

CHILD PHYSICAL ABUSE

A Guide to the CAC Response

1 DEVELOPING CAPACITY
TOWARD SERVING CHILD
PHYSICAL ABUSE VICTIMS

2 MEETING THE MENTAL
HEALTH NEEDS OF
PHYSICAL ABUSE VICTIMS

4 ADVOCACY FOR
PHYSICAL ABUSE
VICTIMS

3 MEDICAL EVALUATION
FOR CHILD PHYSICAL
ABUSE CASES



NATIONAL
CHILDREN'S
ALLIANCE®

OJJDP



Table of Contents

03	Contributors
04	The CAC Response to Child Physical Abuse
04	About This Guide
05	1: Developing Capacity toward Serving Child Physical Abuse Victims
14	2: Meeting the Mental Health Needs of Physical Abuse Victims
21	3: Medical Evaluation for Child Physical Abuse Cases
35	4: Advocacy for Physical Abuse Victims

Contributors

Dr. Karen Farst

Co-Chair

University of Arkansas
for Medical Sciences

Ivy Svoboda

Co-Chair

Nebraska Alliance of
Child Advocacy Centers

Cari Allen

Children's Advocacy
Center of Jackson
County

Sue Ascione

Northeast Regional
CAC

Caitlyn Benedetto

Child Enrichment, Inc.

Adrienne Bass

Harmony House CAC
& SAC

Shelly Bohannon

The Bridge Children's
Advocacy Center

Colleen Brazil

Project Harmony

Mary-Ann Burkhart

Association of
Prosecuting Attorneys,
Child Abuse
Prosecution Project

Ellen Case

Mayo Children's
Advocacy Center

Dawn Cazzolli

Wayne County
Children's Advocacy
Center

Jackie Collard

Child Advocacy Center
of Niagara

Beth Cook

Logan Co. Child
Advocacy Center

Bethany Cottrell

Merrimack County
Advocacy Center

Stephanie Davis

Greater Richmond
SCAN CAC

Kimberly Duffy

York County Children's
Advocacy Center

Ashley Ellis

Heartford House

Suzan Evans

Children's Advocacy
Centers of North
Carolina

Janet Fine

National Vicarious
Trauma Toolkit Project

Justin Fitzsimmons

SEARCH, The National
Consortium for Justice
and Statistics

Brenda George

Children's Alliance of
Montana

Paige Gilliland

AWAKE Children's
Advocacy Center

Jennifer Ginsburg

Safe Harbor CAC

Vicky Gwiasda

Western Regional CAC

Karen Hangartner

Southern Regional CAC

Dr. Karen Hansen

Department of
Pediatrics,
University of Utah
Health Sciences Center

Debra Hawkins

Harmony House, Inc.

Jody Hawthorne

Children's Advocacy
Center of Pierce County,
Washington

Karen Hill

Southern Tier Child
Advocacy Center

Dr. Mark Hudson

MRCAC/ Midwest
Children's Resource
Center

Rachel Johnson

First Witness CAC

Shandi Joubert-Kanz

The Child Center, Inc.

Jodi Kaplan

Delaware County
Children's Advocacy
Center

Margot Kubichek

Randall Tucker CAC

Stacie LeBlanc

New Orleans CAC and
Louisiana Alliance of
CACs

Tori Little

Nashville Children's
Alliance

Misty Marinier

Child Advocacy Center
of McHenry County

Nydia Monagas

New Jersey Children's
Alliance

Donna Moulton

Child Help – Arizona

Wendy Myers

The CRICKET Center

Gwen O'Brien

Synergy CAC

Emily Perry

Susie's Place Child
Advocacy Center

Diane Pisczek

Lake Sumter Children's
Advocacy Center

Brandy Rea

East Mississippi Child
Advocacy Center

Cindy Riddell

Sunflower House4

Carole Swiecicki

Dee Norton Lowcountry
Children's Center

Alyssa Todd

Windham County Safe
Place CAC

Ann Marie Tucker

Child Advocacy Center
of Niagara

Natalie Whitehead

Appalachian Children's
Center

Tiffany Webb

SafePath Children's
Advocacy Center

Leanda Welker

Harford County
Children's Advocacy
Center

Joyce Wientzen

Cumberland County
Children's Advocacy
Center

The CAC Response to Child Physical Abuse

Despite the fact that CACs serve many more victims of child sexual abuse than they do victims of child physical abuse (CPA), federal data show 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.

The CAC model is appropriate for providing evidence-based services to child victims of physical abuse when the CAC and partnering MDT members have the necessary capacity and resources to do so. Physical abuse cases often benefit not only from specialized mental health treatments, but also require special considerations for medical services, victim advocacy, forensic interviewing, and MDT collaboration. This guide identifies numerous considerations and differences in the response and intervention to physical abuse for a CAC currently serving sexually abused children and their families.

About This Guide

As part of ongoing work to develop helpful tools and guidance to improve CAC service delivery to children and families, National Children's Alliance (NCA) convened a collaborative workgroup on the subject of expanding CAC delivery of evidence-based services to victims of physical abuse. This group, comprising professionals representing all of the disciplines required within the multidisciplinary team (MDT) disciplines under NCA's Standards for Accredited Members, worked to develop the following information and resources that will provide guidelines and recommendations both for CACs currently providing services to victims of physical abuse, or those who are considering expanding or enhancing their services for this population.

The objective of this guide is to increase the number of CACs delivering evidence-based intervention designed to meet the specific needs of physical abuse victims. In this guide, CAC directors, staff, boards, and MDT partners will find considerations, tips and resources for CACs and MDTs providing services to child victims of physical abuse to help them meet this objective at their individual CACs.

The content is divided into four sections: One on developing capacity to serve CPA victims; the second on meeting the mental health needs of the victims; the third, covering considerations for medical providers, and the fourth and final on the role of the victim advocate in CPA cases. While each section covers a distinct discipline necessary to serve CPA victims, all sections are intended to be read by the entire complement of MDT members and CAC leadership. Integral to the success of the CAC and MDT response to physical abuse is the deep, interdisciplinary understanding of the role of each provider among every member of the team.



1

Developing Capacity toward Serving Child Physical Abuse Victims

Getting Started

Before a CAC decides to offer or expand their services to victims of physical abuse, the CAC should assess the need of the community, evaluate their available resources, and determine the capacity of their multidisciplinary teams to respond adequately.

These are some steps a CAC should take to begin the process of adding physical abuse response and services at the CAC.

- » Every state has differing statutes and mandates defining child abuse and directing the response to allegations. Check your state laws and local regulations to determine how existing mandates will impact CAC involvement.
- » Explore how each of your MDT partners define and or categorize their agency response to physical abuse.
- » Determine the number/proportion of physical abuse cases within your community.
- » Map out the existing process for the response and intervention in reported cases of physical abuse cases.
- » Determine what the agreed upon case acceptance criteria would be for providing these services at the CAC.
- » Determine how the CAC will work with physical abuse cases involving non-verbal children and children who may be non-accessible, such as those in the hospital where there may be a delay in interview.
- » Assess the community wide training needs that would be required to effectively accomplish the expansion of CAC services.

Expanding Service to Child Physical Abuse Victims for MDTs

Before a CAC makes the decision to expand services to include child physical abuse victims, it is important to determine both the current and needed capacity for all team members and partner agencies involved in the response and provision of services. At minimum, this would include law enforcement, victim advocacy, child protective services, prosecution, medical providers, mental health providers, and forensic interviewers.

Included in these discussions are: the team's agreement to the number of additional cases they can manage; the available knowledge and expertise specific to child physical abuse and how that training will be provided to all team members; a clear definition and agreement of cases that will be included in the CAC case acceptance criteria; and established protocols for any additional services that will be available for caregivers of children who are victims of physical abuse.

The MDT Role in Child Physical Abuse Cases

The MDT should work together with the CAC to develop an agreed-upon case acceptance criteria that will determine which physical abuse cases will be referred to the CAC. This criteria should be included in the CAC protocol.

The team may encounter challenges determining an acceptance criteria that defines physical abuse conducive to the parameters of each involved discipline. For example, child protective service agencies may have differing mandates and procedures from those of law enforcement agencies. It will be necessary to review the related state laws and local regulations and work collaboratively to define what referrals are appropriate for the CAC to receive.

An option may be for the MDT to define a “permissive” referral vs. a “required” referral in order to reconcile the need to have a universal definition. Defining physical abuse acceptance criteria in this manner may also be an effective strategy to introduce physical abuse cases to an MDT or CAC who have not previously worked with these type of cases.

1 Developing Capacity toward Serving Child Physical Abuse Victims

Using a multidisciplinary approach to providing training and increased knowledge specific to physical abuse will be beneficial to the overall process of enhancing these services at the CAC. Each discipline can provide valuable cross-training opportunities for each involved team member. The outcome will be instrumental in assuring that the entire team learns the unique dynamics which may be involved when responding to physical abuse, the differences in investigation techniques and requirements, the types of follow-up services a child and/or caregiver may need to receive, and the mandates involved in both protective services and/or prosecution of these cases.

Discipline-Specific Roles in CPA Service Provision

Victim advocates have the potential opportunity to be a part of preventive efforts and/or to incorporate such parental education/resources into their work with caregivers. The advocate is essential to ensuring a holistic, family-focused approach which can result in the identification of potential domestic violence in the home or of siblings as potential victims/witnesses.

Medical providers on the team are essential in sharing the medical perspective in physical abuse cases. Is an acute medical exam needed or a non-acute exam? How do the different types of exams play out for physical abuse cases? What are the guidelines for an acute case of physical abuse? How does the timeframe look different for acute vs non-acute physical abuse cases?

The MDT should consider how to assess if the medical representative for their team has the necessary capacity and availability to provide quality expertise for the MDT. Make sure the medical representative is willing to serve the team by routinely participating in MDT case review meetings and can appropriately access the necessary records and documentation to provide adequate information. This may be a very different role than the medical provider who conducts exams for these cases.

Often times, physical abuse cases present at the emergency department at a hospital or urgent care setting. Professionals in these settings may not be involved in the MDT and unaware of how the medical information affects the investigation. There may often be numerous medical specialists involved in a specific physical abuse case. Having a committed medical provider on the multi-disciplinary team who can assume the role of liaison to the medical providers at the hospital will have a beneficial impact for both the medical outcome and the future investigative component of the case.

1 Developing Capacity toward Serving Child Physical Abuse Victims

Forensic Interviewers for victims of child abuse or children who have potentially witnessed physical abuse of another child should be aware that , currently, none of the different national protocols for conducting the forensic interview of a child espouse a separate and distinct method between child forensic interviews of sexual abuse versus physical abuse. Furthermore, the history obtained by the medical provider during the medical assessment of an injury carries distinct importance of relating an injury to a history of how it occurred.



Examples of information gathering during FI for possible physical abuse: nationalchildrensalliance.org/CPAguide1 *

*Courtesy: First Witness Child Advocacy Center

Physical Abuse; Modifications to the Forensic Interview

Laura Gopke
Forensic Program Coordinator, Interviewer, & Trainer



The MDT should be prepared to make a team-based decision as to whether the current forensic interview model being used at the CAC is adaptable to interview physical abuse victims and witnesses, or whether additional or expanded training for the forensic interview staff should be sought.



Guidelines on child forensic interview best practice: nationalchildrensalliance.org/CPAguide2 *

* Sept. 2015 Juvenile Justice Bulletin, U.S. Department of Justice Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention



Factors in Developing a Collaborative Response

MDT members from each discipline may have differing thresholds for evaluating cases and determining how their agency will respond. Regardless of the MDT decision on how to proceed in any specific case (e.g., criminal investigation/prosecution, protective services intervention), the CAC should facilitate cross-disciplinary training for all team members. This will enhance the team members' understanding of the benefits of ongoing CAC services for child victims of physical abuse and their caregivers.

Serious physical injury cases involving children too young to be interviewed, which are quite common, are normally not referred to the CAC. Likewise, siblings may also be implicated as additional victims and/or witnesses. In either situation, MDT case review can have a tremendous impact by offering a holistic approach and an opportunity to assess for the potential value of a forensic interview, or other follow-up services. The team should evaluate their capacity for regular inclusion of these cases in their case review meetings.

1 Developing Capacity toward Serving Child Physical Abuse Victims

Cultural competency and diversity education and the opportunity to diversify the knowledge and beliefs of all MDT members are relevant components of the investigative and intervention process. When the MDT enhances its ability to address cultural barriers, multiple professionals are better positioned to provide resources and education for caregivers. Similarly, substantiation bias may result in unnecessary adverse effects on families' lives and it is important that investigative professionals have the tools to conduct an objective evaluation for all cases of child physical abuse.

When determining the capacity of the CAC to begin serving child victims of physical abuse, the CAC should do a thorough review of NCA's current Standards for Accredited Members in effect and review their current policies and protocols to determine what changes in practice and documentation will be necessary to assure continued compliance with all essential components of the accreditation standards.

Determine how physical abuse cases fit into the child fatality response. The response may be jointly conducted or completely separate. As an overlap may exist, there should be a coordinated effort among the responses. Likewise, committing the coordinated investigation to written protocol (if such a protocol doesn't exist already) is encouraged, and should be inclusive of all disciplines' roles and responsibilities and methods for sharing info, typical timelines, etc.

Case Scenarios

Responding to and investigating reports of physical abuse may pose new challenges and decisions for existing MDTs. For example, children reported as physically abused are frequently very young, and a forensic interview of a child may not be possible. Or, a child may be hospitalized for an extended period, requiring a decision to be made about where and when to interview the child. Multiple medical professionals often play a critical role in the determination whether an injury is the result of abuse, as determining when an injury occurred and who had access to the child at the time of injury are key pieces of information needed to identify a primary suspect. Prompt response and immediate coordination is essential.

The below scenarios depict just two example scenarios involving suspected physical abuse. They are designed to facilitate an MDT/CAC discussion to set policy and procedures to address reports of physical abuse in their communities. After reading through the scenarios, please reference the discussion items at the end, which will facilitate team discussion of how the response and evaluation of cases of physical abuse may differ from those a CAC has historically experienced with cases of sexual abuse.

1 Developing Capacity toward Serving Child Physical Abuse Victims

Case Scenario #1

Four-year-old Emma was taken by her mother to the emergency room of a children's hospital with burns on her head, shoulder and face. Her mother stated that Emma sprayed herself with bathroom cleaner four days earlier. The burns were painful and blistered. Mother was accompanied by her boyfriend.

Hospital personnel had concerns regarding the history provided by Emma's mother and that she had waited four days to get treatment for extremely painful injuries. They expressed doubt that the burns could have occurred in the manner and timeframe described and filed a report with child protective services. Emma was admitted to the hospital for treatment. Emma's burns required multiple treatments including skin replacement.

Child protective services contacted the CAC regarding the report. The CPS caseworker stated that a forensic interview would be needed at the CAC as soon as possible. The CPS worker indicated the child had stated at the hospital that she did this to herself.

While Emma was still hospitalized, CAC staff convened a meeting of CPS, law enforcement, an assistant district attorney, CAC advocates, and CAC medical personnel to review the case and plan continued aspects of the investigation and response. CAC medical personnel reviewed the hospital records and discussed them with the team. Areas of inquiry included whether it was possible that the injuries could be self-inflicted, the timeframe that the injury may have occurred

and who was the child's caregiver at the time of the injury. After consultation with medical personnel, it was difficult to determine a specific timeline. Both the child's mother and boyfriend denied that they had anything to do with Emma's burns.

Child protective services indicated that they would conduct an emergency removal when the child was ready to be discharged from the hospital. CAC medical staff and CPS coordinated with hospital personnel to assure that Emma was not discharged to her mother prior to arrangement of the alternative placement. Emma was placed in foster care.

The CAC's forensic interviewer conducted a forensic interview of Emma at the CAC. She did not disclose details about the burn.

CAC staff continue to provide follow-up contact with the child's guardian and coordination with the team. Emma's guardian indicates that Emma is acting out at school. She is aggressive with other children and disruptive. She is also excessively clingy with adults. Emma was enrolled in trauma therapy at the CAC and continues to attend.

The CPS report has been indicated. To date, no charges have been filed by law enforcement due to the inability to determine if mother or her boyfriend inflicted Emma's burns.

1 Developing Capacity toward Serving Child Physical Abuse Victims

Case Scenario #2

Five-week-old Jackson was admitted to children's hospital for multiple fractures and a subdural hematoma. Both parents stated that Jackson had fallen off the changing table. Hospital personnel filed a child protection report.

CPS notified the CAC. An MDT meeting was convened within 48 hours and attended by law enforcement, CPS, a victim advocate, CAC staff, and CAC medical personnel. CAC

medical personnel reviewed the records and recommended a follow-up skeletal survey. CPS reported that a removal petition was being filed in family court.

Both parents have prior CPS history with another child. Jackson was released to his maternal grandparents. The child's father was charged with assault. The Department of Social Services continues to provide services. The CAC case is closed.

Discussion

- » What are the roles of each member (discipline) of the team? Who is going to take responsibility for initiating a coordinated, team response?
- » What activities/services need to be coordinated? by whom/which agency?
- » What are the medical needs of this case? Do we have access to the needed medical expertise to be able to have success in this case? How do we engage others to fill in our weaknesses?
- » How do we reduce duplication of our efforts? How do we ensure that joint investigations and timely information exchange are accomplished while protecting confidential information consistent with legal, ethical, and professional standards of practice?
- » What do we need to do for the child and family to reduce trauma and promote healing?

1 Developing Capacity toward Serving Child Physical Abuse Victims

Resources

- » Regional Child Advocacy Centers. (2015). Community Assessment Regional Protocol Development Tool.
- » National Children's Alliance. (2016). Putting Standards into Practice.
- » Elmquist, J., Shorey, R., Febres, J., Zapor, H., Klostermann, K., Schratter, A., Stuart, G. (2015). A review of Children's Advocacy Centers' (CACs) response to cases of child maltreatment in the United States. *Aggression and Violent Behavior* 25 (2015) 26-34. Elsevier Ltd.
- » Morris, M., Rivaux, S., Faulkner, M. (2017). Provider ambivalence about using forensic medical evaluation to respond to child abuse: A content and discourse analysis. *Child Abuse & Neglect* 65(2017) 140-151. Elsevier Ltd.
- » Jent, J., Eaton, C., Knickerbocker, L., Lambert, W., Merrick, M., Dandes, S. (2011). Multidisciplinary Child Protection Decision Making About Physical Abuse: Determining Substantiation Thresholds and Biases. *National Institutes of Health. Child Youth Serv Rev.* 2011 September 1; 33(9): 1673-1682. Doi:10.1016/j.chilgyouth.2011.04.029. Elsevier Ltd.
- » Lalayants, M. (2013). Multidisciplinary Collaboration in Child Protective Clinical Consultations: Perceptions of Best Practices. *Journal of Public Child Welfare*, Vol. 7:253-274, 2013. Taylor & Francis Group, LLC
- » Jent, J., Merrick, M., Dandes, S., Lambert, W., Haney, M., Cano, N (2009). Multidisciplinary assessment of child maltreatment: A multi-site pilot descriptive analysis of the Florida Child Protection Team model. *National Institutes of Health. Child Youth Serv Rev.* 2009 August 1; 31(8): 896-902. Doi:10.1016/j.chilgyouth.2009.04.003.
- » Valentine, D., Stewart Acuff, D., Freeman, M., Andreas, T. (1984). Defining Child Maltreatment: A Multidisciplinary Overview. *Child Welfare League of America*, Vol. LXIII: 6, Nov-Dec 1984.
- » Douglas, E., Cunningham, J. (2008). Recommendations from Child Fatality Review Teams: Results of a US Nationwide Exploratory Study Concerning Maltreatment Fatalities and Social Service Delivery. *Child Abuse Review* Vol. 17: 331-351 (2008). Wiley InterScience. John Wiley & Sons, Ltd.
- » Brink, F., Thackeray, J., Bridge, J., Letson, M., Scribano, P. (2015). Child advocacy center multidisciplinary team decision and its association to child protective services outcomes. *Child Abuse & Neglect* 46(2015) 174-181. Elsevier Ltd.



2 Meeting the Mental Health Needs of Physical Abuse Victims

Child Physical Abuse Dynamics for Mental Health Providers

Physical discipline of children is common—approximately 70-80% of parents report using spanking. However, sometimes physical discipline causes injury to the child. Although states vary in their definitions, about 20% of children experience physical abuse (defined as when a caregiver causes an injury to a child). Physical abuse can include instances when the caregiver did not intend to physically injure the child—sometimes it is a spanking that “crosses the line.” More infrequently, though it does happen, the injury was intentionally inflicted on the child. As experts in responding to child victims of abuse, CACs are in a unique position to help these children have a coordinated response, and access to evidence-based interventions when needed. However, when CACs and their connected mental health professionals do choose to serve these children and families, there are important dynamics of physical abuse that make serving these families distinct from other forms of abuse.

One unique dynamic of physical abuse is that, frequently, the child remains living with the physically abusive caregiver. Even when the child is placed initially with a relative or in foster care, they are much more likely to return to live with the physically abusive caregiver than after sexual abuse, for example.

Legal issues are another complicating dynamic sometimes limiting caregiver participation in treatment. When a child is injured as a result of the caregiver’s behavior, a criminal investigation may ensue. Sometimes this happens even while the family is living together. In these instances, the caregiver may obtain a lawyer who may advise against open participation in treatment. Although this barrier can be addressed and caregivers can successfully participate in treatment, it is important for CAC professionals to be mindful of this possibility.

While some forms of abuse are routinely founded by authorities without physical evidence (i.e., sexual abuse), legal findings of physical abuse are more often related to an injury to the child. However, physical discipline does not have to result in an injury or a legal finding/substantiation of physical abuse for a CAC intervention to be helpful. Some behaviors, such as threats with lethal weapons or throwing objects at a child that miss the child, may not result in an injury despite being clearly high-risk. While jurisdictions may differ on whether the definition of physical child abuse includes these acts, the CAC is in an excellent position to help reduce the risk of future physical abuse of the child. Professionals who conduct screenings at the CAC should use assessment measures to screen for high risk behaviors. And whether physical discipline causes an injury or not, when high-risk parenting behaviors are present, evidence-based interventions exist that can be extremely helpful in preventing physical abuse from happening.

Overcoming Barriers to Service

Interventions with physically abusive children and their caregivers have excellent evidence and can be incredibly powerful in putting the family on a path to healing and safety. However, there are unique barriers that often require attention. One such barrier is that physical discipline is routinely accepted, and sometimes even encouraged, by society. Given that most parents use physical discipline at some point, CAC professionals and colleagues may have been physically disciplined as children, or use physical discipline with their own children. Using physical force in parenting exists on a continuum, and though physical discipline has been shown to not be the most effective parenting strategy long-term, it is not always inherently abusive. Professionals and other family members are more likely to accept the parent's behavior than they would with sexually abusive behaviors. When parents are getting mixed messages on the appropriateness of their behaviors, it can make it more difficult to change.

Conversely, some professionals have strong beliefs that physical discipline is never appropriate. Particularly when a child is injured, both the child and caregiver may be blamed by other family members and the system. Child victims of physical abuse are at higher risk for behavioral problems, which can be difficult to manage, prompting frustration from other family members and, at times, professionals. It is essential that providers working with caregivers who have been physically abusive to take a non-judgmental stance toward both the child and caregiver.

Lastly, when working with physically abused children and their caregivers, there is often a high risk for re-abuse. Children and offending caregivers in CPA cases often remain together or have ongoing contact, even in the absence of the caregiver engaging in an empirically-supported treatment. This ongoing contact creates an elevated risk for re-abuse that is not as frequently present in other forms of abuse (particularly sexual abuse). In fact, research suggests that after founded physical abuse, approximately 1/3 of families will be re-referred to social services. CAC and mental health professionals need to be mindful of this and trained in methods for assessing and addressing ongoing safety risks.

Working with Physically Abusive Caregivers

When physical abuse occurs, caregivers are often required (or mandated) to attend certain services by authorities. As CACs are charged with linking child victims and their caregivers with evidence-based interventions, they are poised to be excellent coordinators and/or providers of services. However, when a parent is mandated to attend, they often present differently from caregivers who are seeking services voluntarily.

As noted above, caregivers also often times feel blamed (and may actually be blamed) by the system. As a result of these and other factors, caregivers with histories of engaging in aggression toward their children may present with anger. They may also feel very ashamed of their involvement in the system, but more typically show their anger, rather than the shame (especially early in services).

Caregivers often (although not always) are avoidant or reluctant to talk about the referral CPA incident. There may be many reasons for this. For example, the caregiver may be avoiding distress and/or shame they feel for hurting their child, they may have been advised by an attorney not to discuss the incident, or they may believe that their behaviors “was not that bad” (sometimes because their parenting often times is less violent than how their own caregivers parented them). Sometimes they may overtly deny the abuse occurred. Reluctance to engage in services is to be expected with these families, many times for the aforementioned reasons.

In order to optimize engagement, it is critical that professionals working with physically abusive caregivers maintain a collaborative, nonjudgmental stance. There are routinely multiple factors that might have contributed to the caregiver’s use of force, and professionals working with them must be committed to understanding these complexities even with caregivers who may be difficult to engage at first.

Responding to Safety Concerns

Because of the ongoing risk and dynamics around physical abuse, there may be times when the provider or other CAC staff become concerned about their own safety, or the safety of the child. As a result, work must be done in advance to prepare the agency and professional for addressing these concerns.

- » Staff training. All staff (including front line staff) should be trained to understand the dynamics of physical abuse and assess for safety risks (including, the severity of the referral incident, co-occurring interpersonal violence and ongoing contact among the child and caregiver), and how caregivers may present in the building. When very severe physical abuse occurs (e.g., intentional attempted murder), the CAC is in a position to coordinate the case with child welfare authorities and make a plan for ongoing safety parameters while intervention continues. Clinical staff should obtain advanced training in assessing the impact of the physical abuse on the child, safety risks, and methods for intervening with families of various risks.
- » Policies around caregivers in the building. NCA supports the use of evidence-based therapies for physically abusive caregivers and children at CACs. In line with NCA Accreditation Standards, it is essential that CACs who will have physically abusive caregivers in their facilities develop policies that ensure the child's physical and emotional safety while in the building. It might be helpful to distinguish keeping the offending caregiver out of the building at the time of the forensic interview, as the facts and decisions around visitation and reunification are in process. Once reunification is the plan, the CAC can be a great place to help the child and caregiver re-establish safe communication.
- » Training in de-escalation. Both clinicians and other CAC professionals who may interact with physically abusive caregivers (this may include the whole Multidisciplinary Team) should be trained in de-escalation techniques in the event a caregiver is visibly angry or agitated at the CAC. Some evidence-based treatment trainings (e.g., AF-CBT) include these techniques in their trainings. Some tips include (Berliner & Brown, 2015):
 - o Recognize your own physical response and use calming strategies for you to stay calm.
 - o Listen, let the parent speak their mind.
 - o Lower your voice and body. Getting in a struggle for control can escalate the situation. When you speak more softly, the caregiver will move closer to mirroring you.

Strategies for Engaging Caregivers in Treatment

The above dynamics and presentations can make it challenging for mental health providers to engage physically abusive caregivers in services. However, there are evidence-based engagement strategies (e.g., McKay et al. 1998; Motivational Interviewing), which are part of evidence-based therapies for these families (Kolko et al., 2011), that have been very successful in engaging these caregivers. We recommend that clinicians who work therapeutically with physically aggressive caregivers pursue clinical training in these evidence-based techniques for these families.

- » Take a neutral, non-judgmental stance.
- » Allow the caregiver to share their perspective on the referral incident (without agreeing, but it is helpful to give them a chance to voice their perspective).
- » Roll with the resistance
- » Use reflective listening
- » Validate their reservations and worries.
- » Conduct a decisional balance exercise listing the pros and cons of therapy participation.
- » Elicit change talk.

Evidence-Based Interventions for Child Physical Abuse

Physical abuse, and excessive corporal punishment, include physically aggressive behaviors by caregivers toward children that may be considered traumatic to the child. Children may exhibit behavioral symptoms (such as conduct problems, tantrums, defiance) or posttraumatic stress symptoms. Their characteristics are often similar to children who have experienced other potentially traumatic events. When children are with a non-offending caregiver and reunification with the offending caregiver is not expected, Trauma Focused Cognitive Behavioral Therapy (Cohen et al., 2006) may be a good fit. Two additional treatments, described below, have been studied in randomized trials and found to be effective in reducing child symptoms and caregiver physical force among children and their offending caregiver. Each of these treatments involves both the child and the caregiver.

2 Meeting the Mental Health Needs of Physical Abuse Victims

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT)

AF-CBT was developed for caregivers and children age 6 through adolescence with a history of caregiver physical abuse or coercive parenting practices (Kolko & Swenson, 2002; Kolko et al., 2011). Research has shown it to be superior to routine community care for reducing children's conduct and oppositional behaviors, as well as internalizing symptoms, (Kolko, 1996). Further, parents who received AF-CBT demonstrated significantly greater decreases in use of physical discipline/force and anger at post-treatment as compared to routine community care (Kolko, 1996).

Parent-Child Interaction Therapy (PCIT)

PCIT was developed for families of children ages 2-7 years with disruptive behavior disorders and has over 50 randomized controlled trials support its efficacy in reducing children's behavioral problems (Eyberg et al.). Further, PCIT has been used with children and caregivers with a history of physical abuse and shown to be effective in reducing caregiver's use of physical discipline and reducing the risk for re-abuse (Chaffin & Friedrich, 2004; Chaffin et al., 2011). PCIT been shown to be effective with children in foster care (Timmer, Urquiza & Zebell, 2006) and with children who have been exposed to domestic violence (Timmer et al., 2010).

NCTSN's portal on physical abuse definition and services provides a resource for treatment options for physically abused children and their caregivers. nationalchildrensalliance.org/CPAGuide3





3

Medical Evaluation for Child Physical Abuse Cases

An Introduction to Medical Evaluation Factors for Child Physical Abuse

The medical evaluation for physical abuse is influenced by many factors¹:

- » Age/developmental level of the child
- » History from the child as well as history from witnesses/household contacts
- » Presence of patterned injuries
- » Presence of injuries without plausible explanation/changing history over time
- » Delay in seeking care
- » Victimization of siblings/other children in the home (physical abuse and witnessing violence)

The recognition and reporting of physical abuse as a form of child maltreatment is hindered by the lack of a uniform definition across disciplines and organizations. Definitions include:

Child Welfare Information Gateway: “Non-accidental injury to a child which can include striking, kicking, burning, or biting the child and any action that results in physical impairment to a child.”

Centers for Disease Control: “Overt actions by a parent or other caregiver that cause harm, potential harm or threat of harm.”

While an investigation of child sexual abuse typically originates from a disclosure or behavior change in the child, the event that prompts an investigation of physical abuse is typically identification of an injury (or a witnessed event that may have caused injury). Since the majority of serious physical abuse occurs in young, pre-verbal children who cannot provide a history for

1.) MDT members should reference their state-specific criminal and child welfare statutes for what constitutes physical abuse/serious physical harm to a child and parameters for mandated reporting. Many state statutes use terms such as “risk of harm,” “reasonable discipline,” “life threatening,” and “permanent disability” for the purpose of defining criminal charges and determining disposition of child protection investigations. Communication within the MDT is paramount since these terms lack clear, universal definitions and may have different meaning from the perspective of different disciplines. More at: <https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>

the injury, the medical evaluation for physical abuse is a key component to the assessment. A medical provider must make a determination of whether the injury is suspicious for abuse, could have plausibly been caused by an accident or is caused by an underlying medical condition in the child. However, the assessment/investigation should always include input from scene investigators, interviews of collaborative sources and assessment of other children in the care of the potential offending caregiver(s) to include medical evaluation and forensic interview if developmentally able to participate.

The Responsibilities of Medical Providers

Due to the broad differential diagnosis involved in the assessment of injuries potentially suspicious for physical abuse, the medical provider should have advanced practitioner training in the overall assessment of the multi-system health and development of infants and children and be able to make a medical diagnosis within their scope of practice. Practitioner-level training for pediatric care is provided in training programs for physicians (pediatricians, family medicine and pediatric emergency medicine), advanced practice nurses/nurse practitioners, and physician assistants. It is not part of the training for bachelor- or associate-level registered nurses (RNs) or licensed practical nurses (LPNs). Making a medical diagnosis is not within the scope of practice of a RN or LPN.

Child maltreatment/physical abuse is a public health problem with life-long consequences. Adverse childhood experiences like child maltreatment (ACEs) have an increasingly negative impact on adolescent/adult health outcomes as they accumulate in a child's life. Whether a report of suspected physical abuse is substantiated by child welfare or prosecuted in the criminal system, the multi-disciplinary response of the CAC should still focus on providing trauma-informed, evidence-based intervention and support to the patient and family that is culturally relevant².

2.) More at: <https://www.cdc.gov/violenceprevention/acestudy/index.html>

Notes for the CAC Director/MDT:

- » A provider who is qualified to perform medical evaluations for sexual abuse in accordance with the NCA medical standard may not be qualified to perform medical evaluations for physical abuse. For example, Sexual Assault Nurse Examiners (RN-SANEs) would lack training in the practitioner-level assessment of infants and children.
- » RN-SANEs may be asked by colleagues in law enforcement and child protection to assist in the photo-documentation of a child's injuries in the CAC setting. While this specific task would be within the scope of the RN-SANE's discipline, caution should be exercised that this collaborative assistance does not lead to the RN-SANE being asked to provide an opinion on whether the finding represents a diagnosis of physical abuse or not.
- » Resources for the medical evaluation of physical abuse often include access to laboratory and radiology studies that may or may not be available in a CAC (even if the CAC is equipped to provide medical evaluations for sexual abuse onsite). These resources (especially radiology) may not even be available in the home community of the CAC. The director would need to work collaboratively with an appropriate medical provider to assess medical resources in the community and linkages for referral if needed.
- » Provider reimbursement from the state's attorney general office is limited in many states to the evaluations of child sexual abuse.
- » Medical providers entering into linkage agreements with CACs to perform evaluations for physical abuse in their current clinic or hospital setting may have difficulty meeting obligations for time spent in MDT, case review and court prep/testimony without some source of support for professional time spent away from their expected clinical duties.
- » Payment for ancillary services (lab and radiology) typically requires health insurance coverage (and in some areas may even require referral for services by a patient's assigned primary care provider.)
- » Provision of services can be significantly impacted if the alleged offender is also the legal guardian of the child and child/siblings remain in the care of the alleged offender. Victim advocates and child welfare partners will need to work collaboratively to assess potential victimization experience of the caregiver and encourage accountability for the caregiver with follow-up referrals as well as ongoing safety assessment. (See Victim Advocacy information in Section 4 for further information.)

Recognizing the Signs of Child Physical Abuse

As is true for any form of child maltreatment, there are situations associated with an increased risk for physical abuse, but every injury in children (especially in young children) should be assessed for history or findings on exam that would raise a suspicion for maltreatment.

High Risk Situations

- » Children (0-2 years) as they depend heavily on their caregivers for basic needs which can create stress in the caregiver (especially in children with colic/fussiness)
- » Children at any age with disabilities (cognitive, behavioral, physical)
- » Intimate partner violence in the home
- » Substance abuse by one or more of the caregivers in the home
- » Unrelated male caregiver in the home
- » Prior history of physical abuse of the patient or other children in the home

“Red Flag” Indicators of the Need for a Medical Evaluation

- » Any injury in a non-mobile infant
- » “Sentinel” injuries (poorly explained minor appearing injuries in non-mobile infants) are often dismissed as insignificant but have been found to be predictors of subsequent abuse/severe injury
- » Any injury in a child that is inconsistent with history provided or unaccounted for play/activity typical for developmental level of the child
- » Patterned injuries to skin
- » TEN-4 bruising: bruising in torso, ear or neck region in children up to 4 years of age OR any bruise in an infant 4 months old or younger
- » Injuries of differing ages
- » Disclosure/witnessed event of injury/potential injury
- » Siblings of victim child or other children in the same household where abuse occurred

Medical Examination Notes on Injuries for MDTs

- » Coloration of bruising is not a reliable indicator of “age” of the bruise. Bruises that occurred at the same time can have different coloration on different parts of the child’s body.
- » Head injuries/skull fractures/intracranial bleeding are difficult to precisely date by the appearance on radiology studies. The history of the progression of the child’s symptoms is sometimes helpful in assessing timeframe of injury.
- » Callus or new-bone formation around areas of bone fracture can provide estimated “windows” of time injury may have occurred, but are not precise and vary by individual factors.

The Medical Response to Child Physical Abuse

Depending on local resources, response for the medical evaluation of suspected physical abuse may occur on-site at the CAC, off-site in the community or at a tertiary care center in a different community. Depending on the severity of the injury(s) and local resources, the physical abuse medical provider may or may not evaluate the child directly and may function more in a case review role for the MDT. Children evaluated at a tertiary care center may have multiple specialists involved in their evaluation (neurosurgery, radiology, ophthalmology, orthopedics.)

If the tertiary care center has a child abuse pediatrician¹ on staff, input could be sought from this specialist who would likely have insight into the overall evaluation of the child’s injuries.

Medical providers without specific training in child abuse are often unfamiliar with the MDT/ collaborative case review process. CAC directors may consider facilitating cross-disciplinary training

1.) A Child Abuse Pediatrician has completed training as a general pediatrician as well as advanced training in all areas of child maltreatment and has passed a national board examination by the American Board of Pediatrics. Other physicians, advanced practice nurses and physician assistants may have sought additional training from a variety of sources and work as a child abuse specialist. However, child abuse pediatrics is the only specialty training track that currently offers specialty board certification.

3 Medical Evaluation for Child Physical Abuse Cases

between MDT and medical providers in the response area to facilitate understanding of roles and importance of collaborative information sharing. Medical providers may be reluctant to share protected health information due to concerns about violation of federal patient privacy statutes (HIPAA). If this is a barrier between medical providers and MDT, consideration should be given to facilitating a meeting between the MDT's prosecution representative and the medical provider/health care facility legal staff to discuss established HIPAA exclusions for information sharing in cases of suspected child abuse.

If the medical provider in the local community is serving in a case review role, collaborative assistance from MDT members will be needed if the MDT requests the medical provider to review records and provide input on the case.

- » CAC director may need to consider support for “non-billable” professional time of the medical provider.
- » Medical provider/CAC staff may be able to provide linkages for MDT members to discuss case information directly with a medical provider in another community (dedicated case review or tele-video connection during a MDT meeting).
- » If the child is transferred to a tertiary care center, the CAC/MDT should consider designating a “point person” to request information and records so multiple team members are not duplicating requests for information.

Even if the victim-patient is transferred out of the community for medical care, there may be siblings or other child household contacts of the injured child that would benefit from forensic interview, medical evaluation, referral for trauma-informed mental health services and victim advocacy.

Guidelines for Medical Evaluations of Child Physical Abuse

All children with an injury suspicious for physical abuse should have the following assessed by an appropriate medical provider.

Complete history

- » History of Event (what happened, timeline, progression, when brought for care.)
- » Past Medical History (prior injuries, medical problems, medications, surgeries.)
- » Developmental History-developmental abilities at specific chronological ages vary from child to child. Inability to “roll” or “crawl” does not mean patient cannot create body movement to cause a fall.
- » Family Medical History (illnesses that run in the family with emphasis on childhood illnesses.)
- » Social History (who provides care for the patient, other children in the home, presence of substance abuse/domestic violence/mental health issues, prior child welfare involvement.)

Examination

- » Unclothed head-to-toe
- » growth parameter assessment
- » Photographs from an investigator may be helpful for review if the provider is not assessing the child at the same time that the investigation was initiated

Photo-documentation of skin injuries

- » Start macro (wide view of affected area) then focus in on injury(s)
- » Include color and measure standard in field of view

Some cases warrant ancillary testing (laboratory and radiology). Examples include:

3 Medical Evaluation for Child Physical Abuse Cases

Non-mobile infant

- » High risk for “occult” injury (ie. Internal injury can be difficult to identify on general examination due to lack of overlying bruising, deformity or localization of pain).
- » Many of the fractures with high specificity for abuse in infants are caused by mechanisms such as squeezing, shaking or jerking and therefore do not have overlying bruises that would be more common with a blunt force blow(s).
- » Child with injury inconsistent with history provided for occurrence, unaccounted for by play/activity typical for developmental level of the child, patterned injuries to the skin, TEN-4 bruising, multiple injuries, and witnessed/recorded/disclosed event that may have caused injury.
- » Sibling/other children in the household where abuse has occurred. (Twins are at higher risk for inflicted fractures compared to non-twin sibling contacts).

Skeletal Survey

- » All children 0-2 years (regardless of results of the physical examination)
- » Children 2-5 years: at discretion of provider
- » >5 years: Focused xrays of affected areas or guided by history

Neuro/head imaging (non-contrast head CT or brain MRI)

- » ALL children 0-2 years with TEN-4 bruising or rib/skull fracture(s)
- » Any child with altered mental status/ abnormal neurologic exam/seizures
- » Infants under 6 months of age with a witnessed shaking event

Liver Function Tests = LFT's (AST, ALT)

- » All children 0-2 years with abdominal bruising, distension, discomfort OR any injury suspicious for abuse
- » Any age child with abdominal bruising, distension, discomfort

Notes for CAC Director/MDT:

Medical provider will need to obtain detailed medical history. Process/practice of sharing information between MDT members involved in the investigation should be developed to avoid duplication of interviews with patient/other children and to ensure all members have access to complete information for their assessment. History from the scene including photos, measurements, should be provided by investigator and discussed at a team meeting. History from other caregivers or witnesses who are not present for the medical evaluation should also be shared with the team.

“Follow-up” Skeletal Surveys (FUSS) often have additional yield in identifying injuries that were not detectable by plain film in acute phase but visible on FUSS (2-4 weeks from original) due to formation of callous and new-bone.

Head ultrasound is not sensitive for exclusion of findings that could occur with abusive head trauma.

Resources for Medical Evaluation and Providers

- » Anderst JD, Carpenter SL, Abshire TC, AAP Section on Hematology/Oncology and Committee on Child Abuse and Neglect. Evaluation of bleeding disorders in suspected child abuse. *Pediatrics* 2013;131:e1314-1322.
- » Christian CW, AAP Committee on Child Abuse and Neglect. The evaluation of suspected child physical abuse. *Pediatrics* 2015;135:e1337-1354.
- » Flaherty EG, AAP Committee on Child Abuse and Neglect, Section on Radiology, Section on Endocrinology, Section on Orthopedics, and Society for Pediatric Radiology. Evaluating children with fractures for child physical abuse. *Pediatrics* 2014;133:e477-489.
- » Glick JM, Lorand MA, Billka KR. Physical abuse of children. *Pediatrics in Review* 2016;37:146-158.
- » Kemp AM, Dunstan F, Nuttall D, et al. Patterns of bruising in preschool children-a longitudinal study. *Arch Dis Child* 2015;100:426-431.

3 Medical Evaluation for Child Physical Abuse Cases

- » Lindberg DM, Shapiro RA, Laskey AL, et al. Prevalence of abusive injuries in siblings and household contacts of physically abused children. *Pediatrics* 2012;130:193-201.
- » Pierce MC, Kaczor K, Aldridge S, et al. Bruising characteristics discriminating physical child abuse from accidental trauma. *Pediatrics* 2010;125:67-74.
- » Sheets LK, Leach ME, Koszewski IJ, et al. Sentinel injuries in infants evaluated for child physical abuse. *Pediatrics* 2013;131:701-707.
- » Wood JN, Fakeye O, Mondestin V, et al. Development of hospital-based guidelines for skeletal survey in young children with bruises. *Pediatrics* 2015;135:e312-320.

Training Resources

Medical for Medical:

- » Midwest Regional Medical Academy (topical webinars, training courses, peer review)
<http://www.mrcac.org/learning/>
- » UpToDate
-Physical Abuse Recognition
<http://www.uptodate.com/contents/physical-child-abuse-recognition>
- » -Abusive Head Trauma
<https://www.uptodate.com/contents/child-abuse-evaluation-and-diagnosis-of-abusive-head-trauma-in-infants-and-children>
- » -Retinal Hemorrhages after Abusive Head Trauma
<http://www.uptodate.com/contents/child-abuse-anatomy-and-pathogenesis-of-retinal-hemorrhages-after-abusive-head-trauma>
- » Society for Pediatric Radiology-Child Abuse Imaging:
<http://www.pedrad.org/Specialties/Child-Abuse-Imaging>

3 Medical Evaluation for Child Physical Abuse Cases

- » CHAMP program of SUNY Upstate Medical Program: Fractures and Child Abuse webinar:
<https://www.champprogram.com/courses.asp>
- » Stop-Look-Listen
case-based physical abuse on-line course for medical providers (registration fee):
<http://stoplooklistentraining.com>
- » The Quarterly Update (reviews recent peer-reviewed articles in the medical literature on the diagnosis, prevention and treatment of child abuse and neglect)
<https://quarterlyupdate.org/index.php>

Medical for non-medical/Multi-disciplinary Team:

- » Child Protector App (medical and non-medical portals):
<http://www.childrensmemory.org/childprotector>
- » US Department of Justice: Recognizing when a child's injury or illness is from abuse
<https://www.ojjdp.gov/pubs/243908.pdf>
- » US Department of Justice portable guide to imaging in child abuse:
<https://www.ncjrs.gov/pdffiles1/ojjdp/161235.pdf>
- » Midwest Regional Medical Academy (topical webinars for MDT audience)
<http://www.mrcac.org/learning/>
- » Southern Regional CAC (topical webinars for MDT audience)
<http://www.nationalcac.org/online-training-catalog>

3 Medical Evaluation for Child Physical Abuse Cases

Multi-disciplinary conferences:

- » Southern Regional CAC Medical-Legal Training Academy (in-person, 3.5 days covering sexual and physical abuse evaluations)...typically held every November
<http://www.nationalcac.org/core-trainings>
- » National Children's Advocacy Center Symposium on Child Abuse (3 day multi-disciplinary conference with medical track of presentations)...typically held every March
<http://www.nationalcac.org/symposium-about>
- » San Diego Conference on Child Maltreatment (1-day pre-conference workshop on assessment of physical abuse and 4-day conference with various medical presentations...multi-disciplinary conference)...typically held every January
<http://sandiegoconference.org>

STATE/REGIONAL GUIDELINES

(for reference only...states/regions will have varying responses depending on resources and system-specific statutes)

- » Maryland
https://phpa.health.maryland.gov/mch/Pages/MDChamp_Referral_Guidelines.aspx#PHYSICAL_ABUSE
- » Texas
https://txpeds.org/sites/txpeds.org/files/documents/tps_version_of_inpatient_clinical_practice_guideline_for_child_abuse.pdf
- » West Virginia
<http://wvcan.org/what-we-do/wv-champ>

Professional Society connection and support:

- » Pediatricians: American Academy of Pediatrics, Section on Child abuse and Neglect
<https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Membership-Criteria/Pages/Child-Abuse-and-Neglect.aspx>
- » Multi-disciplinary: American Professional Society on the Abuse of Children
<https://www.apsac.org>

These resources are compiled as a selection of resources currently offered and do not represent an endorsement of specific course or product, nor a complete list of possible resources or training opportunities.



4

Advocacy for Physical Abuse Victims

Role of the Victim Advocate in Child Physical Abuse Cases

Victim advocates have a critical role to play in supporting and providing direct services to the children and families who are their clients in cases of suspected child abuse. It is fairly typical for victim advocates to interact more consistently with the adult caregivers than with child clients throughout the life of the case. They will have more of a direct role with children during the investigation—specifically while at the CAC for a forensic interview – and for court preparation should the case be prosecuted. In addition, direct and more consistent involvement may be more frequent with teens than with younger children. However, in physical abuse cases, if the nature of the physical abuse reported is severe and the child is hospitalized, the victim advocate may only have interactions with the adult caregiver. It is well documented that effectively engaging and supporting a caregiver directly correlates with reducing trauma and improving outcomes for children and other family members.

Developing a comprehensive response to physical abuse cases affords CACs a critical opportunity to reinforce the victim advocate’s primary responsibilities on all cases. While there may be some services/interventions that may be shared with other members of the MDT, Advocates are typically responsible for a constellation of services including, but not limited to the following: initial contact, crisis assessment and intervention, educating clients about victim rights and ensuring rights are afforded, coordinating with law enforcement and CPS to assess safety and assist with safety planning, making referrals and ensuring access to relevant services, providing ongoing support and supportive counseling, communicating relevant information to and from the MDT, and helping victims and witnesses navigate the court system. At the outset of many cases of suspected physical abuse, all caregivers may be potential suspects. This can pose unique challenges for victim advocates. CACs need to carefully and collaboratively address Advocates’ critical roles with non-offending caregivers and those that are subjects of an ongoing CPS and/or criminal investigation in ways that preserve the integrity of the investigation while providing core services and legal rights.

Protocols for Working with Caregivers

In many cases of suspected physical abuse, it is not immediately clear whether the caregiver is an alleged perpetrator. Law enforcement and medical aspects of the investigation are key to determining when injuries may have occurred and who had access to the child at that time. Eliciting

and documenting caregiver history and statements in the earliest stages of the investigation and response are viewed as essential steps in identifying a primary suspect.

Until it is clear whether a caregiver is responsible for inflicting abusive injuries to a child, defining whether the caregiver is a client of the victim advocate remains a question. Therefore, MDTs must discuss the specific nature and timing of interactions between the victim advocate and the client. Furthermore, victim advocates must actively participate in the team's development of investigation and case management protocols to safeguard the integrity of the investigation, ensure they are not serving in an investigative role, and address points of overlap or potential conflict with other MDT members.

Key Issues for Written Protocols

The following are several key issues for MDT discussion, agreement and inclusion in written protocols:

- » The primary role of CPS with initial crisis and safety assessments and monitoring of safety and family progress;
- » Definition of the scope of victim advocate role relative to crisis intervention, medical evaluation, referrals, ongoing support, court advocacy and follow-up;
- » Clarification of the victim advocate's role if the caregiver is the alleged perpetrator or if the non-offending caregiver poses an ongoing risk to the child (e.g., allowing access to the alleged perpetrator, communicating blame to the child, etc.);
- » The importance of non-offending caregivers having solid, trusting relationships with victim advocates who understand the complexities of such cases that will ultimately help guide them toward positive outcomes overall;
- » Recognition of the "fine line" at times between the roles of victim advocates and CPS by promoting the sharing of information and concerns regarding safety assessments and safety planning, crisis assessments and intervention, support and referrals during investigations and beyond.

4 Advocacy for Physical Abuse Victims

- » Preventing victim advocates from being placed, even inadvertently, in the role of investigative agent of the MDT;
- » Addressing relevant legal requirements for victim advocates specific to their state including, but not limited to, confidentiality and mandated reporting, such that advocates will be clear about what information can or must be shared with the MDT and that which is protected by statutory privilege;
- » Need to provide verbal and written information to clients regarding confidentiality and its limitations to ensure informed decision-making and open and honest communication;
- » Recognition of cultural issues that inform families' perceptions or beliefs about abuse and that may present potential barriers between the family and the MDT; strengthening Advocates' abilities to effectively serve families and educate the team about ways in which caregivers may feel misunderstood; and
- » Inclusion of victim advocates at all times when refining or revising relevant protocols for their role and the MDT.

Recommended Resources

- » Mandated Reporting Statutes (state-specific): <https://www.childwelfare.gov/pubPDFs/mandapdf#page=5&view=Summaries%20of%20State%20laws>
- » Privileged Communications for victim advocates (state-specific): https://www.americanbar.org/content/dam/aba/administrative/domestic_violence1/Resources/statutorysummarycharts/2014%20Advocate%20Confidentiality%20Chart.authcheckdam.pdf

Serving Non-Offending Caregivers & the Co-Occurrence with Domestic Violence

The co-occurrence of child physical abuse and the non-offending parent's own experience with domestic violence by the offending parent is well-documented. This co-occurrence is common with both physical and sexual child abuse; indeed, 30-60% of children residing in homes with domestic violence are also victims of child abuse. Additionally, domestic violence is the number one predictor of child fatalities, the most extreme form of child physical abuse. Lastly, parents victimized by domestic violence are at greater risk for perpetrating child physical abuse. Victim advocates, indeed, all MDT members need to have a deep understanding of the dynamics of domestic violence and its incidence, the impact of current domestic violence perpetration and trauma histories on adult caregivers and how it may contribute to being perceived as unable to protect their children. Victim advocates, in coordination with CPS, need to be keenly skilled in discerning crisis, risk, and safety needs of the caregivers and in discussing, developing, and monitoring comprehensive safety plans for children and caregivers. Victim advocates also serve in a key role for educating the MDT, reducing the potential for victim-blaming of caregivers who are victims themselves, and contributing to system change.

Issues to Consider

The MDT should address poly-victimization overall, including during the intake process and the forensic interview. As part of this holistic focus, for example, the forensic interviewer should inquire about child abuse and maltreatment (including physical abuse) when domestic violence is present and vice versa. [See Section 1 on MDTs] This will allow the victim advocate and CPS to better coordinate their efforts and assess and respond to the needs of all family members who may be directly experiencing and/or exposed to violence and abuse. This will also aid law enforcement in more thoroughly investigating the co-occurrence of criminal offenses. All of these issues are central to the victim advocate's role and guide their intervention and role as liaison for the family. When a child or parent is involved with a domestic violence shelter or provider, this provider should be an integral part of the MDT and work in collaboration with the victim advocate. Teams may also consider including the expertise of batterer intervention specialists to inform investigations and service delivery.

The victim advocate plays an essential role in linking non-offending caregivers in violent relationships to appropriate services. Important considerations include empowering victims of

domestic violence and providing safe alternatives while holding the batterer accountable. Every CAC should screen for domestic violence in the home and the victim advocate should communicate with the MDT when they learn of the existence of domestic violence. Communication and MDT collaboration are essential to addressing the co-occurrence of domestic violence in physical abuse cases with the goal of positive outcomes for each family member and the family as a whole.

Victim Advocate Needs: Training, Outreach, & Coordination

In order to confidently and effectively address the comprehensive needs of children and caregivers in physical abuse cases, victim advocates need to have specialized training, independently and in concert with the entire MDT, regarding the broad and complex subject of child physical abuse and poly-victimization. This includes understanding of the patterns of various forms of physical abuse, legal definitions and the limits of physical punishment, the co-occurrence of physical abuse with neglect, psychological abuse, sexual abuse and domestic violence and related risk factors, and the various ways in which children and families are impacted. These are foundational to advocate service delivery. In addition, advocates should be well-informed about the response process in their community, including the roles of MDT members, and other related systems of care.

Training Needs for Victim Advocates

Victim advocates require extensive knowledge of the broad and complex subject of child physical abuse and the relevant services that are critical to meeting the needs of their clients. Such training should include:

- » Various forms of physical abuse; and domestic violence and relevant risk factors;
- » Legal definitions;
- » Social norms associated with corporal punishment as prevalent risk factor for physical abuse;
- » Effects on children and caregivers;
- » Co-occurrence of physical abuse with neglect, psychological abuse, sexual abuse
- » Communication with caregivers regarding effective means of parenting and discipline;
- » Cultural issues, beliefs and barriers; and
- » Investigation and response processes in their community, including MDT member roles.

Outreach and Coordination Needs of Victim Advocates

To ensure that clients receive swift, coordinated and relevant referrals and services, a significant part of the advocate's role is to conduct outreach and education and develop both formal and informal linkages with critical resources. In addition to the typical agencies and providers with which advocates work and to whom they make referrals, cases of physical abuse involve additional medical and social services professionals. The advocate needs to conduct outreach and education and coordinate referral systems and linkages with:

- » children's hospital, healthcare, and rehabilitation facilities;
- » resources for children with disabilities;
- » early intervention;
- » other community-based programs that address childhood trauma and domestic violence, and that assist children in recovering from injuries and adapting to the effects of those injuries.

The Victim Advocate Role in Child Physical Abuse Prevention

Prevention initiatives can address the number-one risk factor of child physical abuse—social norms surrounding the use of corporal punishment. These initiatives help shift community norms surrounding spanking and other forms of corporal punishment. Pediatricians and other CAC staff and MDT members serve as opinion leaders and can set a precedent in local communities. Prevention programs raise awareness about the harmful effects and ineffectiveness of corporal punishment. Corporal punishment, no matter the intent, strains parent-child relationships, leads to more “acting out” in school, and leaves children vulnerable to depression. Corporal punishment also erodes the developmental growth in children and influences intelligence and learning abilities. Prevention programs promote the use of effective positive parenting techniques built on respect and understanding between the parent and child. As victim advocates do not have an investigative role and are skilled at building trusting relationships with caregivers and coordinating with other resources and providers in the community, they can be key players in contributing to these critical efforts.

4 Advocacy for Physical Abuse Victims

Issues to Consider

- » Prevention initiatives present potential compatible opportunities for CACs and victim advocates but are not mandated components of CAC services. Resource challenges need to be considered as funding does not often support prevention activities.
- » If prevention initiatives are determined by the CAC's leadership, Board and/or MDT to be a priority, identifying and implementing initiatives that are feasible and effective are critical. One such way is for CACs to partner with neighboring CACs, opinion leaders, and other relevant organizations to collaborate on prevention initiatives for the surrounding community. Selection of prevention initiatives should be based on available evidence of effectiveness.
- » CACs should be aware that community and cultural norms surrounding corporal punishment take time to change. Physical discipline was widely accepted in the past and is a sensitive topic that must be explored in a non-judgmental manner. Families may be hesitant to adjust their parenting methods or may be experiencing denial and disbelief consistent with their state of crisis.
- » Revise victim advocate job descriptions to incorporate their roles and participation in prevention initiatives and related issues to address in their work with caregivers. Consider caseload capacity in determining the amount of time that staff can lend to such initiatives; for CACs with several advocates, consider ways in which the responsibilities can be shared.
- » Enable victim advocates to participate in necessary training and professional development opportunities, and to coordinate with community partners to determine their and the CAC's role in prevention initiatives.
- » Identify and/or develop valuable print and online resources for families regarding the use of physical discipline and ways for exploring it with caregivers.
- » These additional responsibilities need to be consistent with the trauma-informed approach advocates utilize that reflects their understanding of the co-occurrence of domestic violence, the impact of trauma histories, and the need for ongoing safety planning and access to supportive services.

The CAC Vicarious Trauma Response for Victim Advocates

Victim advocates meet with families in the throes of crisis, and are chronically exposed to abuse and violence that is unspeakable and unfathomable. During their conversations with non-offending caregivers they listen and bear witness to what is often described as “invisible injuries”—the pain and suffering of their clients. In physical abuse cases they are additionally exposed to reports, images and the actual bruises or marks that were the results of an act of violence.

The trauma-informed response to clients by both individual advocates and MDTs must include consideration of vicarious trauma. Advocates are very aware of the importance of understanding and addressing trauma for the families with whom they work; they and MDT members must also focus on individual self-care and organizational responses to address the negative impact. For advocates specifically, CACs need to ensure that they have access to ongoing training, education, peer support, and supervision and to be recognized and valued as a central and integral member of the MDT.

Ensuring Well-Being Among Team Members

It is incumbent upon CACs to ensure the well-being of all staff and MDT members and safeguard against the negative consequences that can arise by providing a physically and psychologically safe work environment. To do so, a CAC should:

- » Make responding to vicarious trauma a priority
- » Raise awareness, train staff and MDT members, and develop policies and practices to address vicarious trauma
- » Encourage and support victim advocates (indeed all staff and team members) to engage in individual self-care practices
- » Conduct a comprehensive assessment, inclusive of input from staff and MDT members, of strengths and gaps of their organizational response
- » Develop an action plan for addressing identified gaps (including, but not limited to, taking time to debrief after difficult interactions with clients, giving time, space and forums to process the exposure to clients’ trauma, allowing for time away to have a good work/life balance, ensuring that advocates have equal access to the resources of the MDT and are able to actively participate in case review)
- » Identify positive consequences of the work and explore concepts and experiences such as vicarious resilience, compassion satisfaction and vicarious transformation.

Resources for Victim Advocacy in Child Physical Abuse Cases

- » National Child Traumatic Stress Network
<http://www.nctsn.org/resources/topics/child-welfare-system>
- » NCTSN Guide for Court-Based Child Advocates <http://www.nctsn.org/search/node/%E2%80%A2%09NCTSN%20Guide%20for%20Court-Based%20Child%20Advocates>
- » National Council of Juvenile and Family Court Judges - Effective Intervention in Domestic Violence and Child Maltreatment - Guidelines for Policy and Practice (1999) – “Greenbook”
- » OJJDP – Children Exposure to Violence, Crime, and Abuse: An Update (September 2015)
<https://www.ojjdp.gov/pubs/248547.pdf>
- » OJJDP – Polyvictimization: Children’s Exposure to Multiple Types of Violence, Crime, and Abuse (2011) <https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf>
- » Report of the Attorney General’s National Task Force on Children Exposed to Violence (December 2012) <https://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>
- » US Dept of Justice, Office on Violence Against Women - Reflections from the Field on Victim/Survivor Advocacy Report (2017) <https://www.justice.gov/ovw/page/file/936746/download>
- » Field Guide to Family Advocacy (2017)
https://childadvocacymys.org/themes/childadvocacy/assets/images/flipbook_reduced.pdf
- » US Dept of Health & Human Services – Child Protection in Families Experiencing Domestic Violence (2003) <https://www.childwelfare.gov/pubpdfs/domesticviolence.pdf>
- » The New Orleans CAC has developed a program called Painless Parenting, which comes in two forms and can train CAC staff and the larger community. First, Painless Parenting allows victim advocates, among others, to practice difficult conversations utilizing forensic interview equipment. Conversations are recorded and observed for purposes of providing feedback. The program also includes trainings where participants role-play conversations with their peers.
<https://www.loveandlogic.com/painless-parenting-for-the-preschool-years-ii>

4 Advocacy for Physical Abuse Victims

- » Play Nicely, created by Vanderbilt University, is a free online 40-minute multimedia program that teaches how to manage aggression in young children. Play Nicely is designed for anyone who cares for young children aged one to seven. The program has versions for parents, teachers, and health care professionals. Play Nicely can serve as a training tool for Advocates and also as an additional resource to give to parents.
<http://www.childrenshospital.vanderbilt.org/services.php?mid=1998>
- » Afifi, T. O., et al. Spanking and adult mental health impairment: The case for the designation of spanking as an adverse childhood experience. *Child Abuse & Neglect* (2017),
<http://dx.doi.org/10.1016/j.chiabu.2017.01.014>
- » Prevention programs developed by CACs raise awareness of child physical abuse, highlight the importance of prevention and stop abuse before it happens.
- » The No Hit Zones, created by Lolita McDavid, MD, promote healthy relationships and safe environments across the lifespan through awareness, education and skill-building. No Hit Zones are implemented in hospitals and institutions across the county. In these spaces, no adult shall hit another adult, no adult shall hit a child, no child shall hit an adult and no child shall hit another child. <http://www.thisisanohitzone.org/thisisanohitzone>
- » CACs can utilize signage and pamphlets around their offices to remind families of the harms associated with spanking and provide alternative methods.
- » CACs can participate in Child Abuse Prevention Month, an annual observance in April dedicated to raising awareness and preventing child abuse. The federal Office on Child Abuse and Neglect within the Children's Bureau provides information and releases national statistics about child abuse and neglect each April.
- » Fortson, B.L., Klevens, J., Merrick, M.T., Gilbert, L. K., & Alexander, S.P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available at
<https://www.cdc.gov/violenceprevention/childmaltreatment/prevention.html>

4 Advocacy for Physical Abuse Victims

- » CALiO - <https://calio.org/resources/vicarious-trauma-resources/vicarious-trauma-research>
- and - <https://calio.org/resources/vicarious-trauma-resources>
- » Vicarious Trauma Toolkit - <https://vtt.ovc.ojp.gov>
- » NCTSN - Child Welfare Work and Secondary Traumatic Stress <http://www.nctsn.org/>
- » NCTSN/NCA CAC Directors' Guide to Mental Health Services for Children
http://nctsn.org/nctsn_assets/pdfs/CAC_Directors_Guide_Final.pdf
- » NCAC Vicarious Trauma Plan Guide
<https://www.nrcac.org/resources/vicarious-trauma-resources/>
- » Vicarious Trauma Organizational Readiness Guide - Victim Services
https://vtt.ovc.ojp.gov/ojpasset/Documents/OS_VT-ORG_Victim_Services-508.pdf



NATIONAL
CHILDREN'S
ALLIANCE®

OJJDP

National Children's Alliance
516 C Street, NE
Washington, DC 20002 US

nationalchildrensalliance.org

This project was supported by Grant # 2015-CI-FX-K002 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Department of Justice.