in the work and include (at a minimum) the following staff members: a pediatrician, a consulting psychiatrist, a psychologist and a social worker. Each of these staff are to be "trained to evaluate and treat children who have been abused or neglected and their families." State law further requires that at least one staff member "have an appropriate professional credential or significant training and experience in the identification and treatment of substance abuse."

The centers are to have a "liaison" with both the district offices of the Division of Youth and Family Services (DYFS) and county prosecutor offices. The purpose of such centers includes:

- "Evaluate and treat child abuse and neglect;
- Serve as resources for the region and develop additional resources within the region;
- Provide training and consultative services; and
- be available for emergency phone consultation 24 hours a day."

Also, they should serve as a "source for research and training for additional medical and mental health personnel dedicated to the identification and treatment of child abuse and neglect." The RDTCs receive referrals from child welfare, law enforcement and county prosecutors to "assist with investigations of child abuse or neglect by providing timely comprehensive medical and mental health evaluations or record reviews of children with suspected physical abuse, sexual abuse, and/or neglect."[129] Request for funding proposals (RFPs) reinforce the purpose of the RDTCs and the medical evaluations:

> *"The purpose of these evaluations is to ensure accurate diagnosis of any signs and symptoms of child abuse and neglect, ensure appropriate handling of forensic evidence, minimize the risk of secondary trauma to the child through examination itself, and maximize access to timely and appropriate treatment."*

State officials were asked, during the 2015 RFP process, whether there was an "expectation that pediatricians" employed at the RDTCs need to be "board certified in child abuse pediatrics." State officials responded, "Pediatricians should be qualified to perform the work described in the RFP and expectations are that the pediatricians "are trained to evaluate and treat children who have been abused or neglected and their families." Given the evolution of the field, in general, expectations are that physicians performing this work will be board certified in child abuse pediatrics."[130]

In June 2018, the New Jersey Department of Children and Families Policy Manual was updated specific to Referral Guidelines for RDTC. [131] These guidelines underscore that nothing set forth in them "preclude the Local Office staff from referring any other case situation to the RDTC for their assistance and expertise." Also where the child welfare caseworker or supervisor are "unsure" about whether a referral should be made, they should contact the RDTC staff "who can help determine if the RDTC is the appropriate entity to examine, evaluate, or provide other services for the child or children in a particular case."

The guidelines than outline when "in general" there is an expectation of a referral of a child to the RDTC "during the initial phase of investigation" and when the report is specific to physical abuse. The guidance then says such referrals should be made when a child has "sustained the following types of injuries when there is a suspicion for abuse or neglect:

- head injuries,
- internal injuries,
- burns,
- bone fractures/breaks,
- cuts/bruises/welts/abrasions/oral injuries,
- human bites,
- sprains/dislocations,
- facial injuries,

- children who have consumed, or been exposed to, a poisonous substance, noxious substance, mood-altering substance, or other dangerous substance and there is concern for abuse or neglect."

Staff at the RDTC are to be contacted "immediately" when a report of physical abuse involves a child "who may need immediate evaluation in an emergency department" or where the child has experienced "life-threatening and serious injuries that are unexplained, the result of suspected abuse and/or neglect, and/or the perpetrator is unknown." Also, RDTC staff are to be immediately engaged when an infant has been referred to CP&P "by medical professionals (including hospital, emergency room personnel, private practitioners."

At a June 2018 meeting of the New Jersey Child Advocacy Center – Multidisciplinary Team Advisory Board, which was established by the 2017 law (establishing it "in, but not of" the Department of Children and Families), members underscored that "although RDTCs work together with MDTs, they have different roles than the CACs" and that there is "no duplication of services."[132] It was also noted that "medical issues are outside the purview" of the Advisory Board.

There were no publicly available records available suggesting that New Jersey employs a medical director for child protection – either at a state or regional level.

While not fully able to be determined, it appears the state's investment exceeds $3 million underwriting costs associated with six state designated RDTCs. [133]

NORTH CAROLINA

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	Yes
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[134]	Number of Children Under 18 Years of Age[135]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[136]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
North Carolina	2,302,346	52.4 (n=120,734)	3.2 (n=7,392)	6.8 (n=818)	3.8 (n=467)	3.8 (n=462)

Since the 1970s, there has been a "cooperative" effort between the UNC School of Medicine's Department of Pediatrics, the North Carolina State Division of Social Services (DSS), the North Carolina Legislature, local Departments of Social Services, and local medical and mental health providers resulting in the Child Medical Evaluation Program (CMEP).[137]

In 1986 in the Journal of Forensic Science CMEP was cited as examining 1,500 children per year suspected "of having subtle physical evidence of abuse or neglect."[138] The program was further described as utilizing "private practitioners, primarily pediatricians, in a systematic manner and provides consultation, direction, and quality control." CMEP was described as "unique" with the costs being "low" and the "government involvement minimal" even as the service "extensive." CMEP was "recommended to other states."

Through CMEP, there exists a "statewide network of local providers who perform medical and psychological assessments of children referred by DSS agencies to help determine the presence or extent of abuse and neglect." North Carolina's DSS utilizes a mix of federal and state funding to contract with the Division of Community Pediatrics at the University of North Carolina at Chapel Hill to administer CMEP.[139] Molly Berkoff, MD, MPH oversees CMEP serving as Principal Investigator and Medical Director.[140] Currently there are 170 medical providers and 50 psychological providers participating in the program and most major medical centers operate referral clinics.[141]

NC's DSS describes the CMEP/CFEP program as providing for:

> *"A structured system for medical and child/family evaluations in alleged cases of child abuse and/or neglect. Local physicians and psychologists, who have agreed to provide the service(s) in accordance with the program guidelines, perform evaluations of children (ages 0 through 17) at the request of county child welfare agencies. The program's professional staff has developed, and periodically updates, evaluation protocols designed to document physical and emotional symptoms in keeping with the latest research relative to significant findings. The program's professional staff provides daily telephone and written consultation to local examiners, child welfare staff, and the legal system regarding appropriate services and an interpretation of the recommendations and case findings. The program is actively involved in educational programs for medical and mental health practitioners, child welfare staff, law enforcement, juvenile judges, and the legal community. The CMEP/CFEP has served as a program model for several other states."*[142]

CMEP "follows national guidelines such as from the American Academy of Pediatrics regarding the medical evaluation of child maltreatment" and participating providers "are expected to follow and be familiar with guidelines."[143] DSS describes the "objectives" of the medical evaluations as:

1. "Enabling county child welfare agencies to obtain an assessment of abuse and neglect through a medical evaluation;
2. Assisting county child welfare agencies and the courts in determining the most appropriate case decision; and
3. Providing the county child welfare agencies with recommendations that help in determining appropriate services for the child or children."

There are two distinct types of evaluations provided through CMEP[144]:

1. **Medical: Child medical evaluations (CMEs)** that "occur in child's community" often at a child advocacy center or in a child's community and can include: an interview with the child welfare worker, caregiver, and child along with a "complete exam with laboratory/radiology evaluations." Also pursued is a "careful assessment of risk factors" and review of the record toward development of a comprehensive report and detailed recommendations.
2. **Mental Health: Child and family evaluations (CFEs)** that occur at a county agency or provider office and is "complementary to" a CME. It includes "collateral interviews and assessments," multiple interviews of child and family and "may include limited psychological testing."

A child welfare worker does not need prior permission to seek a medical evaluation and the state's policy manual outlines when such evaluations are suggested, to include[145]:

- Determining the plausibility of the parent's or caretaker's explanation for any injury (e.g. bruise, wound).
- Interpreting whether bruises or marks are the result of normal childhood activities. Certain locations of bruises raise concern for abuse/neglect in young children: bruises on vulnerable areas of the body such as on the head, torso, genitalia, and buttocks.
- Understanding whether significant bruising (such as multiple or extensive bruises) are the result of normal play, a medical condition, or abuse/neglect.
- Interpreting fractures and whether they are the result of abuse and/or neglect, normal childhood activities, or a medical condition.
- Evaluating head injuries. Any concerns for a head injury in an infant or young child should be evaluated by a medical provider. This includes allegations that a child was shaken, hit, or fell and sustained head trauma. Head trauma evaluations can include children who are alleged to be victims of shaken baby syndrome (which may also be referred to as abusive head trauma, nonaccidental trauma, and other terms).
- Understanding if a burn is a result of abuse, neglect/lack of supervision, or accidental means.
- Evaluating statements made to parents, teachers, or other individuals that may represent physical abuse.
- Assessing children when physical abuse was witnessed.
- Evaluating and interpreting developmental delays in a child.
- Evaluating and interpreting delays in a child's growth (e.g. failure to thrive).
- Evaluating allegations of Munchausen by Proxy (this may also be referred to as Pediatric Condition Falsification and Medical Child Abuse).
- Assisting with the interpretation of behavioral concerns and recommending appropriate referrals.
- Evaluating untreated or inadequately treated medical conditions which have had a negative impact on the child's overall health or physical development.
- Assessing children when an investigation of the home environment reveals a lack of basic necessities to ensure a safe and healthy environment for the child.

A pediatrician and preventive medicine physician was appointed in 2017 to serve as State Health Director and the Chief Medical Officer for the North Carolina Department of Health and Human Services.[146] This position is expected to "promote public health and prevention activities, as well as provides guidance and oversight on a variety of cross-departmental issues."[147]

In 2017, state lawmakers approved $901,868 "to fund the Child Medical Evaluation Program, which pays for evaluations of children who may have been physically or sexually abused."[148] North Carolina also directed some of its federal $49.7 million Social Services Block Grant (SSBG) funding for CMEP.[149]

OREGON

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[150]	Number of Children Under 18 Years of Age [151]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[152]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
Oregon	873,619	51.9 (n=45,316)	12.7 (n=11,070)	29.9 (n=1,395)	16.7 (n=780)	15.9 (n=754)

Karla "Karly" Sheehan was three years old when she was brutally killed by her mother's boyfriend in 2005. Following Karly's death, there were concerns raised about the fact that she had been reported as a possible victim of child abuse twice before her death. Among the issues that surfaced after Karly's death was the level of training afforded medical professionals, who come into contact with children in a pediatric or family practice or emergency department, but the medical professional may not have sufficient enough training and expertise to recognize and diagnosis child abuse.

In 2008, Oregon enacted Karly's Law and today Oregon's child abuse law underscores the following:[153]

> *"A serious need exists for a coordinated multidisciplinary approach to the prevention and investigation of child abuse, for intervention and for the treatment of children who are victims of child abuse in a manner that is sensitive to the needs of children. No child in this state should be denied access to a child abuse medical assessment because of an inability to pay. The cost of not assessing and treating abused children with the aid of specially trained personnel is too high."*

State statute requires that the district attorneys for Oregon's thirty-six counties "be responsible for developing county multidisciplinary child abuse teams." [154] Each county team "shall designate at least one physician, physician assistant, naturopathic physician or nurse practitioner who has been trained to conduct child abuse medical assessments, as defined in ORS 418.782 (Definitions for ORS

418.746 to 418.796), and who is, or who may designate another physician, physician assistant, naturopathic physician or nurse practitioner who is, regularly available to conduct the medical assessment described in ORS 419B.023 (Duties of person conducting investigation under ORS 419B.020)."

The "child abuse medical assessment" is conducted by "or under the direction of a licensed physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse."[155] This assessment results in "a thorough medical history, a complete physical examination and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child."

Statute also sets forth the following definitions:

- "**Community assessment center**" that is defined as "a neutral, child-sensitive community-based facility or service provider to which a child from the community may be referred to receive a thorough child abuse medical assessment for the purpose of determining whether the child has been abused or neglected."
- "**Regional assessment center**" is one operated by a community assessment center which "provides child abuse medical assessments, assistance with difficult or complex child abuse medical assessments, education, training, consultation, technical assistance and referral services for community assessment centers or county multidisciplinary child abuse teams in a region or regions." Such regional centers are "designated by the administrator of the Child Abuse Multidisciplinary Intervention Program."

The Oregon statute includes a list detailing what should be considered a "Suspicious physical injury" with this list including, but not limited to[156]:

- Burns or scalds;
- Extensive bruising or abrasions on any part of the body;
- Bruising, swelling or abrasions on the head, neck or face;
- Fractures of any bone in a child under the age of three;
- Multiple fractures in a child of any age;
- Dislocations, soft tissue swelling or moderate to severe cuts;
- Loss of the ability to walk or move normally according to the child's developmental ability;
- Unconsciousness or difficulty maintaining consciousness;
- Multiple injuries of different types;
- Injuries causing serious or protracted disfigurement or loss or impairment of the function of any bodily organ; or
- Any other injury that threatens the physical well-being of the child.

Whenever a person “conducting an investigation….observes a child who has suffered suspicious physical injury and the person is certain or has a reasonable suspicion that the injury is or may be the result of abuse,” this investigator has several statutory obligations including to “ensure that a designated medical professional conducts a medical assessment within 48 hours, or sooner if dictated by the child’s medical needs.”

In 1993, Oregon lawmakers established The Child Abuse Multidisciplinary Intervention (CAMI) Account within the Department of Justice. Criminal fines and assessments generate the revenue deposited into CAMI with such funding utilized to:

- “Establish and maintain a coordinated multidisciplinary community-based system for responding to allegations of child abuse that is sensitive to the needs of children;
- Ensure the safety and health of children who are victims of child abuse to the greatest extent possible; and
- Administer the grant programs established under ORS 418.746 (Child Abuse Multidisciplinary Intervention Account) and 418.786 (Grant program).”

The CAMI Account is administered by the Attorney General. As a condition of receiving CAMI funds, county-level teams “shall submit” a “coordinated child abuse multidisciplinary intervention plan” every two years. County teams are also required to bi-annually report on how many medical assessments were completed and within what time frame.[157]

All 36 Oregon counties received a share of the $11 million CAMI funding for 2017-2019 specific to their multidisciplinary teamwork.[158] Meanwhile, CAMI funding totaling approximately $582,000 was awarded to five regional assessment centers in 2017-2018.[159][160]

SOUTH CAROLINA

Medical Evaluation and Consultation Program	**Yes**
Medical Director Identified	**No**
Specific Injuries or Age of Child Require Specialized Medical Evaluation	**Yes**
Designated Funding for Medical Evaluation and Consultation Program	**Yes**

2017[161]	**Number of Children Under 18 Years of Age**[162]	**Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response**[163]	**Rate of Child Victims of All Ages per 1,000 children**	**Rate of Child Victims <1 year per 1,000 children**	**Rate of Child Victims 1 year of Age per 1,000 children**	**Rate of Child Victims 2 years of Age per 1,000 children**
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
South Carolina	**1,104,674**	**62.2** (n=68,718)	**15.5** (n=17,071)	**38.1** (n=2,195)	**21.4** (n=1,254)	**19.8** (n=1,182)

The South Carolina Children's Advocacy Medical Response System (SCCAMRS) Program evolved from a 2003 partnership between the South Carolina Children's Hospital Collaborative and the South Carolina Network of Children's Advocacy Centers intended "to address the shortage and training of clinicians specializing in the medical assessment of child abuse and neglect (CAN) and the disparity in quality and delivery of these services."[164]

The University Of South Carolina School of Medicine, Department of Pediatrics, supported by the Collaborative and Network of CACs, pursued a grant from the Duke Endowment "to fund the initial stages of a statewide program to focus on these concerns." Several years later South Carolina's Department of Health and Human Services recognized "the complexity of the medical services required for the assessment of child maltreatment and the need for the continued enhancement of the quality and availability of such services to their Medicaid eligible child population" adding the agency's support for the SCCAMRS framework.

By 2014 state statute was enacted stipulating[165]:

> *"There is created the South Carolina Children's Advocacy Medical Response System, a program to provide coordination and administration of medical service resources to those entities responding to cases of suspected child abuse or neglect. The program is administered by the University Of South Carolina School of Medicine."*

The SCCAMRS Program "is housed within the Department of Pediatrics at the University of South Carolina School of Medicine." SCCAMRS "coordinates and administers child abuse medical service

resources for the State, assisting and collaborating with children's advocacy centers and state agencies charged with the investigation, assessment, treatment, and prosecution of child abuse or neglect for children in the State." It is through this program that "a consistent quality standard of care and practice for the following services intrinsic to the assessment of children with suspected abuse or neglect" are developed and supported. Specifically, there is a pursuit of "consistent" practice related to:

- forensic medical examinations, assessments, and diagnoses;
- medical consultations;
- participation in multidisciplinary team case conferences and reviews; and
- medical expert witness services.

The program is required to "develop, support and maintain:

- guidelines for the educational, clinical training, and professional development requirements of health care providers participating in the forensic medical assessment of children who are suspected victims of child abuse or neglect;
- a standardized clinical assessment tool to report the findings of the forensic medical assessment; and
- guidelines for the South Carolina Department of Social Services and law enforcement agencies on when to obtain a forensic medical assessment."

A standardized Child Maltreatment Protocol tool is utilized throughout the state.[166] There is also a regularly updated Health Care Provider Directory that in addition to general contact information highlights if the health care provider has a specific board certification.[167]

South Carolina's Human Services Policy and Procedure Manual directs the actions to be taken once a child welfare caseworker has been assigned a child abuse report.[168] Among the initial steps this professional is to take is to check to see if law enforcement has made a referral to a CAC.

If such a referral has not been made, the child welfare worker is to make a referral "as soon as possible after receipt of the report, but in no more than 5 working days." This referral can be made to a CAC "or similar multidisciplinary abuse assessment facility for medical examination by a physician, or by an advanced practice registered nurse or physician assistant who is working under the supervision of a physician who has been trained in child abuse and neglect."

Referrals are required when "presenting issues" include, but are not limited to:

- Head injury to children less than 3 years of age;
- Burns in children 3 years of age or younger;
- Fractures in children 5 years of age or younger;
- Bruises located on the face, next, chest, back, buttocks with a pattern or multiple in number.

The Policy Manual sets forth situations where a “medical evaluation by the CAC may not be necessary.” This might occur when the child “has already had a medical examination by a physician or other licensed healthcare provider” or the child welfare caseworker (with a supervisor’s approval) has conducted a safety assessment and “there are no indication of injuries” as outlined in the policy manual (e.g., head injury in young children, bruises on the face, fractures).

South Carolina statute outlines the duties of the Department of Social Services to include operation of a “separate organizational unit” operating with “qualified staff and resources” to accomplish a number of functions including (but not limited to) “assisting in the diagnosis of child abuse and neglect.”[169] It doesn’t appear the state has created a Medical Director or something similar.

South Carolina’s 2018-2019 budget directed “not less than” $2.075 million” be appropriated to the University of South Carolina School of Medicine for the Child Abuse and Neglect Medical Response Program.[170]

TEXAS

Medical Evaluation and Consultation Program	Yes
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	Yes
Designated Funding for Medical Evaluation and Consultation Program	Yes

2017[171]	Number of Children Under 18 Years of Age [172]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[173]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	**74,312,174**	**47.1** (n=3,501,407)	**9.1** (n=673,830)	**25.3** (n=100,457)	**11.7** (n=46,843)	**11.0** (n=44,503)
Texas	**7,366,039**	**38.5** (n=283,764)	**8.3** (n=61,506)	**27.0** (n=10,871)	**13.0** (n=5,288)	**11.8** (n=4,855)

In 2005, The Texas legislature enacted legislation requiring that the Texas Health and Human Services Commission (HHSC) "shall collaborate with health care and child welfare professionals to design a comprehensive, cost-effective medical services delivery model, either directly or by contract, to meet the needs of children served by the department."[174]

Among the required elements of this medical services delivery model:

- "The designation of health care facilities with expertise in the forensic assessment, diagnosis, and treatment of child abuse and neglect as pediatric centers of excellence."
- "The establishment of a statewide telemedicine system to link department investigators and caseworkers with pediatric centers of excellence or other medical experts for consultation."

By 2006, the Family and Protective Services Department (DFPS) had contracted with The University of Texas Health Science Center-Houston "to create the Forensic Assessment Center Network (FACN)."[175] Through this network which continues today, DFPS began to make "expert pediatricians available for consultation to Children's Protective Services and Child Care Licensing on cases of suspected child abuse and neglect."[176]

In 2007, the Texas Legislature created a 10-member "committee on pediatric centers of excellence relating to abuse and neglect" requiring that 3 members of this committee were to be "pediatricians who specialize in treating victims of child abuse."[177] This Pediatric Center of Excellence (PCOE) committee was expected to "develop guidelines for designating regional pediatric centers of

excellence" that would then "provide medical expertise to children who are suspected victims of abuse and neglect and assist the department in evaluating and interpreting the medical findings for children who are suspected victims of abuse and neglect." This committee was directed to "recommended procedures and protocols" for health care providers "to follow in evaluating suspected cases of child abuse and neglect" and how best to finance pediatric centers.

In 2009, the PCOE committee released its findings acknowledging the "significant strides" Texas had achieved through FACN. It also acknowledged that, in addition to FACN, there were also children's advocacy centers (CACs), child fatality review teams (CFRTs) and child abuse teams in children's hospitals. The committee did not suggest that existing initiatives be replaced or significantly altered. Instead, the committee observed that a "more comprehensive approach" was required."[178]

The committee identified the "limited number of clinicians with training and expertise on child abuse" as a "major barrier to providing timely and effective child abuse assessment, diagnosis and treatment." The committee also highlighted that medical evaluations for a child who may be a victim of child "is a complex and time-consuming undertaking" and providers were reimbursed "only a fraction" of the costs associated with the services provided. The committee recommended a three-tiered (e.g., basic, advanced and center of excellence) Medical Child Abuse Resources and Education System (MEDCARES).

The Texas Legislature responded by authorizing, in statute, the MEDCARES grant program and appropriated $5 million to the Texas Department of State Health Services (DSHS) for the establishment of a competitive application process by January 2010.[179] The enacted statute also required a biennial report submitted to the governor and legislature and created a MEDCARES Advisory Committee, which was abolished by the legislature in 2015.

Eligible grantees were hospitals, academic health centers, and health care facilities with expertise in pediatric health capable of "developing and supporting regional programs to improve the assessment, diagnosis, and treatment of child abuse and neglect."[180]

In 2017-2018, the Texas Department of State Health Services (DSHS) awarded a total of $5.54 million to 11 entities, including 2 that met only the basic criteria (see chart below).[181]

Texas MEDCARES Program Criteria	Basic	Advanced	Center of Excellence
Physician(s) – full time	At least 1 "experienced and trained in all types of child abuse and neglect"	At least 1 physician "board-certified as a child abuse pediatrician" or that demonstrates "completion of a pediatric child	At least 2 "board eligible/certified child abuse pediatricians as part of full multi-disciplinary team."

Texas MEDCARES Program Criteria	Basic	Advanced	Center of Excellence
		abuse fellowship with experience providing child abuse and neglect services."	
Dedicated social work assessment/program coordination	One	One	Yes
Increased size, volume and support from medical subspecialties, mental health care and counseling	---	---	Yes
Comprehensive medical evaluation, psychosocial assessments, treatment services, and written and photographic documentation of abuse	Yes	Yes	Yes
Medical case reviews, consultations, and testimony regarding those reviews and consultations	---	Yes	Yes
Utilization of telemedicine to extend services into regional, underserved areas	---	Yes	Yes
Education and training for health professionals	Yes	Yes	Yes
Research, data collection, and quality assurance activities	---	Yes	Yes
Regional resource	---	---	Yes
Regional leadership on prevention	---	---	Yes
Advanced training for pediatricians interested in becoming child abuse specialists	---	---	Yes
Recognized authority for child maltreatment research	---	---	Yes

In October 2018, DSHS "re-competed the grant program" awarding funding only to contractors who met the advanced category criteria.[182] The reconfigured grant opportunity required that respondents be a "hospital or academic health center with advanced expertise in medical child abuse and neglect services that meet the criteria of an advanced or center of excellence program described in detail in the Pediatric Centers of Excellence Advisory Committee Report."[183]

Among the requirements that respondents were required to meet:

- Have a minimum of one full time equivalent Pediatrician board certified as a Child Abuse Pediatrician ("CAP") or a Pediatrician with 5 or more years of experience in forensic child abuse assessment, diagnosis and treatment.
- Have a minimum of one full time equivalent social worker with experience in trauma informed care.

- Currently be providing comprehensive medical evaluations for child abuse and neglect patients, including consults on inpatient and outpatient cases.
- Have in-house access to related subspecialty services such as pediatric radiology, geneticists, and endocrinologists, who specialize in identifying unique health conditions, including the following:
    a. Rickets
    b. Ehlers-Danlos Syndrome
    c. Osteogenesis imperfecta
    d. Vitamin D deficiency
    e. Other similar metabolic bone diseases or connective tissue disorders

A current list of MEDCARE contractors is available at https://www.dshs.texas.gov/mch/medcares.shtm/.

According to the 2017-2018 Biennial Report, 19 of the 22 CAPs practicing in Texas are employed by MEDCARES contractors.[184] Activities or improvements realized "through MEDCARES providers" included increasing "cooperation with Child Protective Services", law enforcement and judicial personal "through consultations, medical care review, and providing testimony in court."[185]

In early 2019, DSHS committed to evaluating the quality of monthly program measures submitted by MEDCARES contractors after discovering that "the reported number of children examined through outpatient consultations was underrepresented".[186] As a result the "percent of confirmed abuse cases reported by contractors may have been inflated". As part of the process, DSHS discovered there was "variation" in how contractors were defining DSHS' required measures (e.g., number of consultations, case reviews, trainings). Effective July 2019, DSHS "developed new data measures, standardized data definitions, and developed a new data submission tool to improve data quality."[187]

The Child Protective Services Handbook published by the Texas Department of Family and Protective Services (DFPS) sets forth when a child protective caseworker is required to enlist FACN, with FACN noted as including "physicians who specialize in child abuse and neglect." [188] FACN must be enlisted under the following circumstances:

- "There does not appear to be any reasonable explanation for an injury, or the explanation is not consistent with the injury.
- Assistance is needed to determine whether abuse or neglect has occurred.
- There is a disagreement between a medical professional and DFPS regarding whether abuse or neglect occurred or the seriousness of an injury or condition, and clarity is needed.
- There is evidence of medical child abuse (also known as Munchausen syndrome).
- There is bruising on an infant or child who is not mobile.
- The caseworker has a lingering question about abuse or neglect that a medical professional may be able to clarify."[189]

The handbook instructs caseworkers that they “generally do not need to consult the FACN if a child has already been seen by a local physician and there are no lingering questions or concerns.”

The Pennsylvania Perspective

Medical Evaluation and Consultation Program	No
Medical Director Identified	No
Specific Injuries or Age of Child Require Specialized Medical Evaluation	No
Designated Funding for Medical Evaluation and Consultation Program	No

2017[190]	Number of Children Under 18 Years of Age [191]	Rate of Children, per 1,000 in the Population, receiving an Investigation or Alternative Response[192]	Rate of Child Victims of All Ages per 1,000 children	Rate of Child Victims <1 year per 1,000 children	Rate of Child Victims 1 year of Age per 1,000 children	Rate of Child Victims 2 years of Age per 1,000 children
National	74,312,174	47.1 (n=3,501,407)	9.1 (n=673,830)	25.3 (n=100,457)	11.7 (n=46,843)	11.0 (n=44,503)
Pennsylvania[193]	2,664,515	16.1 (n=42,890)	1.7 (n=4,625)	2.6 (n=361)	1.6 (n=220)	1.7 (n=245)

In 1993 as Pennsylvania lawmakers were debating amendments to the Child Protective Services Law, which was initially enacted in 1975, a member of the Pennsylvania House of Representatives offered an amendment stipulating:[194]

> *"If the investigation indicates physical abuse, an immediate medical examination shall be performed on the subject child by a certified medical practitioner to assist in determining whether there is a history of prior physical abuse."*

The sponsor of the amendment said the catalyst to his amendment was the death and autopsy of a child that had been abused. He said the autopsy revealed "that this child had been abused on many occasions prior to this." The sponsoring lawmaker underscored, "This amendment simply says that when a child is brought in for an injury, that there be a more extensive medical examination to determine and in fact if there was previous evidence or evidence of previous abuse so that it could be taken into consideration insofar as the treatment of that case."[195]

The prime sponsor of the underlying child protection reform bill said the proposed amendment was an "excellent idea", but also cited a $1.2 million cost telling his legislative colleagues, "I am told that we do not have the money for it."

Eventually, as enacted, Act 151 of 1994 included the following language within the CPSL:[196]

> *"If the investigation indicates serious physical injury, a medical examination shall be performed on the subject child by a certified medical practitioner. Where there is*

> *reasonable cause to suspect there is a history of prior or current abuse, the medical practitioner has the authority to arrange for further medical tests or the county agency has the authority to request further medical tests."*

By 2013, Pennsylvania lawmakers altered the "shall" provision related to a child's connection to a "medical examination" to a "may require" provision as part of a significant package of child protection reforms. As of November 2019, Pennsylvania statute states that if an investigation "indicates bodily injury, the county agency may require that a medical examination by a certified medical practitioner be performed on the child."[197]

Pennsylvania's child protection statute has long authorized the Pennsylvania Department of Human Services (PA DHS) to "provide for the establishment of regional facilities or a regional coordination of licensed professional service providers to provide county agencies with access to licensed physicians and psychologists."[198] Still, as of November 2019, no such program – statewide or regionally – has been created.

While there is no statewide statute outlining specific situations when a child must be connected to a medical evaluation in the course of a child abuse investigation nor a statewide medical evaluation and consultation program or contract, individual counties do directly engage clinical insight from nurses and/or child abuse pediatricians.

As part of submitting their annual child protective services (CPS) budget to the Pennsylvania Department of Human Services (PA DHS), Pennsylvania's 67 counties were asked in 2019 to identify if the county has established any contracts or consulting arrangements with physicians or "other appropriate medical professionals to assess the health and well-being of children in their own homes to determine the appropriate medical treatment?".[199]

Allegheny County responded in its draft 2020-2021 budget plan, crafted in July 2019, that the county has "embedded" nurses in its child welfare system through a contract with Children's Hospital of Pittsburgh. This Child Health Evaluation Coordination Support (CHECs) permits nurses, under the supervision of a child abuse pediatrician, to "conduct record reviews and in-home consultations, translate medical information for case workers, and improve continuity of care for any case that comes into the office." The county further cites the CHECs in a discussion about how the county implemented "improved investigative practices" in 2018. The development of an investigative practice standard manual and training is intended to support CPS caseworkers and supervisor staff.

The City of Philadelphia Department of Human Services hires nurses "to help social workers ensure the health and safety of children in their caseload."[200] Philadelphia DHS also contracts with the Health Federation of Philadelphia to connect families raising an infant born affected by prenatal substance exposure with intensive home visitation and case management services.[201]

In 2012, a Task Force on Child Protection, created by the Pennsylvania General Assembly, issued a report and a series of comprehensive recommendations to rework how the Commonwealth defined, reported and investigated child abuse and neglect.[202] The Task Force noted the work of Philadelphia DHS, including (at the time) employment of a part-time medical director along with "highly qualified nurses" able to provide "expert advice" to CPS caseworkers. The Task Force observed, "Although the cost of hiring nurses may be well beyond the budgets of many counties in the Commonwealth and may or may not be an appropriate part of needs-based budgeting process, medical outreach by local hospitals or other organizations could serve as an important resource."

As part of the 2014 agreement negotiated between Penn State and the National Collegiate Athletic Association (NCAA), Penn State paid $48 million to the Commonwealth of Pennsylvania. This $48 million was then "deposited into an endowment" established as a "separate trust fund in the State Treasury." The road map Pennsylvania must follow to invest the $48 million (and any earned interest) is set forth in The Higher Education Monetary Penalty Endowment Act (Act 1 of 2013).[203] PA's elected Treasurer makes endowment funding available to the PA Commission on Crime and Delinquency (PCCD) for the following purposes:

1. Programs or projects preventing child sexual abuse and/or assisting the victims of child sexual abuse;
2. Multidisciplinary investigative teams established by PA law, which must include a CPS caseworker, law enforcement and a (broadly defined) health care provider;
3. Child advocacy centers;
4. Victim service organizations that provide services to children subjected to sexual abuse; or
5. Training of persons who are mandated by law to report child sexual abuse or to treat victims of child sexual abuse.

PCCD is guided in its decisions related to the endowment act funding by the statutorily created Children's Advocacy Center Advisory Committee (CACAC).[204] The CACAC also provides advice and recommendations to PCCD on other state and federal funding streams. Between 2012 and July 2019, PCCD's CACAC has awarded 402 grants.[205]

Act 28 of 2014 provided a direct funding source for children's advocacy centers (CACs) and multidisciplinary investigative teams (MDITs). In enacting Act 28, the Pennsylvania General Assembly described CACs as "state-of-the-art treatment for victims of child sexual abuse and child abuse" and that such centers "bring together doctors, nurses, prosecutors, social workers and police in order to provide a unique and essential program of treatment and healing for child victims." The statute stipulates, "Children's advocacy centers not only treat child victims, but assist in preventing and detecting child abuse and provide, through forensic interviewing and other techniques employed by the multidisciplinary investigative teams, the most effective way to bring perpetrators of child sexual abuse to justice."

Act 28 imposed a $10 fee increase for a certified copy of a birth certificate. Seventy-five percent of the generated revenue is directed to PCCD annually to provide grants for child advocacy centers and MDITs. The remaining 25% is available to the Pennsylvania Department of Human Services (PA DHS) to train mandated reporters

Annual reports issued by Children's Advocacy Centers (CACs) and the budget plans submitted by county CPS agencies illustrate that there is an extensive degree of infrastructure established to respond to child victims within the Commonwealth, but the type of abuse addressed at CACs is most often related to sexual abuse allegations. Pennsylvania CACs undertake large volumes of forensic interviews, but far fewer children are being connected to medical services. For example:

- The Over the Rainbow CAC serving children in Adams County provided forensic interviews to 170 children between July 1, 2016 and June 30, 2017. [206] In that same time period, the CAC's annual report indicates 100% of the children evaluated at the CAC "were eligible for medical exams, but only 31% received one. Types of abuse reported was overwhelmingly sexual abuse (n=109) followed by physical abuse (n=41).
- Beginning in 2017, the Bucks County Children's Advocacy Center (CAC), which is a program of the Network of Victim Assistance (NOVA), "contracted with St. Christopher's Hospital for Children, to provide specialized medical exams for children who have been sexually abused." This contract "enhances the coordination of services and provides parents and caregivers with access to the vitally important forensic medical services right in Bucks County - reducing stress and increasing compliance during emotional trauma to the family and, in particular, the child."
- Cambria County noted in its child welfare plan and budget that for "child sexual abuse cases, the Child Advocacy Center works with the agency, the District Attorney's office, the Courts, Victim Services, medical services and hospitals, and the police departments in the county."[207]
- Mission Kids, which serves children and families in Montgomery County, reports that in 2017, the agency" performed 579 forensic interviews; 15.8% (n=92) of children received a referral to Children's Hospital of Philadelphia's Child Abuse, Referral and Evaluation (CARE) Clinic. [208] Types of abuse addressed by Mission Kids is listed as 464 related to sexual abuse, 125 physical abuse, 23 other and 23 where the child was a witness to violence.
- Philadelphia Children's Alliance (PCA) reported that there were 3,313 reports of alleged child sexual abuse in Philadelphia in 2017"[209] Approximately 58% (n=1,916) of these children were interviewed by the multidisciplinary team at PCA and 17% (n=560) received an "on-site medical evaluation."[210]

Beyond the Act 28 and Endowment Act funding, additional state funding can be directed to CACs when a county CPS agency requests funding to support a CAC. For example, Lancaster County noted it provided $128,000 of the $435,190 budget of the Lancaster County CAC. The county further noted, "All children with allegations of sexual abuse are interviewed at the Children's Alliance and have the opportunity to have a medical exam."[211]

Pennsylvania's Crime Victims Act limits permits a hospital or other licensed health care provider to submit a claim to be reimbursed for the cost of a forensic rape examination (FRE).[212] Costs associated with medical evaluations unrelated to reports of child sexual abuse are unaddressed in the Crime Victims Act or administered compensation program.

As of November 2019, Pennsylvania did not have a statewide medical director involved in developing and overseeing child protection policies and practices.

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[24] Child Maltreatment 2017, Table 3–6 Victims by Age, 2017.

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[26] Child Maltreatment 2017, Table 3-1 Children Who Received an Investigation or Alternative Response, 2013-2017.

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[28] Pennsylvania operates what the Pennsylvania Department of Human Services (PA DHS) describes as an "alternative response" where certain reports are classified as General Protective Services (GPS). GPS reports often trigger a legally required assessment of the child or family. To date, Pennsylvania has not reported data about the number of GPS assessments or related outcomes (e.g., validated or invalid) within the data submitted to The National Child Abuse and Neglect Data System (NCANDS). As a result, the data within the annual Child Maltreatment, which was the source of the above chart, does not provide a reliable measure of the number or rate of children in Pennsylvania receiving an investigation or alternative response. Additionally, variation in state definitions of child abuse and neglect assures that what some states might capture as neglect is instead categorized as a GPS case in Pennsylvania. These factors then should be understood when comparing Pennsylvania's data to national or another state's data reported within Child Maltreatment.

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[190] *Child Maltreatment* 2017, Table 3–6 Victims by Age, 2017.

[191] *Child Maltreatment* 2017, Table C–2 Child Population, 2013–2017.

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[193] Pennsylvania operates what the Pennsylvania Department of Human Services (PA DHS) describes as an "alternative response" where certain reports are classified as General Protective Services (GPS). GPS reports often trigger a legally required assessment of the child or family. To date, Pennsylvania has not reported data about the number of GPS assessments or related

outcomes (e.g., validated or invalid) within the data submitted to The National Child Abuse and Neglect Data System (NCANDS). As a result, the data within the annual Child Maltreatment, which was the source of the above chart, does not provide a reliable measure of the number or rate of children in Pennsylvania receiving an investigation or alternative response. Additionally, variation in state definitions of child abuse and neglect assures that what some states might capture as neglect is instead categorized as a GPS case in Pennsylvania. These factors then should be understood when comparing Pennsylvania's data to national or another state's data reported within Child Maltreatment.

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[205] https://www.pccd.pa.gov/Funding/Pages/Grants-App.aspx

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[207] Fiscal Year 2019-20 Needs-Based Plan & Budget submitted by Cambria County on August 28, 2018.

[208] Mission Kids 2017 Annual Report http://missionkidscac.org/wp-content/uploads/2018/09/Mission-Kids-Annual-Report-PDF-For-Website-Use.pdf

[209] Philadelphia Children's Alliance 2017 Annual Report http://www.philachildrensalliance.org/annual-report

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[211] Fiscal Year 2019-20 Needs-Based Plan & Budget submitted by Lancaster County on August 15, 2018, page 31.

[212] Pennsylvania Crime Victims Act retrieved at https://www.legis.state.pa.us/WU01/LI/LI/US/HTM/1998/0/0111..HTM