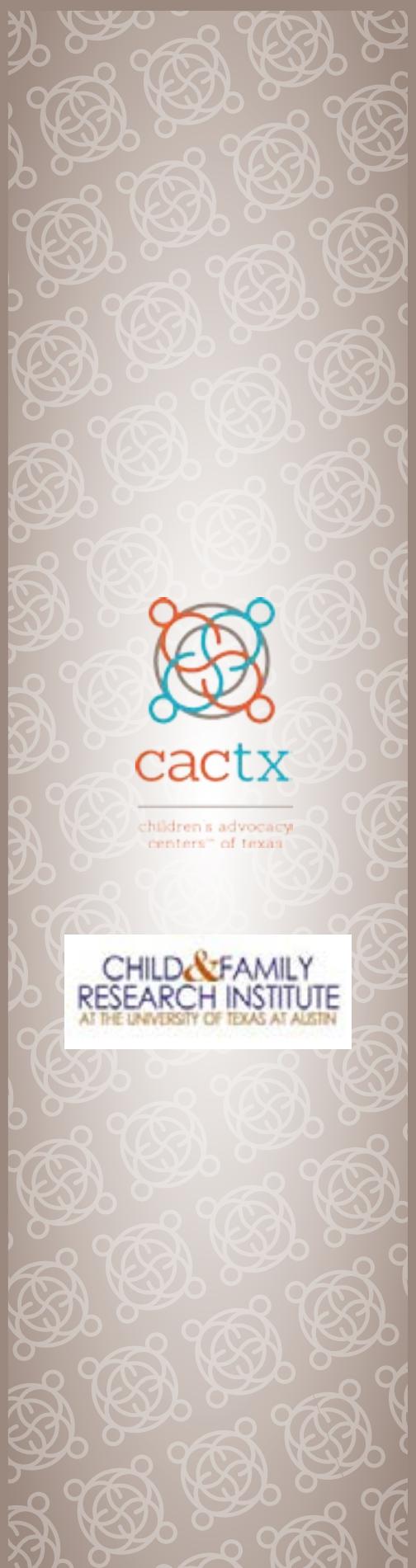


Child Abuse Medical Evaluations in Texas: *Current Practices & Challenges*

Funded By:



This research study was conducted by the Child and Family Research Institute on behalf of the Children's Advocacy Centers™ of Texas. The research team would like to thank those MDT members who shared their time, stories and opinions with us. We appreciate your insight and the valuable work you do on behalf of Texas' children.

RESEARCH STAFF

PRINCIPAL INVESTIGATORS

Monica Faulkner, PhD, LMSW
Stephanie L. Rivaux, PhD, LMSW

PROJECT COORDINATORS

Laura Marra, MSSW

RESEARCHERS

Rebecca Gomez, PhD, LCSW
Beth Gerlach, PhD, LCSW

RESEARCHER ASSISTANTS

Irene Acosta
Elizabeth Aviles (Team Lead)
Alejandra Cerna Rios
Sharon Coughlin
Linh Thy Doan
Michelle Gerbozy
Crystal Nguyen
Brenda Solorzano
Lorena Urbina

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EXECUTIVE SUMMARY

When an allegation of child abuse is reported, it is important that children receive medical evaluations for both medical and forensic purposes (National Children's Alliance, 2012; Texas Children's Justice Act Task Force, 2012). A 2011 report by the Midwest Regional Children's Advocacy Center stated that nationally, 34% of children referred to a non-profit children's advocacy center (CAC) receive a medical evaluation. However, Children's Advocacy Centers™ of Texas (CACTX) has found that, in Texas, only 21% of children with alleged abuse receive medical evaluations, with even lower rates in smaller communities and rural areas. As a result, CACTX identified a need to research existing policies about and barriers to children receiving medical evaluations so that recommendations and strategies can be developed to increase the rates of evaluations in Texas. CACTX contracted with the Child and Family Research Institute (CFRI) at The University of Texas at Austin School of Social Work to conduct this research.

CFRI researchers conducted a mixed methods study in two parts. The first part of the study consisted of 60 focus group interviews of multidisciplinary team (MDT) members in twelve CAC service areas. The service areas were chosen using two criteria: (1) community size (e.g. small/rural, mid-sized, and large/urban centers); and (2) rates of medical evaluations in the service area (either higher or lower than service areas of similar sizes). Researchers used the focus group interviews to explore existing practices for medical evaluations in alleged child abuse cases, barriers to evaluations, and possible strategies to increase evaluation rates. In the second part of this study, researchers used the initial focus group findings to develop and distribute an online survey statewide to all MDT members. Over 300 MDT members completed the survey. The research was conducted between October 2012 and June 2013.

Results suggest that multiple barriers prevent child abuse victims from receiving proper medical evaluations. The findings document the processes of obtaining medical evaluations for children, factors that impact whether or not a medical evaluation is conducted, and the functioning of MDTs. Complex issues related to children obtaining evaluations include a lack of medical professionals with child maltreatment specializations; complicated reimbursement structures; factors related to a child's outcry, the child and the child's family; and community factors such as the proximity to specialized services. Finally, MDT functioning, collaboration and understanding between team members impacts the processes of referrals for medical evaluations.

Based on these findings, primary recommendations for improving rates of medical evaluations include: 1) changing the funding structure to help streamline the billing process; 2) highlighting and reinforcing hospital support; 3) developing statewide guidelines for medical evaluations; 4) including policies and procedures for improving rates of physical abuse and neglect evaluations;

5) expanding access to MEDCARES; 6) providing cross-training to improve understanding of medical evaluations among MDT members; and 7) engaging in broader discussions about forensic medical services, particularly in rural areas.

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BACKGROUND

The following section reviews current literature and research on topics pertinent to this study, which examined the rates of medical evaluations for suspected child abuse victims. Included are discussions on child maltreatment prevalence and consequences, descriptions of children's advocacy centers (CACs) and the multidisciplinary teams (MDTs) they coordinate, and the exploration of several key issues related to medical evaluations in child abuse cases. More specifically, medical evaluation rate, medical models and best practices for child abuse evaluation, medical evaluation importance, barriers limiting access to medical evaluations, and statewide efforts to coordinate medical evaluation programs are discussed. This review concludes with an overview of the need for additional research on this topic.

CHILD MALTREATMENT PREVALENCE AND CONSEQUENCES

Impact of child abuse. Child abuse can have a wide-ranging impact in both the short- and long-term for a child's physical health, mental/emotional health, and behavior (Administration for Children and Families, ACF, 2012; ChildHelp, 2012; Irish, Kobayashi, & Delahanty, 2009; van Roode, Dickson, Herbison, & Paul, 2009). For example, when compared to non-abused counterparts, child sexual abuse victims are at increased risk for multiple problems later in life, including revictimization, criminal justice involvement, substance abuse and mental health difficulties, social and sexual problems, and physical health problems (Golding, Wilsnack, & Cooper, 2002; Haven, 2001; Howard & Wang, 2005; Irish et al., 2009; van Roode et al., 2009; White & Smith, 2001; Widom, 1995; Widom & Kuhns, 1996; Widom, Marmorstein, & White, 2006).

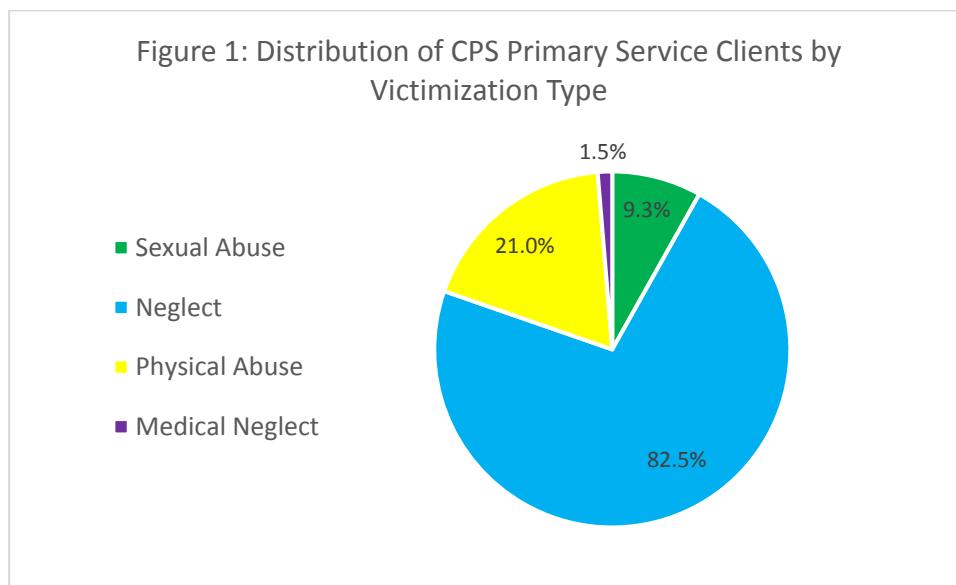
Child abuse also has a significant impact on society as a whole through direct costs to victims and families (e.g., medical or psychological care), as well as direct and indirect costs to systems and organizations (e.g., child welfare, law enforcement, judicial, juvenile and adult criminal justice health, and mental health systems) (ACF, 2012). Some researchers have estimated that, in the United States, the annual cost associated with child abuse and neglect is approximately \$103.8 billion (Wang & Holton, 2007).

Prevalence of child abuse. Child abuse can include physical abuse, sexual abuse, emotional abuse, and/or neglect. Legal definitions of child abuse in Texas are detailed in Section 261.001 of the Texas Family Code and Chapter 481 of the Texas Health and Safety Code. Although it is likely most child abuse incidents are not reported to authorities, significant numbers of alleged child abuse cases are reported each year. The National Child Abuse and Neglect Data System (NCANDS) reported that Child Protective Services (CPS) agencies across the nation received reports of approximately 3.3 million cases of child abuse (U.S. Department of Health and Human Services, U.S. DHHS, 2010). Of these, there were nearly 700,000 substantiated incidents of abuse and more than 1,500 known fatalities due to child abuse (U.S. DHHS, 2010).

Data regarding child maltreatment is generally cited from state child protection agencies and national level sources that summarize data across states. In Texas, there are two main sources

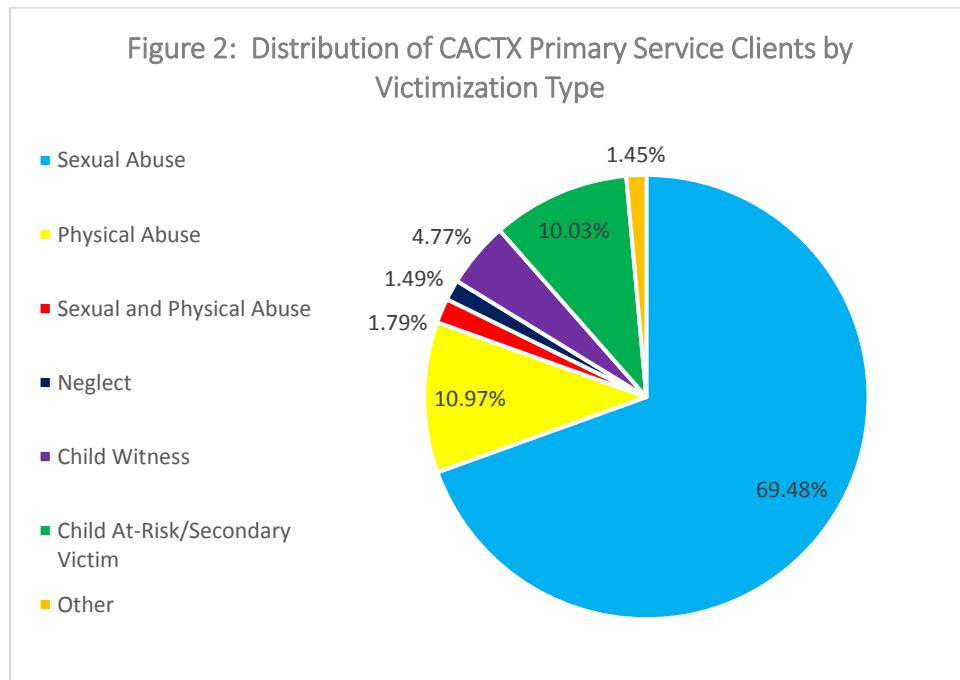
for annual child maltreatment data: Child Protective Services (CPS) and Children's Advocacy Centers™ of Texas, Inc. (CACTX). In examining this data, it is important to recognize that these organizations function differently and have different mandates for the populations they serve. Administered by the Texas Department of Family and Protective Services, CPS releases statewide data annually; however, much of CPS data relies on information from cases served directly by CPS. CACTX is the statewide membership organization for the 68 children's advocacy centers (CACs) in Texas. Each CAC coordinates a local multidisciplinary team (MDT) to respond to child abuse allegations from the time of the report. CACTX data shows a different distribution of cases than those served by CPS because of the CACs' central role in coordinating the criminal investigation and prosecution of child abuse cases. While CPS serves children whose primary caregivers have either perpetrated abuse or failed to protect them from abuse, CACs serve children whose perpetrators may or may not be family members. Thus, not all CAC children are involved in CPS cases and vice versa. In discussing the prevalence of abuse in Texas, this section utilizes national data and state data from CPS and CACTX.

CPS data shows that in Texas during 2011, out of a total child population of 6,663,942, there were 297,971 alleged victims of child abuse, 98,435 children whose alleged abuse was confirmed by CPS investigation, and 17,108 children removed from their homes to keep them safe (Texas Department of Family and Protective Services, TX DFPS, 2011). In 2010, Texas also had a total of 222 child fatalities due to child abuse, a rate of 3.22 deaths per 100,000 children (Texas Department of State Health Services, TX DSHS, 2010).



As shown in Figure 1 above, most of the confirmed CPS cases of abuse in Texas were neglect cases (82.5%), followed by 21% that were physical abuse cases, 9.3% that were sexual abuse cases, and 1.5% that were medical neglect cases (TX DSHS, 2010). However, children referred to CACs tend to be mostly victims of alleged sexual and/or physical abuse, which more often

involves criminal offenses that are better prosecuted through a multidisciplinary approach. Figure 2 below summarizes CACTX's most recent statistics (2012) about abuse type for CACTX clients. Specifically, CACTX statistics show that for primary clients referred, the majority were referred for alleged sexual abuse only (69.48%), with another 10.97% referred for physical abuse only, and 1.79% referred for both sexual and physical abuse (CACTX, 2012).



Demographics of child abuse victims. In Texas, most child victims of any form of maltreatment are between one and three years old (34%), a rate of 20.6 per 1,000 children in the population of the same age (TX DSHS, 2010). In 2011, approximately 60% of children in CPS cases of confirmed child maltreatment in Texas were six years old or under (TX DFPS, 2011). The high rates of abuse among young children reflects the fact that the majority of CPS cases are related to neglect, rather than the more overt forms of abuse (physical and sexual) experienced by children served at CACs. In addition, clients of Texas CACs have a different age distribution than those associated with CPS cases. Nearly half of the children served by CACs in FY 2012 were between the ages of six and 12 years (48.2%), approximately one-quarter were ages five or younger (26.3%), another quarter were between the ages of 13 and 17 years (25.1%), and the remaining 0.4% were 18 years or older.

Though Texas CPS reports a nearly even gender split of child maltreatment victims (TX DFPS, 2011), CACs tend to serve more females than males. Sixty-seven percent of CAC clients were female and only 33% were male (CACTX, 2012). The gender difference is likely due to a higher prevalence of reported sexual abuse of girls compared to boys and the fact that CACs serve a higher proportion of sexual abuse victims.

In addition, the racial demographics of the clients served by CPS and CACs also differ. Of the children reported to TX DFPS for suspected child maltreatment, 31.4% were White, 16.5% were African American, and 46.1% identified ethnically as Hispanic (TX DSHS, 2010). Texas CAC data more closely matched U. S. Census estimates. Of those children served by CACs, 40.1% were Hispanic, 39% were Caucasian, 14.3% were African American, 5.3% were multi-racial and 1.3% were Asian, Native American, other or an unknown ethnicity (CACTX, 2012).

MEDICAL EVALUATIONS IN CHILD ABUSE CASES

One function of CACs and their respective MDTs is to determine the need for and facilitate medical evaluations for alleged victims of child abuse. Medical evaluations are often considered a best practice in cases of child physical abuse and neglect, and especially in cases of child sexual abuse. In fact, the National Children's Alliance (NCA) (2011) formally recommends as best practice that all children who are suspected victims of any form of child abuse be assessed to determine the need for a medical evaluation, and that all children involved in sexual assault cases receive medical evaluations. It also recommends that medical evaluations should be required based on specific screening criteria developed by skilled medical providers or by local multidisciplinary teams that include qualified medical representation (National Children's Alliance, NCA, 2011). To facilitate peer review, continuous quality improvement and consultation, NCA guidelines promote photographic documentation of evaluation findings as the standard of care. Photo-documentation may also obviate the need for a repeat evaluation of the child. This section addresses the importance of medical evaluations, rates of medical evaluations in alleged child abuse cases, resources for medical evaluation and challenges to obtaining medical evaluations.

Importance of medical evaluations. Medical evaluations are a critical piece of both the therapeutic and criminal justice responses to alleged child abuse. A medical evaluation assesses the child's emotional and physical health, while also providing crucial forensic findings to support prosecution of the alleged offender. Specifically, the purpose of these evaluations is "to identify injuries that require treatment, to screen for or to diagnose sexually transmitted infections, to evaluate and if possible to reduce the risk of pregnancy, and to document findings of potential forensic value" (Atabaki & Paradise, 1999, p. 178).

Medical importance. Obtaining medical evaluations in alleged child abuse cases serves an important medical role by ensuring the overall health and safety of the child. During an evaluation, a trained physician or medical professional has the ability to check, treat, and document injuries that are not readily apparent (Pence & Wilson, 1992), while also providing answers and reassurance about the child's health, bodily integrity and other concerns (Adams et al., 2007). Additionally, the medical professional has the ability to "assist in the assessment of the match between the injuries noted and the explanation offered" (Pence & Wilson, 1992, pg. 19).

Although further research is needed to verify the impact of professionals with specialized training conducting child abuse medical evaluations (Jones, Cross, Walsh, & Simone, 2005), the research to date suggests that professionals trained in conducting child abuse evaluations provide valuable medical services for children and their families. For example, Crandall and Herlitzer (2003) found that when a Sexual Abuse Nurse Examiner (SANE) participated in the services a victim received at a hospital, the victims received more comprehensive care that included treatment for sexually transmitted diseases (STDs), pregnancy testing and referrals to victim services. Similarly, research shows that for sexual abuse cases in pediatric emergency departments, SANEs increased prophylaxis treatment and the number of mental health referrals, and provided more documentation of the physical evaluation (Bechtel, Ryan, & Gallagher, 2008; Patterson, Campbell, & Townsend, 2006). A study by Erickson, et al. (2002) found that SANEs were a therapeutic part of the medical evaluation, with victims feeling respected, safe, and reassured. Other studies suggest that SANEs may be effective in reducing posttraumatic stress symptoms (Little, 2001; Patterson et al., 2006). Increased feelings of comfort during a medical evaluation may increase the likelihood of sexual abuse victims disclosing additional information to a SANE. Finally, Sievers, Murphy, and Miller (2003) found that evaluations done by SANEs were completed with higher fidelity to protocols and more accuracy than those done by physicians and nurses not certified in child sexual abuse evaluations.

Forensic importance. Aside from the medical importance, evaluations serve a crucial forensic purpose as well. Research suggests that medical evaluations aid in the substantiation and prosecution of child abuse cases. Evidence from the medical evaluation may assist in determining the strength of the case and the severity of the offense (Besharov, 1987), and may also assist in CPS investigations of alleged child abuse (Anderst, Kellogg, & Jung, 2009). For example, Palusci, Cox, Cyrus, Heartwell, Vandervort, and Pott (1999) conducted a retrospective review of child sexual abuse cases to examine predictors of legal outcomes. The authors found that when a medical evaluation had positive physical findings the case was 2.5 times more likely to result in a prosecution with a guilty verdict.

One reason medical evaluations may assist in the prosecution and conviction of cases is the nature of children's interactions with medical professionals. Children often disclose information to medical professionals because they see doctors and nurses as safe and trusted allies, and such disclosures can often provide vital information for prosecution of child abuse cases (NCA, 2011). The Federal Rules of Evidence Rule 803 stipulates that "statements made for medical diagnosis or treatment are not excluded by the rule against hearsay" (2012). Since the medical history is taken as a part of the medical evaluation, it may be protected under this exception and children's disclosures to medical professionals may be able to be introduced at trial. Because medical evaluation findings can often be inconclusive, the history collected from the child by the medical provider is often the most important part of the overall evaluation (Adams et al, 2007; Heger, Ticson, Velasquez, & Bernier, 2002).

Without evaluations by practitioners who are trained in both forensics and empathetic forensic interviewing of children, convictions may be harder to obtain in sexual assault cases (National Network to End Domestic Violence, 2010). Though existing research on this topic is primarily

focused on adult victims, the research is generalizable to child abuse convictions. For example, Crandall and Herlitzer (2003) found that in cases in which victims were seen by SANEs and later pressed charges against their assailants, there were, on average, higher conviction rates and longer sentences compared to cases in which the victims were not seen by SANEs. In Wasarhaley, Simcic, and Golding et al.'s 2012 study of jury perceptions of medical professional testimony, the researchers found a higher rate of guilty verdicts when a SANE testified than when an RN testified. Mock jurors in the study attributed higher credibility to the SANE, and the jurors reported more positive perceptions of the victim when a SANE testified (Wasarhaley, Simcic, & Golding, 2012). Though it is not known whether medical evaluations in general impact conviction rates, these findings suggest that at least with adult victims, it is possible that a medical evaluation by a SANE may increase convictions. However, it is important to note that research regarding SANE programs with child victims is lacking and child cases are managed differently than adult cases.

Technological advances, including photo-documentation and telemedicine, increasingly enhance the value of forensic evidence collected during medical evaluations (Kellogg, 2001). Telemedicine is a cost effective, timely method of consultation and peer review, and is particularly useful in remote areas that lack experienced, trained medical providers (Kellogg, 2001). While photo-documentation for peer review and consultation is considered a standard of care (NCA, 2011), most of the literature on the role of these technologies in the field of child abuse evaluations is descriptive. While indicators point to improvements in the quality of the investigations, empirical evidence about the effects on outcomes is limited.

Rates of medical evaluations. In a review of court files, Campbell, Patterson, Dworkin and Diegel (2010) found that only 22 to 44% of child sexual abuse survivors receive medical evaluations. The Midwest Regional Children's Advocacy Center (MRCAC) reports that nationally, 34% of alleged child abuse cases referred to non-profit CACs receive medical evaluations (2011). In comparison, CACTX reports that the rates of medical evaluations for Texas CACs are:

- Small/Rural CACs – 8%
- Mid-sized CACs – 14%
- Large/Urban CACs – 25%

These rates of medical evaluations in Texas are substantially lower than national rates, particularly in mid-sized and rural communities.

Medical resources for child abuse evaluation. Medical evaluations for alleged child abuse cases can occur in a variety of contexts (e.g., CACs, hospitals, emergency rooms, clinics, doctor's offices) and can be performed by a range of medical professionals (e.g., nurses, physicians, or physician assistants). The following is a discussion of the roles of specialized nurses and CAC-MDTs, as well as the resources available through Texas state programs for child abuse medical evaluations.

Specialized nurses. To improve their evaluation of abuse cases, nurses may receive advanced, specialized training as either Sexual Assault Nurse Examiners (SANEs) or Forensic Nurse

Examiners (FNEs). The FNE title is a broader term referring to nurses in a wider range of forensic contexts. In some contexts, FNE does not refer to a certification, but to a job title for a nurse who works in a forensic context. However, various FNE certifications are available, each with somewhat different requirements. According to the International Association of Forensic Nurses (IAFN) (2006), the board certification offered for SANEs, “is different than state credentialing or earning a ‘certificate’ at the end of an educational course. Although board certification is not a requirement to practice in most areas, getting certified signifies that a nurse is committed to professionalism and has the expert knowledge necessary to meet the highest standards of forensic nursing.” To earn SANE certification, registered nurses must take a Sexual Assault Examiner Class comprised of 40 hours of classroom training, followed by an average of 40 hours of clinical training. IAFN has Educational Guidelines that recommend this training as a minimum starting point for SANEs (IAFN, 2006).

Although the SANE certification focuses on sexual abuse evaluations, it also requires substantial knowledge of physical abuse assessment. The SANE certification can be specific to only adults or only children, though in Texas most SANEs receive both certifications. Because puberty defines when a SANE evaluation is considered adult or pediatric, it is important to note that nurses need both certifications to provide SANE evaluations to both pre- and post-pubertal children. Physicians may complete a clinical subspecialty qualification in child abuse pediatrics (CAP), offered by the American Board of Pediatrics (n.d.). However, most medical professionals do not receive specialized training in child abuse evaluation and treatment.

Children’s Advocacy Centers and the multidisciplinary team. CACTX was founded in 1994 with a membership of 13 local centers. In fiscal year 2013, that membership had grown significantly to include 68 developing and established centers located in all types of communities ranging from large urban cities to small rural areas. CACTX describes the CAC’s mission as “(to) provide a safe, child-friendly environment where law enforcement, child protective services, prosecution, and medical and mental health professionals may share information and develop effective, coordinated strategies sensitive to the needs of each unique case and child. It is a core belief of all CACs that the best interests of the child and non-offending family members should be protected as the case proceeds through the investigation and prosecution stages and beyond.”

According to current CAC standards, the local MDTs are required to include CAC staff, law enforcement officers, prosecutors, and CPS investigators. New MDT standards for 2014 will also require inclusion of medical and mental health professionals, as well as victim advocates. Representatives from other organizations and disciplines may also serve on MDTs according to client and community needs. The MDT has two main goals: (1) to reduce trauma to the child by coordinating intervention while also allowing each MDT member to pursue their respective mandates; and (2) to improve forensic processes by gathering evidentiary information and improving investigation efficiency (Ells, 2000; Lindberg, Lindsell, & Shapiro, 2008; Wolfteich & Loggins, 2007).

The MDT model has numerous benefits in responding to alleged child abuse cases. These include: collaborative review of cases of alleged child abuse; less service fragmentation resulting in less

service duplication; and more successful resolution of cases (Lalayants & Epstein, 2005). Research also suggests that the CAC approach leads to improved outcomes for children (Newman & Pendleton, 2005) and improved experiences of caregivers as they accompany their children through sexual abuse investigations (Jones, Cross, Walsh, & Simone, 2007).

State Programs in Texas. To improve the medical response to child abuse, the Texas Legislature mandated the creation of the Medical Child Abuse Resources and Education System (MEDCARES), which, by way of the TX DSHS, provides grants to improve medical evaluations of child abuse. MEDCARES grantees are located in major children's hospitals throughout the state that have been identified as centers of excellence in child abuse and neglect evaluation. These centers combine an array of integrated services that may be needed by a child victim, including specialized equipment needed for evaluations, on-site mental and behavioral health services (e.g., mental health services, domestic violence screening and referral, and substance abuse screening/ treatment referral), forensic photo-documentation, and sometimes even follow-up care. Medical professionals at MEDCARES sites have specialized training in child abuse evaluation and can provide consultation, case review, and other technical assistance to medical professionals around the state. They also provide training to other members of the MDTs such as law enforcement, prosecutors, and CPS caseworkers. Such trainings may cover a range of topics including how to identify and document abuse, reporting requirements, and the importance of medical evaluations (Texas DSHS, 2012).

Another resource to aid the medical evaluation of child abuse cases is the Forensic Assessment Center Network (FACN), which was developed by Texas DFPS and the University of Texas Health Science Center – Houston (UTHSC-Houston). FACN and MEDCARES collaborate closely, and the Child Abuse Resource and Education (CARE) Center at UTHSC-Houston serves as FACN's hub. FACN was established in response to state legislation passed in 2005. According to its website, as of December 2008 FACN physicians had served 4,000 children from 158 counties. The network consists of physicians from six medical schools in Texas who are available to provide consultation and recommendations to CPS workers, nurses and administrators in cases of suspected abuse through a 24-hour toll free number and a web-based system. In addition to written consultations for reviewed cases, the program also provides in-person and remote training for CPS workers. To ensure coverage of underserved areas of the state, Texas's 254 counties were grouped into regions, each designated to one of the six participating medical centers.

Barriers to medical evaluations. Multiple barriers may contribute to low rates of medical evaluations in Texas. Detailed below, such barriers include a lack of trained medical providers, a lack of positive findings, cost and administrative burden, a lack of understanding about the importance of medical evaluations, and in the broader context, a lack of statewide coordination of a medical evaluation program.

Lack of trained medical providers. Many communities in Texas lack sufficient medical care facilities and professionals. For example, the Texas Children's Justice Act Task Force (2012) reports that in 2009, 74% of Texas' 254 counties lacked a sufficient number of primary care doctors and 54% were without a pediatrician. In addition, Texas also has a significant lack of

medical professionals with specialized training in child abuse and sexual abuse evaluations (Busch-Armendariz & Vohra-Gupta, 2011). This is significant because although most medical professionals will encounter child abuse at some point in their careers, specialized training is needed to accurately assess and treat child abuse cases. Without specialized training it can be difficult to differentiate between normal and suspicious findings, and to know how best to assess and intervene with child victims (Kellogg, 2005). A 2009 study by Anderst et al. found that when evaluating the same cases, there were significant discrepancies between physicians with and without specialized training in child abuse pediatrics. Additionally, several studies have found that without specialized training, many doctors are unprepared to identify normal and abnormal genitalia (Dubow, Giardino, Christian, & Johnson, 2005; Lentsch & Johnson, 2000; Makoroff, Brauley, Brander, Myers, & Shapiro, 2002).

A related issue involves a lack of understanding about appropriate procedures for documenting medical evaluations among medical providers who complete them and the law enforcement officers, district attorneys, CPS workers, etc. who review them. The absence of standardized protocols, including standardized terminology for anatomic and clinical findings, assessment and conclusions may hinder the transfer of clear, concise information (Lahoti & Kellogg, 2001), thus minimizing the impact of medical evaluations. Because the medical record is a legal document, appropriate documentation is essential for the best legal outcome for the child. Although research on this topic is limited, two articles generated from a study on physician knowledge of child sexual abuse demonstrate how physicians' lack of understanding of protocols for medical evaluations weakens the strength of the reporting. The first investigation found significant variations in physicians' documentation of relevant historical and physical findings and gaps in clinical knowledge (Socolar, 1996). The second concluded that standardization of protocols in reporting and documentation would improve the accuracy, and thereby the strength of medical evaluations (Socolar, Raines, Chen-Mok, Runyan, Green, & Paterno, 1998). A number of states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence (NCA, 2011); however, similar state protocols for physical abuse and neglect cases appear to be lacking.

A number of studies have examined the importance of training not only for the quality of the evaluation, but also in building physicians' willingness to handle child abuse cases. This research focuses heavily on the physicians' comfort, experience and competence associated with child abuse evaluation. An investigation by Lane and Dubowitz (2009) analyzed survey data for 147 randomly selected American Academy of Pediatrics members to determine how frequently they performed child abuse evaluations and their level of access to consultations with child abuse pediatricians. They were also asked to rate their knowledge, comfort level and competence in managing these cases. Results revealed that respondents had very little experience with child abuse evaluation and reporting, and that they expressed a strong desire for increased expert consultation. While respondents often felt competent in conducting exams for suspected cases of child maltreatment, they expressed less competence in rendering definitive opinions and did not generally feel competent about testifying in court. A similar study by Heilser, Starling, Edwards & Paulson (2009) focused on child abuse training, comfort and knowledge among emergency medicine, family medicine and pediatric residents, finding major gaps in the residency

training in child abuse. A 25-item survey was distributed to 274 residents at two medical schools in Virginia and Texas. Results showed that family medicine residents performed significantly worse on both clinical and overall knowledge, and that knowledge of genital anatomy and comfort with sexual abuse evaluations was poor among all specialties. The authors concluded that improvements in and a more systematic approach to residency training in child abuse were requisite.

Another study that examined reluctance by physicians to engage in child abuse evaluations concluded that interventions that enhance interdisciplinary/interagency communication and training might facilitate higher physician involvement and improved accuracy in case reporting (Socolar & Reives, 2002). This was based on survey findings in which physicians identified time, scheduling and problems interacting with legal, judicial and social services systems as impediments to greater involvement in child abuse cases. Physicians also signaled that more medical information, training and follow-up about the disposition of cases would motivate them to engage more in child abuse medical evaluations.

Nurses may also conduct medical evaluations in child abuse cases. However, similarly to physicians, specialized training (e.g., SANE training) is needed to be able to perform these evaluations accurately. Due to a number of factors (e.g., funding, distance, training needs, etc.), it can be difficult to implement and maintain a SANE program, particularly in smaller communities. The cost and administrative burden of SANE programs is discussed further below.

For remote areas lacking trained clinicians, photo-documentation and telemedicine have created cost effective and time efficient avenues for consultation; however, implementation of telemedicine networks face various challenges associated with training medical staff (Kellogg, 2001). These include the need for ongoing training and technical support; secure, confidential storage and transmission of patient electronic records; ensuring patient consent; medical license reciprocity for interstate consultations; liability issues; and limited reimbursement for consultations.

Cost and Administrative Burden. Another possible barrier to the completion of medical evaluations relates to cost, legal protocol, and complex administrative procedures, especially reimbursement. For example, health care facilities must conduct a sexual assault evaluation if the victim has not reported the assault to law enforcement and arrives at the facility within 96 hours of the assault. If, however, a child sexual abuse victim first reports the assault to law enforcement and it is within the 96-hour timeframe, law enforcement must still request an evaluation for child. Beyond the 96-hour time limit for sexual abuse cases, law enforcement has discretion about whether or not to request an evaluation. Additionally, for child victims of physical abuse, neglect, or failure to thrive, medical evaluations are not legally mandated.

The source most frequently discussed in relation to medical evaluations for child sexual abuse victims is Crime Victims Compensation (CVC), which is administered through the Office of the Attorney General. The Texas Legislature passed the Crime Victims Compensation Act in 1979 creating the CVC program (Abbott, 2011). CVC provides financial assistance to victims of crimes

to cover financial costs incurred due to their victimization. CVC is funded through multiple sources, including court fees paid by persons convicted of crimes, federal grants, restitution paid by offenders, donations and subrogation of civil awards paid to victims.

In Texas, CVC has clear payment policies in place for the costs of medical evaluations for child sexual assault cases. The sexual assault forensic (evidence collection) exam is billed directly to the local law enforcement agency; neither the hospital nor the victim is responsible for this portion of the costs (Office of the Attorney General of Texas, OAG TX, 2010). However, since medical assessment and treatment are not considered evidence collection, victims usually incur costs related to these procedures (OAG TX, 2010). Conversely, if eligible, the victim may be able to receive funds from the CVC program for reimbursement of the medical assessment and treatment related to the abuse if they do not have other resources to cover those expenses (OAG TX, 2010). Victims must also cooperate with law enforcement investigations in order to qualify for CVC. There are no such clear payment policies for child physical abuse or child neglect medical evaluations, though it may be possible for victims to recoup some costs through CVC, which may pay up to a total of \$50,000 for approved benefits (OAG TX, 2009).

In order to receive reimbursement for sexual assault evaluations, law enforcement must first cover the cost of the evaluation as billed by the medical provider. Law enforcement then must complete a Sexual Assault Examination Reimbursement form. Submission of this form to the OAG must include all relevant bills and detailed charges related to the evaluations from the medical providers. CVC reimburses law enforcement for expenses related to sexual assault evaluations that are reasonable and do not exceed \$700 (OAG TX, 2011). In 2011, CVC received almost 4,387 applications for child victims of sexual abuse. The average reimbursement rate for these evaluations was \$474.

Although CVC reimburses for evaluations, there is evidence to suggest that even with reimbursement, the medical providers of these evaluations incur unpaid expenses. In conducting a needs assessment of sexual assault services in Texas, Busch-Armendariz and Vohra-Gupta (2011) found that hospitals often incurred unreimbursed expenses related to running SANE programs and SANEs not employed by hospitals incurred personal costs. For example, training re-certification and on-call time are estimated to cost \$3,000 to \$4,500 annually per SANE. Additionally, Busch-Armendariz and Vohra-Gupta's findings (2011) suggest the real cost of a SANE exam ranges from \$900 to \$1200 in comparison to the \$700 that is reimbursed by CVC (OAG TX, 2011). Thus, the financial security of SANE programs coupled with extensive training and re-certification requirements are a primary concern to the continuation of the SANE programs despite compensation from CVC (Maier, 2012).

Lack of understanding about medical evaluations. Lack of understanding among caregivers, law enforcement and MDT members about medical evaluation procedures can also pose barriers to child abuse victims receiving evaluations. For example, some adults might worry that a medical evaluation would be painful or compound trauma to a child. It is possible that some professionals assume medical evaluations are similar to "well woman" evaluations, which is not generally so. Most child abuse cases are non-acute and do not require internal genital evaluations (CACTX,

2012). Waibel-Duncan (2001) found that the majority of parents or guardians reported a relatively high level of concern about the evaluation and its potential painfulness. Similarly, Scribano, Hornor, Rhoda, Curran, and Stevens (2010) examined anxiety levels among child/parent dyads where the child was receiving a medical evaluation due to alleged sexual abuse. These authors found that anxiety tended to decrease after the evaluation for both child and parent. This research suggests that medical evaluations may actually reduce anxiety for many children and their parents and that initial anxiety on behalf of professionals, parents and children can be alleviated by educating them on the process. A recent investigation (Rheingold, Danielson, Davidson, Self-Brown, & Resnick, 2012) examined the effect of a brief, cost-effective video intervention for child and caregiver distress related to the child sexual abuse medical evaluation. The developmentally appropriate, psychoeducational video designed to instruct children and caregivers about the evaluation procedures and coping strategies to be used during the evaluation was found to be well received by families. It helped to increase caregiver knowledge and decrease stress during the evaluation.

Another misunderstanding may relate to the necessity and value of non-acute evaluations. MDT members may think a medical evaluation is not needed if the abusive incident exceeds the 96-hour acute time period because the possibility of obtaining evidence, which was already minimal, is further reduced. This belief can be a significant barrier to obtaining evaluations, particularly in child sexual abuse cases, since reporting often happens long after the incident occurred. Studies by Kellogg and Huston (1995) and Kellogg and Menard (2003) suggest that most children do not disclose abuse within 96 hours and thus, most cases are non-acute. In their studies, the average time from an abusive incident to disclosure was 2.3 years. However, even in non-acute cases, medical evaluations may be indicated because such assessments assure that the child has been examined for infections and other injuries, and because the evaluation may collect other forensically important information from the child that may be admissible in court (Heger et al., 2002; Adams et al., 2007). Additionally, as discussed above, children and families may find medical evaluations affirming because they are reassured that their bodies are “normal” and healthy despite the abuse they have experienced (Adams, et al., 2007).

Lack of positive findings. Even when medical evaluations are completed, most are inconclusive for child sexual abuse and this lack of evidence may decrease motivation to request an evaluation. For example, Heger et al. (2002) found positive physical findings confirming abuse in only 4% of the 2,384 children referred for evaluation in their study. Further, when there is a delay in conducting the medical evaluation, rates of positive findings may decrease significantly (Johnson, 2009). Low rates of positive findings may be due to factors such as how quickly the body begins to heal and evidence being lost over time. For example, if a victim does not receive a medical evaluation within 96 hours of the assault (the time period required by Texas statute) evidence may disintegrate as the victim may bathe, change clothes, or in some other way unknowingly compromise evidence (Johnson, 2009; Texas Department of Criminal Justice, online; VAWOR, 2010). It is important to note that a lack of physical findings in no way indicates abuse did not occur. For example, Kellogg, Menard, & Santos (2004) found that most pregnant teenagers and most females with sexually-transmitted diseases have a normal exam despite the fact that vaginal penetration had obviously occurred.

Weak statewide systems for medical evaluation in child abuse. Academic research is limited on statewide systems for medical evaluations in child abuse cases; however, the few investigations focused on this topic demonstrate the benefits of having such systems in place, and expose the weaknesses associated with their absence. For example, an investigation of Missouri's Sexual Assault Forensic Examination (SAFE) Network compared outcomes of children evaluated by SAFE Network providers with children seen with other providers (Kivlahan, Kruse & Furnell, 1992). It found that substantiation of child abuse neglect by CPS was higher among children seen by SAFE Network providers even in the absence of physical evidence. Investigators concluded the network had a more reliable standard of care in comparison to non-SAFE network providers, attributing the advantage to mandatory training, standard data form and protocol utilization, uniform reimbursement, and continuing education.

A related case study by Socolar et al. (2001) cites evidence that suggests that states without coordinated statewide medical programs have significantly lower substantiation rates of reported child abuse by CPS compared to similar states with statewide programs. The authors make the case that, although such programs are rare, coordinated statewide programs for the medical diagnosis of child abuse result in better outcomes. While further research is needed on the influence of statewide programs on child abuse outcomes, in light of the other barriers outlined in this report (lack of trained medical providers, lack of positive findings, cost and administrative burden, lack of understanding about medical evaluations), these studies make a compelling case that comprehensive statewide medical programs are uniquely positioned to address these limitations.

STATE INVOLVEMENT IN PROMOTING BEST PRACTICE

As described above, states play an important role in guiding the medical response in child abuse investigations. To be eligible for federal funding, states are required to comply with the requirements of certain federal programs; however, the primary responsibility for child welfare services rests with the states (Child Welfare Information Gateway, 2012). An examination by Kolbo and Strong (1997) of state participation in MDTs provides a valuable framework for assessing state-level involvement, which can be difficult to analyze because no two states' structures and approaches are alike. Kolbo and Strong found that establishing state statutes to accomplish participation in MDTs was common. Statutes were used to mandate statewide participation, or at least to permit or encourage the development of teams and the sharing of information under specific conditions. Alternatives to the state statute approach could include voluntary, community-level recognition and/or departmental regulation or directive. Outside of legislation, states also developed manuals, handbooks or protocols to guide local MDTs in areas such as treatment, case oversight, and investigation, including guidelines for interviewing children and conducting forensic evaluations. Some states offered planning and provision of initial and ongoing training. In the absence of a statewide initiative for training, Kolbo and Strong found that MDTs took it upon themselves to provide training to one another, locally and informally.

Also in their study, Kolbo and Strong (1997) documented a dramatic expansion of state legislation mandating or permitting MDT use between 1987 and 1997. They attributed the growth to two major pieces of federal legislation, the Victims of Crime Act of 1984 and the Children's Assistance Act of 1986, which authorized Children's Justice Grants. These grants established state-level task forces, which helped lead the development of MDTs. Most were carried out on the local level, but in some cases, task force recommendations resulted in mandates to form statewide MDT programs.

Kolbo and Strong (1997) concluded that legislation legitimizes the work and roles of MDT members, shapes team composition, and, to a large extent, determines the activities taken on by MDTs. A 2005 survey conducted by Newman and Pendleton that queried law enforcement and CPS investigators about their use of CACs also found that state directives played a central role. Whether administrative or legislative, state mandates and protocols for multidisciplinary approaches were identified by CPS and law enforcement investigators as the primary reason for using CACs for investigations of suspected child abuse (Newman & Pendleton, 2005). Described below, three state initiatives in Oregon, Missouri and Pennsylvania highlight different ways that statewide programs are currently influencing medical response to child abuse.

The State of Oregon. The Oregon State Legislature allocated funds in 1997 to the Child Abuse Multidisciplinary Intervention (CAMI) Program to establish regional centers and expand community child abuse assessment services throughout the state (Reichert, Keltner, Reilly & Skinner, 2004). This legislation expanded Oregon's child abuse assessment services in an effort to ensure that "every child reasonably suspected of having been physically or sexually abused has access to a skilled, complete, and therapeutic child abuse medical assessment." As a result, efforts were strengthened to develop and support the operation of community-based child abuse intervention centers (CAICs). Since that time, CAICs have been created in most counties in Oregon. In addition, Oregon legislation includes the requirement that the District Attorney in each county is responsible for developing an MDT, which consists of both mandated and non-mandated members. The "Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents" (2005) also was developed in response to the 1997 legislation. Published by the State Office of Services to Children and Families, the 232 page document presents a comprehensive "user-friendly handbook of information, resources and references to guide medical providers in the evaluation of child sexual abuse." First published in 1999, the most recent 2004 edition, maintains the mission statement of the original version, but was revised to reflect advancements in the field. The extensive document includes examples of standard forms for collecting the child's history, scripts for addressing both children and caregivers before and during the medical exam, illustrations and diagrams of anatomy, detailed medical diagnosis information, information on the health care providers' role in court proceedings, and more.

The State of Missouri. Missouri's Sexual Assault Forensic Examination Child Abuse Resource and Education program, (SAFE-CARE) was established in 1989 and is administered by the state's Department of Health and Senior Services (Missouri Department of Health and Senior Services, n.d.). The primary objective of the SAFE-CARE program is to provide comprehensive, state-of-

the-art medical evaluations to alleged child victims in their own communities. SAFE-CARE provides statewide training to physicians and nurse practitioners in the medical evaluation of alleged victims of child sexual abuse, physical abuse, and neglect. To enhance sustainability, these trained physicians and nurse practitioners provide community and professional education regarding child maltreatment on behalf of the SAFE-CARE Network. The program requires training for network providers and, in order to ensure peer review and consultation, each member must have a collaborating physician who is a SAFE-CARE provider. To assure appropriate peer consultation and review in the case of nurse practitioners, the collaborating physician must have at least as much SAFE-CARE training and experience as the nurse practitioners. As illustrated in Missouri's Child Welfare Manual, the SAFE-CARE program also features standardized reporting forms and protocol for medical evaluation and treatment, as well as a standard procedure for reimbursement (Missouri Department of Health and Senior Services, 2013). State agency personnel are "strongly encouraged to use a SAFE-CARE Network provider, whenever possible, for sexual abuse, physical abuse or neglect evaluations;" however, they are not mandated to do so.

The State of Pennsylvania. In the wake of the Jerry Sandusky child sexual abuse case in 2011, Pennsylvania created the State Task Force on Child Protection that has since led a bipartisan proposal to overhaul that state's child protection laws (Office of Senator Kim Ward, 2013). Included is Senate Bill 25, which improves the exchange of information among medical practitioners and county agencies (Pennsylvania General Assembly, 2013). It requires county agencies to provide medical practitioners 1) information regarding the abused child's condition and well-being; 2) protective services records of the child and any other child in the household if it relates to the case; and 3) the identity of other licensed medical practitioners providing medical care to the child so that medical records can be shared. When an assessment, investigation or the provision of services is initiated by a county agency, that agency must notify the child's primary care provider and any other licensed medical practitioner who is providing ongoing care to the child. The information that is required to be exchanged includes 1) the purpose of the investigation or provision of protective services to the child, and 2) a service plan developed for the child and the child's family. Final passage of the bill is pending, and is will be determined by the close of the 2013-2014 session.

Fig. 3// Lessons learned from initiating and sustaining medical programs

FUNDING

State funding is vital for program initiation, but because state funding is at the whim of political change, program sustainability is enhanced by diversifying funding beyond the legislature to include third party payers for service (i.e. insurance, managed care, Medicaid, state/county agencies, the state agency handling VOCA; private donors).

Services must be adequately reimbursed to be sustained. Negotiate standard reimbursement rates for standard services. Ensure adequate reimbursement for court time as expert witnesses.

Harness media coverage of situations when children have not been served well to leverage support for services and funding.

SERVICES

While there is no one-size-fits-all approach to organizing services, it is vital that provision of quality services be standardized statewide, and that they address needs on the local level.

Establish regional medical evaluation offices. Provision of some services is best regionalized, while others are better decentralized.

Standardize forms to help assure quality of services, streamlined administration and uniformity in case documentation. Doing so can enhance interagency communication and strengthen the accuracy and integrity of reports and findings.

Based on the plan above, establish regional diagnostic evaluation offices.

TRAINING

Establish a central training center responsible for training health/mental health providers, law enforcement, attorneys, judges, and/or child protection workers.

Use this central training center to establish quality assurance mechanisms.

Best Practice for Statewide Programs. Little empirical research exists on statewide medical programs for child abuse; however, a case study by Socolar et al. (2001), which compared five case studies of established or fledgling state programs, found that coordinated state programs result in better outcomes. States included in the study were Kansas, Florida, Oklahoma, North Carolina and Louisiana. The study showed that while each state took a unique approach, those that were successful in establishing and maintaining comprehensive programs shared commonalities involving funding, services and training. The authors highlighted lessons learned

for initiating and sustaining effective statewide medical programs, which could be applied in any state (see Figure 3 on the previous page).

NEED FOR ADDITIONAL RESEARCH

Despite the numbers of child abuse victims annually, there are many gaps in research about the importance of and access to medical evaluations in child abuse cases. First and foremost, more empirical research is needed to demonstrate the importance of medical evaluations on outcomes for child abuse victims. Even with the low rates of positive findings with medical evaluations, experts in the field suggest these evaluations can be critical to the child's emotional well-being and to substantiation and prosecution of alleged child abuse.

A second gap in the extant research literature relates to the completion of medical evaluations by medical professionals and how they are related to the outcomes for child abuse victims. Most research in this area is focused on the importance of using SANE nurses to conduct medical evaluations. More information about the effectiveness of specially trained pediatricians or other medical professionals is needed. While a number of studies have surveyed physicians and pediatricians about their level of engagement and competence with child abuse medical evaluations, empirical research on the outcomes of the child abuse cases they handle is lacking.

Additionally, there is little information about medical evaluations for child abuse victims of crimes other than sexual assault. The bulk of the literature focuses on sexual assault evaluations. Therefore, the importance and impact of evaluations for children who have experienced physical abuse and/or neglect is not explored. These forms of abuse do present with more obvious signs of abuse, but the impact of evaluations on the child's emotional well-being and case prosecution may still be relevant.

There is little information available to understand the process by which some children receive evaluations and others do not. Therefore, identifying specific barriers to children receiving medical evaluations requires additional investigation.

Finally, there is limited up-to-date research on the effects of coordinated statewide medical programs for child abuse on outcomes pertaining to the welfare of children and families, the quality of investigations, and the rates of substantiation and prosecution. It is evident that a number of states are moving toward strengthening coordination of statewide programs, with CACs and MDTs playing a central role. Due to the lack of published research on the topic, however, assessment is currently limited to a state-by-state review of legislative statutes and procedures. More research is needed to synthesize these developments and determine which efforts result in positive outcomes (Jones et al., 2005).

METHODOLOGY

The purpose of this study was twofold: (1) to examine current practices across Texas for obtaining medical evaluations in alleged child abuse cases; and (2) to explore strategies to improve access to medical evaluations. More specifically, the study sought to answer the following research questions:

1. What are current practices for obtaining child abuse medical evaluations across Texas?
2. How do these practices vary by community size and other community characteristics?
3. What factors increase or decrease the likelihood a child will receive a medical evaluation in an alleged child abuse case?
4. What can be done to improve practices for obtaining child abuse medical evaluations in Texas?

The research team used a mixed-methods approach to answer these research questions. The qualitative portion of the study consisted of focus groups and/or interviews of CAC multidisciplinary team members from 12 CAC areas in Texas. The quantitative portion consisted of an online survey distributed to all multidisciplinary team members in all Texas CACs.

QUALITATIVE STUDY

Sample. The sample for the qualitative study was a purposive sample of multidisciplinary team members (MDT) from twelve CACs, chosen by CACTX to be representative by community size (small/rural, mid-sized, and large/urban) and rates of medical evaluations (higher or lower rates of medical evaluations). Rates of medical evaluations were based on the rates reported in the CACTX Quarterly Statistical Report (2011).

For each community size, CACTX staff chose the two CACs with the highest medical evaluation rates and the two CACs with the lowest medical evaluation rates for inclusion in the sample, resulting in a sample of twelve CACs. (Note: To reduce the potential for bias or preconceived ideas about each MDT, research team staff members were not informed of each community's medical evaluation rates until after data collection was complete.) One of the selected sites elected not to participate, so CACTX staff selected an alternate community with similar characteristics. Once the sample was chosen, CACTX staff contacted the executive director of each CAC to explain the study and request their participation. The final sample of communities included: Abilene, Bonham, Cleburne, Dallas, Houston, Kerrville, Laredo, Livingston, Paris, San Antonio, San Marcos, and Sweetwater. Research team staff then worked with CAC staff to arrange site visits.

The researchers conducted a total of 60 in-depth focus groups and individual interviews. (Note: For ease of reading, "focus groups" will refer to both the groups and the individual interviews.) To begin the project, the research Principal Investigators (PIs) held two focus groups with representative CAC executive directors from around the state. Then, in each of the 12

communities, the researchers sought to conduct in-depth focus groups with representatives of the five core MDT membership organizations: CACs, law enforcement (LE), prosecutors, CPS, and medical. However, not all groups were held in all locations because in three cases, there was overlap in service providers between sample communities, resulting in shared prosecutors, medical personnel, or CPS units. To avoid redundancy, these shared providers were interviewed only once. Additionally, in one community, not all key CAC staff could attend the focus group, so an additional interview was done. The total number of focus group participants was 205. Groups had 1-15 participants with an average of 3-4 participants. Table 1 below shows the number of participants for each focus group.

Table 1: Number of focus group participants by community type and discipline.

Discipline	Small/Rural	Mid-size	Large/Urban	Total
Children's Advocacy Center staff	17	18	9	63
Law Enforcement	31	10	7	48
Child Protective Services staff	33	15	7	55
Medical Providers	8	8	3	19
Prosecutors	13	6	4	23
Totals	102	57	30	208

Procedures

Interview guide. The research team developed an interview guide based on the review of relevant literature and input from CACTX staff, CAC executive directors, doctors specializing in child abuse evaluation, and other stakeholders. The interview guide was piloted and subsequently revised after completing two focus groups with CAC executive directors (see Appendix A). After the research team completed focus groups in five communities, further revisions were made in order to add more in-depth and discipline-specific questions.

Data collection. Focus groups were conducted between November 2012 and March 2013. Two research team members were present for each focus group, one to lead the group discussion and one to write field notes and provide backup. Whenever possible, one of the project's PIs led the groups, though this was not always feasible due to scheduling and timeframe constraints. Prior to beginning focus group discussions, the research team explained the purpose of the study and obtained informed consent for both study participation and audio-taping. Most focus groups took approximately an hour, though timeframes ranged from about .75 - 1.5 hours.

Transcription and coding. All focus group audio-tapes were transcribed by an external contractor. Dedoose qualitative software was used for coding transcripts, maintaining a focus group descriptors file, and performing reliability and content analyses.

Research team members coded all transcripts for concepts relevant to the project's research questions. A number of strategies were used to ensure team members were coding in a way that was both rigorous and reliable. First, prior to beginning coding, a project PI provided training on qualitative analysis and coding to all research assistants and project staff. Second, a reliability procedure was implemented that included the following steps:

1. The PI initially coded a transcript and then had an expert in qualitative analysis verify and/or critique the coding.
2. Each trained team member then coded part of the same transcript so that discrepancies in coding could be identified and addressed.
3. Once actual coding began, coders initially worked in teams to assure similar understandings of codes and how to apply them.
4. The PI reviewed each coding team's work and provided feedback when necessary. After each team had coded at least one transcript together, coders began to work independently and the PI continued to monitor code application.
5. After the team had coded all transcripts, someone other than the original coder reviewed, verified, and, if necessary, supplemented the coding.

Data analysis. Analysis of the transcripts began with a group "brainstorming" session. This session included nearly all the research team members who had either conducted interviews or participated in coding transcripts. Through this discussion, the team was able to identify overarching, preliminary trends in the data. Next, several members of the team each analyzed the data for a particular MDT group (CAC, LE, prosecutors, CPS, or medical) and compiled this information in a spreadsheet format. Finally, a project PI read through all of the transcripts and, using all of the above resources (transcripts, group discussion results, spreadsheets, etc.), began to conduct the final analysis by checking all provisional findings against original text. As a final check on researcher subjectivity, other research team members conducted detailed reviews of the results to ensure consensus. This analysis process resulted in the findings presented in this paper.

QUANTITATIVE STUDY

Information from the qualitative study was used to inform a quantitative study designed to verify themes found from focus groups and hone in on the most important issues raised in focus groups.

Sample. The sample for the quantitative study included all MDT members in Texas. However, there was no sampling frame for this study because a comprehensive list identifying all MDT members in Texas does not exist. Thus, a convenience sample was obtained by soliciting assistance from each of the 66 CACs throughout the state.

Data collection. As stated above, the researchers developed an online survey based on findings from the qualitative study. This survey had three main parts. The first part gathered data about the respondents and their professional backgrounds. The second part addressed the study's primary research questions and delved deeper into issues and potential solutions suggested in the qualitative study. Questions asked respondents for information about where and by whom medical evaluations were conducted in the community, the barriers to obtaining medical evaluations, and ways the rates of medical evaluations could be improved. The final part of the survey asked for general information related to MDT functioning, since MDT functioning and relationships among MDT members were noted in the qualitative component as issues limiting the use of medical evaluations. The survey was developed with consultation from CACTX and research team members who coded and conducted focus groups.

The survey was administered online via Qualtrics. CACTX sent an introductory email and link to the survey to each of its 66 centers. CAC directors were asked to forward the survey to all their MDT members. Participants were given two weeks to respond to the survey and in an effort increase response rates, were sent multiple reminders from CACTX. In order to encourage participation, CACs were entered into a raffle for each MDT member who completed the survey from their MDT. One CAC was chosen from each of the community size categories (small/rural, mid-sized and large/urban) to receive a \$400 gift card to Target or Walmart.

Data analysis. Quantitative data were descriptively analyzed using SPSS. Tables, charts and graphs were developed utilizing the data.

HUMAN SUBJECTS PROTECTIONS.

Prior to beginning data collection, the researchers received approval of the study protocol by The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects (UT IRB # 2012-11-0003). IRB oversight of the project continued through study completion and reporting. Using forms and processes approved by the IRB, informed consent was obtained from all participants both to participate in the study and to have the focus groups audio-taped. All research team members had current human subjects training certification and the study complied with relevant institutional standards and applicable laws for the protection of human research subjects, including HIPAA and HHS regulation 45 CFR part 46. Participants were promised confidentiality; therefore, all results from the study are presented in aggregate only.

FOCUS GROUP FINDINGS

Findings from the focus groups are presented in three main topic areas: current practices for obtaining child abuse medical evaluations in Texas, factors impacting medical evaluation in Texas, and multi-disciplinary team (MDT) functioning and needs. Each topic area is discussed in detail below.

CURRENT PRACTICES FOR OBTAINING CHILD ABUSE MEDICAL EVALUATIONS IN TEXAS

The general CAC model. Children with alleged or suspected abuse can enter the CAC/MDT service system if a CPS and/or law enforcement case has been opened. Generally, cases referred to the CAC/MDT have the potential to become criminal cases, necessitating law enforcement involvement. Additionally, if a family member or other caretaker is the alleged perpetrator, CPS will also be involved early in the case investigation. When a case is reported to CPS, CPS staff members assign a priority level that determines how quickly CPS must begin investigating the allegation. Though some MDTs in the study reported more disjointed case coordination, most MDTs who participated in the qualitative study reported some method of coordinating case investigation from the outset. Usually this occurs when the organization receiving the initial report contacts the local CAC to facilitate joint investigation of the allegation. This joint investigation may include forensic interviewing, evidence collection, documentation of any injuries, witness interviews, and medical evaluations.

After an allegation enters the CAC system, the CAC coordinates regular case reviews with all MDT members to assure the smoothest case processing possible. Once CPS investigation is complete, CPS staff members either close the case, open the case for services, or remove the child from the home. When law enforcement completes its investigations, the cases are presented to the local prosecutor, who then either charges the suspect or refuses the case. The degree to which other MDT members participate in either CPS or law enforcement investigations varied considerably across communities, with more participation noted in highly-cohesive MDTs.

General medical evaluation procedures. MDT procedures for obtaining medical evaluations had some commonalities across communities, but there were also significant differences noted. Findings about procedures included:

1. When a child needs urgent medical attention, the agency receiving the initial outcry prioritizes medical care prior to contacting others in the MDT.
2. When a medical evaluation is requested for a child who has been sexually abused, most often that evaluation is conducted by either a nurse with specialized training or possibly by a doctor with specialization in child abuse, if the community is close to a Medical Child Abuse Resources and Education System (MEDCARES) site.
3. Law enforcement pays for medical evaluations in sexual abuse cases and is then compensated by CVC. Other MDT organizations can request sexual abuse medical evaluations, but can only receive CVC compensation by way of law enforcement. Physical

abuse and neglect medical evaluations are not routinely compensated by CVC, though families may be eligible to apply for CVC funds in some cases.

4. Many law enforcement officers who participated in the study stated that they referred only acute sexual abuse cases for medical evaluation. Chronic sexual abuse cases were much more likely to be referred to pediatricians for medical services, though some law enforcement saw benefit to referring chronic cases for SANE exams also. (*Note: Acute cases are those in which the alleged abuse occurred within 96 hours of the report. Chronic cases are those that occurred more than 96 hours after the report of alleged abuse.*)
5. Physical abuse and neglect medical evaluations were often handled differently based on community factors such as proximity to a MEDCARES site. Communities closer to MEDCARES sites had readier access to medical professionals with the expertise to conduct evaluations of alleged physical abuse and neglect. Conversely, in communities further from MEDCARES sites, pediatricians (non-acute) or emergency room (ER) physicians (acute) were more likely to complete medical evaluations of physical abuse or neglect. Since pediatricians and ER physicians rarely have specialized training in both forensics and child abuse assessment and treatment, evaluations by these physicians may result in less accurate conclusions about whether child abuse occurred.
6. Finally, in most communities medical evaluation results were shared with MDT members in case review meetings and other forums.

Medical providers conducting evaluations. Medical professionals completing evaluations of alleged child abuse may or may not have specialized training or certification in assessing and treating child abuse. Of those professionals with specialized training and certification, the most common are Sexual Assault Nurse Examiners (SANEs) and Child Abuse Pediatricians (CAPs). SANEs are nurses with specialized training in assessing and treating sexual assault. Registered nurses can earn SANE certifications for adult (CA-SANE or SANE-A) or child (CP-SANE or SANE-P) evaluations, or both (CACP-SANE or SANE-A). SANEs can be certified either by the Texas Office of the Attorney General (TXOAG) or by the International Association of Forensic Nurses (IAFN). CAPs are physicians with a sub-specialty in child abuse assessment and treatment, granted through the American Academy of Pediatrics.

Some study participants also held other specialized certifications such as Certified Forensic Nurse (CFN) or Certified Medical Investigator (CMI), but these certifications were less common. In addition to certifications, some medical professionals in the study used job titles referencing their work with victims of violence. Such titles included Forensic Nurse Examiner (FNE) for nurses and Sexual Assault Forensic Examiner (SAFE) for doctors or physicians assistants. Professionals who use these titles may or may not have specialized training and certification in child abuse evaluation.

Finally, Emergency Room (ER) staff or pediatricians evaluate some allegations of abuse, particularly physical abuse and neglect. Generally, these professionals do not have specialized training child abuse and study participants reported that these professionals were often reluctant to participate in either law enforcement or CPS investigations, or in any court proceedings. This

greatly limited the utility of these evaluations to the MDT. Study participants also frequently noted concerns about these professionals' abilities to accurately assess whether child abuse occurred, a concern that is supported by existing empirical studies (Andrest, Kellogg, & Jung, 2009; Dubow et al., 2005; Kellogg, 2005; Lentsch & Johnson, 2000; Makoroff et al., 2002).

Three factors predicted what type of medical professional will most likely conduct the evaluation: type of abuse, time since the alleged abuse incident, and proximity to a MEDCARES site. In sexual abuse cases, particularly if the incident was recent, SANEs most often conducted medical evaluations in small/rural and mid-sized communities, although access was a problem for certain communities. In large/urban areas, both SANEs and CAPs conducted medical evaluations. Most SANE and CAP evaluations were conducted in a hospital or clinic setting, though some CACs have medical evaluation rooms set up specifically for child sexual assault evaluations. ER physicians and pediatricians generally conducted physical abuse and neglect evaluations unless the community had access to specialized physical abuse and neglect services (e.g., through a MEDCARES site) or the child's injuries were severe enough to warrant transport to a site with specialized services.

Some Texas communities, particularly more rural communities, lack sufficient medical services, including access to medical professionals with specialized training in child abuse. This could pose a significant barrier to obtaining medical evaluations. In these communities, MDT members tended to weigh the need for an evaluation based on potential benefits (forensic, medical, emotional, etc.) and costs (e.g., resources, personnel, transportation, funding, time), and this calculus tended to be based on the type of abuse and its severity.

Payment for medical evaluations. Payment for medical evaluations differed depending on the type of abuse. In acute sexual abuse cases, law enforcement typically paid for the forensic medical evaluation and was later reimbursed through the CVC program. However, sexual abuse cases reported after the 96-hour timeframe were often referred to pediatricians for medical services and were more likely to be billed directly to insurance. Physical abuse and neglect cases are not routinely covered by the CVC and are also more likely to be billed to insurance. In all instances where insurance is billed, families can seek compensation through CVC.

The CVC compensates up to \$700 for sexual assault evaluations, an amount that has held steady since 1999 despite rising healthcare costs. Often the medical provider's bill for the evaluation may exceed the CVC compensation amount significantly. In these cases, either the law enforcement agency requesting the evaluation or the medical provider has to absorb the excess costs. Because of this situation and because there is no standardization of medical evaluation fees across the state, a few study participants suggested that sometimes law enforcement may "SANE shop" to try to get the lowest fees possible. Occasionally this may create other difficulties such as longer wait times for victims when the cheapest services are not the closest.

Another issue in CVC compensation for forensic sexual abuse evaluations is that law enforcement must pay for the evaluation up-front and wait to be compensated at a later time. Most law enforcement study participants did not have direct knowledge of this process, but those who did

noted some concerns. First, some officers stated that it could be burdensome for smaller law enforcement departments to carry the costs of evaluations on their budgets while waiting for compensation. Other officers noted that while payment for the evaluations came out of the department's budget, compensation often was made into a city or county general fund and may or may not be put back into the law enforcement budget.

Forensic Assessment Center Network (FACN). In communities without ready access to a MEDCARES site, the FACN often provides consultation services to CPS workers. The FACN is a group of physicians from six Texas medical schools who have specialized training in child abuse and who provide consultation and recommendations to CPS workers about child abuse assessment and treatment. CPS in some study communities accessed FACN services quite frequently, while CPS units in other communities reported rarely using the service. Those who used the service generally found it very useful. As one respondent stated:

[FACN is] quality. They're well-known, very respected, renowned doctors in the child abuse field.they can tell you. We get reports where it says, 'This is child abuse.' They even will go as far as [saying] we recommend this child be removed from the home or from the family. [The feedback] gets detailed."

FACTORS IMPACTING MEDICAL EVALUATION IN AN ALLEGED CHILD ABUSE CASE

Focus group data showed that a wide range of factors impact both medical evaluation protocols and the likelihood a child will receive a medical evaluation in an alleged child abuse case. These data can be roughly grouped into factors related to the outcry, child, or family; the community; and the dynamics of the MDT and its members. Each of these is discussed in detail below.

Factors related to the outcry, the child, or family. Characteristics of the outcry, the alleged victim, or the family often impacted if and how a child would receive a medical evaluation. The organization receiving the initial outcry and characteristics of the reported incident, including abuse type, severity, time since the incident, and context of abuse all were factors. Each is discussed in more detail below.

Organization receiving the initial outcry. Any MDT member organization might be the first to whom abuse is reported and sometimes this led to differences in how cases were initially processed. For example, when a child with alleged abuse was brought to a hospital, medical services were usually provided first. However, if LE or CPS brought the child to the CAC, the forensic interview might take precedence over the medical evaluation unless there was a pressing medical need.

Abuse type. The type of abuse was strongly predictive of variations in medical evaluation protocols because, as stated above, CVC will compensate law enforcement for evaluations of reported sexual abuse/assault, but not for evaluations of physical abuse or neglect. Therefore, law enforcement seemed to coordinate obtaining medical evaluations for sexual abuse cases in most communities, often with assistance from the CAC or other MDT members. However, with

physical abuse and neglect cases, the organization that received the initial outcry often coordinated obtaining the medical evaluation.

Abuse severity. The severity of the alleged abuse predicted the likelihood that a medical evaluation would be obtained. The cases most likely to be referred for medical evaluation were the more severe physical abuse or neglect cases and those acute sexual abuse cases with an outcry of penetration. Forensic medical evaluations were rarely obtained for physical abuse and neglect cases, as most of these cases were seen in an emergency department or physician's office. A few MDTs referred most sexual abuse cases for medical evaluation, usually because the MDT members in those communities believed that medical evaluations could provide more information for case investigation and/or provide other supports to the victim (i.e., reassurance that their bodies were okay). In one community, the prosecutors reported that they requested medical evaluations in every sexual abuse case because even if there were no physical findings, many victims "cycled" back through the system and the first evaluation provided a "baseline" against which future findings could be compared.

Time since incident. Whether the abuse had occurred recently or in the past (what participants commonly referred to as acute or chronic) was strongly predictive of whether a medical evaluation would be requested. Most law enforcement agencies had a period of time after the incident during which they were more likely to request an evaluation. For sexual abuse cases, these time periods were generally based on Texas statute guidelines, which state that hospitals must provide a medical evaluation for sexual abuse cases reported within 96 hours of the incident. However, many law enforcement officers were not aware of current guidelines and as a result, were using 72, 48, or even 24 hour time periods as their cutoff points for requesting an evaluation. For physical abuse cases, victims with acute injuries were much more likely to receive medical evaluations than victims who reported an incident in the more distant past.

Victim and family characteristics. Victim and family characteristics also impacted both medical evaluation protocols and the likelihood that an evaluation would be requested.

Age. Age impacted medical evaluation referrals in a number of ways. Pre-verbal children or those who are young might be more likely to be referred for evaluation because the evaluation might be able to find information that the child could not convey directly. For example, one CAC member said:

"If you've got a fairly young child, who has out cried to like penetration type stuff over a period of years that would be something where we definitely would probably get an exam if we could, no matter how long it's been."

However, some MDT members, particularly law enforcement, did not understand the scope of a medical evaluation and thought it would be similar to a well-woman exam. These individuals were often less likely to refer young children for a medical evaluation, assuming it would be particularly re-traumatizing for them. Age could also impact sexual abuse cases with older youth. Often, teens who were sexually active were much less likely to be referred for a medical

evaluation. In these cases, law enforcement investigators were hesitant to use resources to obtain an evaluation with likely ambiguous physical findings.

Citizenship / Documentation. Family or victim citizenship sometimes led to alterations in medical evaluation protocols. For example, if any family members are undocumented, victims may fear coming to the attention of authorities out of fear of deportation. Additionally, if victims or family members are undocumented, it is more difficult to transport them to medical services for several reasons. First, it is illegal for most MDT members to provide transportation to undocumented individuals within the U.S. Second, if the medical provider is on the other side of a border control station, the undocumented individual runs the risk of being identified as undocumented. As a result, in cases such as this, the MDT might utilize alternative medical services that are not as specialized to ensure medical care is received without placing the individual at risk of deportation.

Insurance. The Type of medical insurance or lack thereof may impact the likelihood of getting a medical evaluation, particularly in the case of physical abuse or neglect cases where private insurance is billed. For example, some providers will not accept Medicaid:

"I'll be honest, [doctor's name] doesn't wanna work with Medicaid, and no other doctors will do [these exams]. I've gotten it done once or twice with private insurance."

Custody conflicts. When a parent involved in a custody conflict alleged abuse and there was no other evidence to support the allegation, MDT members reported they sometimes suspected the report was fallacious. In these instances, MDT members might be more reluctant to have the child medically evaluated.

Siblings. In some cases when one child in a family had alleged or substantiated abuse, MDT members might have wanted to obtain a medical evaluation of other siblings in the family.

Victim and family preferences. Medical evaluations are more likely to happen in cases where both the alleged victim and the family want the evaluation. Sometimes medical evaluations can be reassuring to victims by providing information about the impact of the abuse, reassuring them about their bodies, giving them a safe person to ask questions, and other such benefits. However, sometimes the alleged victim or family does not want to obtain a medical evaluation for the child. Typically in these cases, the MDT members would explain the process to the child and family in an attempt to allay fears. Should the child or family remain adamant about not wanting the evaluation, then most MDTs had policies not to force the issue. However, participants in one community reported that law enforcement would obtain evaluations if the parents wanted it, even if the victim adamantly did not. Another issue that might make victims and families reluctant to obtain evaluations was if the community was a very small one because this made privacy and confidentiality much harder to maintain. As one participant said, just sitting in triage waiting to get services could "out" a victim:

"Well, even if they didn't have to go through triage, if [they could use] that office just like any of the other doctor's offices. It's down the hall by itself. It has its own entrance."

If they could go straight to that back entrance into the SANE suite instead of having to sit through triage-"

Community factors. Community factors have significant impact on both formal and informal protocols for obtaining medical evaluations, as well as on the likelihood that alleged victims will receive medical evaluations. In most communities, at least some respondents stated some variation of "Anyone who needs a medical evaluation gets one." Yet, significant differences were noted in criteria used to assess the need for medical evaluations. As one participant stated:

"You know, the reason that law enforcement in [name of community] might be reluctant to pursue medical examinations could very well be different than the same exact problem that you'd run into in [another community]. They do it for different reasons. You run into that, even though you might find the same thing occurs in three or four areas that you're targeting to service. The reason that they do it may vary from place to place."

Without an accepted operationalization of "need" and case-level research examining the match, it is not possible to assess whether those who need medical evaluations actually get them.

Coordinating the MDT. Coordination between MDT members can be complicated and community factors may exacerbate difficulties in coordination. For example, some rural CACs cover several counties and smaller towns over a wide geographic region. This results in MDT members needing to coordinate with many law enforcement agencies, prosecutors, and even CPS units. As one respondent said:

"Then there's another issue we hit on earlier, about the [multiple] counties and the [numerous] different [law enforcement] agencies. It's one thing if you're dealing with a big city where you've got one [CPS] organization, and you've got two different law enforcement agencies. [Here if you get] one place that's workable, you have to figure out ways to duplicate that workability in all these other areas with other groups. When you're dealing with eclectic, diverse groups like we are, that's a tough sell when you have to go from place to place to place."

Proximity to specialized services. Unless they close to a MEDCARES facility, most communities found it difficult to obtain a medical evaluation from a trained forensic practitioner. These communities often reported having access to an insufficient number of providers, difficulties in accessing a facility to conduct the evaluation, and excessive time requirements to drive long distances to obtain services. As one respondent said, "We don't do very many SANE exams. I think part of that might be because we're an hour away [from where we can get those]." Having ready access to SANE services seemed to increase referral for medical evaluation.

Communities closer to MEDCARES facilities seemed to make more medical evaluation referrals. This is likely due to a number of factors, including: 1) Staff from the MEDCARES sites seem to be relatively committed to participating actively on their local MDTs and providing consultation to its members; 2) MEDCARES staff seem to have the knowledge and commitment to participate in the criminal justice process and this makes evaluations more useful to law enforcement, CPS, and

prosecutors; 3) MEDCARES sites have more staffing and resources, resulting in shorter wait times; 4) MEDCARES sites may have funding available to cover gaps in hospital bills and CVC compensation, saving law enforcement from having to cover the gap. One respondent explained how they lost the ability to easily gather forensic evidence when they lost their local SANE nurse:

"About a year ago, we had a nurse who, this is what she did. She didn't have any other job. Actually, she was here probably every day, actually in the building, doing research, and networking and things like that. Whenever we would have a case that a child had severe bruising, they would just ask her, "Hey, do you mind taking pictures?" She's here, the kid is here, and so she would. Now, since, of course, she now left, and has a real job now, whenever we have kids that have serious physical findings, I'm guessing they just refer them to their pediatrician or to a doctor, or, if it's bad enough, go to Children's Hospital."

Having a trained medical professional with which to consult. MDTs that had stronger relationships with a child abuse pediatrician were more likely to seek medical consultation and seemed to make more referrals for medical evaluations. Generally, the strongest relationships between medical providers and the rest of the MDT occurred in communities where a physician or SANE nurse actively participated in the MDT. However, in at least one community that lacked a SANE or trained physician on their MDT, the FACN played this role. Even when the case was not necessarily a CPS case, CPS workers would serve as an intermediary between the agency with the case and the FACN physician to obtain advice.

Facility in which to conduct the evaluation: The MDT needs to have good relationship with a hospital or clinic where evaluations can be done. As one respondent stated:

".... if we didn't have [access to a MEDCARES site], I don't know what we would do. [This local hospital] doesn't wanna do it. [That local hospital] doesn't wanna do it. Then the closest other children's hospital is [far from here]."

However, hospitals or clinics may have several barriers to providing medical evaluations in child abuse cases. First, the facility may have increased liability from granting privileges to SANEs or CAPs. Second, the hospital may be reluctant to provide the infrastructure needed to conduct medical evaluations (e.g., dedicated space, expensive medical equipment such as colposcopes or SDFI cameras, etc.). Third, even when CVC compensates law enforcement for exams, CVC compensation rates are often less than the full cost of medical evaluations. As a result, the facility may have to absorb some of the costs for medical evaluations, which creates a difficult situation for them. Several communities were struggling with this issue and trying to find other ways to "compensate" hospitals. The one strategy that seemed somewhat effective and did not require excessive additional funds was to assure public recognition of the facility's commitment to child victims. Some MDTs focused on getting good press for their local hospitals. Another community suggested that some sort of state-level recognition might support their local hospital in participating.

It is also worth noting that even when local hospitals support a SANE or related program, the MDT members and medical providers may “hospital shop,” choosing a hospital based on cost, access, attitudes towards victims, policy strictness, reporting policies, and other factors. For example, one SANE nurse reported:

“We do adults over there because in [the other community] the patient is charged for the morning-after pill on their insurance. A lot of the times it is students, so the information goes to parents’ insurance, and then they want to know why you were treated with these. Why are we getting this bill? Why didn’t our insurance get the bill for these drugs? It’s just more of a confidentiality thing, because in [this community] the hospital donates the medications.”

Another SANE nurse reported that she was uncomfortable with how loose confidentiality was in one hospital, so tended to refer her patients to another hospital:

“In [this community] their name is on our board in the ER. It says SANE next to it. You know, so everybody in there knows that we have a patient there for a SANE exam. It’s on the tracking board. ... [In this other community] I don’t even give them the patient’s name. They don’t even have an ER record. They just have—I give them date of birth, and social security number, and I give ‘em the law that’s gonna pay for the exam. They don’t have to be registered as an ER patient.”

Finally, when SANE nurses are so poorly compensated to begin with, it can be hard for them not to hospital shop based on which facility provides better support or compensation. For example:

“I get paid more on call for being in [that community], too. I mean, that’s not my biggest deciding factor, but I do get paid more for call pay [there], and I take more call there, and if I get a call from a detective here and I’m on call over there, then I’ll take the patient over there and do the exam.”

Because there is no set fee for SANE services and no standardized forms or procedures, MDT members may “SANE shop” for the provider who charges least or has the simplest reporting/procedures. For example, one community had no local SANE program, so law enforcement had to travel to other communities to obtain medical evaluations for children. However, evaluation fees varied widely across those providers, so officers would often be told to take the victim to the hospital with the cheapest rates, rather than the one that was closest.

Recruiting and retaining SANEs. SANEs are the most common providers of sexual assault medical evaluations in Texas, yet recruiting and retaining SANEs can be both expensive and difficult. There is significant burden on SANEs for a number of reasons and all of these may impact retention. First, SANEs spend a lot of money out of pocket for training, recertification, travel, and even medical supplies. Some SANE study participants reported spending thousands of dollars on these costs. Second, SANE training and recertification both require clinical hours and these can be difficult to obtain in rural areas where there tend to be fewer reported sexual assault cases. Thus, SANEs have to travel to large/urban areas in hopes of meeting clinical requirements. Third, SANEs often have to juggle demanding on-call schedules and extra work hours. Many employers

will not allow SANEs to count the time spent doing medical evaluations, attending court, or attending MDT meetings as part of their regular work week. In fact, SANEs may even be penalized by their employers if they miss time from their regular jobs in order to attend court. Fourth, the fees paid to SANEs usually cover only the time spent on the exam, and do not cover time spent coordinating with the MDT or attending court. Finally, many SANEs may enter the field because they want to help victims, but may not anticipate the burden of gathering forensic evidence and attending court. As one respondent put it:

"Nurses are good at seeing patients. That's who they are. Court is a huge burden for many nurses. ... The emotional and psychological toll it takes has high burnout. No other field of nursing feels that weight of court. It requires a precision of practice. There is no margin for error. ... It's like being in a pressure cooker while under a microscope."

As a result of these many challenges, MDTs may need more focus on strategies to support SANEs. One CAC director explained her motivation to facilitate payment between the SANE and law enforcement, as follows:

"They send me the bills for the SANE nurse. I pay her immediately so we keep her happy; we only have one SANE nurse. Good Lord, we don't want her upset. We keep her very—as happy as possible, and we pay her directly. Then I bill all of the law enforcement entities and get paid."

Some effective strategies to support SANEs as reported by study participants included:

- Providing them a small stipend for transportation, liability insurance, attending court, attending MDT meetings, and obtaining training.
- Advocating with their employers so they get comp time for SANE hours worked.
- Advocating with local hospitals to ensure SANEs get hospital privileges.
- Providing a safe place for them to debrief their cases (e.g., with a social worker from the local victim advocacy organization).
- Providing social events for the SANEs to support self-care.
- Assuring they have a medical director who is both a good advocate for them and qualified to supervise forensic nurses.
- Sending SANEs to conferences where they can be with others doing similar work.

These are preliminary ideas only and further research should be done about how best to support SANEs, given resources available. Ideally, this might be done on the local level since different communities have varying resources to offer and each SANE may have different ideas about what they would find supportive.

Providing physical abuse and neglect medical evaluations: As discussed above, physical abuse and neglect cases are often treated either in an ER or through a primary care pediatrician. This results in several problems.

1. These physicians rarely have specialized training in child abuse and this can lead to inaccurate conclusions about whether abuse occurred.
2. The physicians rarely have training in gathering forensic evidence, so any evidence may be lost.
3. ERs are generally ill-equipped to follow-up with child abuse cases, meaning physically abused or neglected children may not get ongoing care.
4. ER physicians and pediatricians are usually reluctant to participate in the criminal justice process. This may be due to both lack of knowledge and lack of compensation for court attendance and other criminal justice activities.

Other resources needed to obtain medical evaluations: In addition to funding for medical evaluations, SANE programs, and the other needs addressed above, many MDT members mentioned a lack of other resources that could impact the likelihood of a child receiving a medical evaluation. Foremost among these were transportation and personnel, particularly in rural areas where distances to medical facilities may be substantial and travel time might be excessive. If the LE department is small, it can be quite difficult for them to free up an officer and a vehicle to provide transportation and stay through the evaluation so that the chain of evidence is maintained.

Factors related to MDT members. Characteristics of the MDT and its members often predicted the likelihood that a child would receive a medical evaluation. The primary factors in this category included: having an advocate for medical evaluations on the MDT, level of motivation to obtain medical evaluations, knowledge, and the relationships between MDT members.

Advocate for medical evaluations on the MDT: Ideally, all members of the MDT would see the value of medical evaluations and ensure that evaluations are obtained when needed. However, this is not always the case. The study found that when someone in a position of power pushes for more consistent medical evaluations, they are much more likely to occur. It did not seem to be as important who advocated for medical evaluations, only that someone in power did. In some communities, this person was a prosecutor, while in other communities, the person was a doctor, a sheriff, or a CAC executive director. When the local prosecutor advocated strongly for evaluations, it did seem to increase law enforcement investment in medical evaluations. Medical MDT members seemed to be most effective advocating for medical evaluations when they spent time building the relationships with other team members and when they were effective at explaining the need for medical evaluations, particularly with cases where the need for an evaluation was less obvious.

Motivation: Obtaining medical evaluations requires time, effort, and other resources, so MDT members need to be motivated to pursue them. Different MDT groups had different motivations to pursue medical evaluations.

For example, law enforcement was generally most interested in obtaining medical evaluations to help in case investigation and prosecution. Because positive findings are rare in an evaluation,

their motivation to obtain evaluations seemed to increase when they saw the evaluations providing other evidence, such as additional outcry details and/or medical histories that are an exception to the hearsay rule. One participant described old protocols for deciding which cases received medical evaluations:

"Protocol was, especially in the sexual assault cases, you got an exam. In the years past it was only if it was penetration, because there was a decision to be made by law enforcement, who's paying for those exams, which ones they were going to pay for and which not. The ones that were more probable to have evidence were the ones you focused on."

Another law enforcement officer described why they now request medical evaluations in a wider range of situations:

"It's also not only just to check their innards. It's also for evidence cuz they [medical professionals] play a separate role with what they can testify to in court than we can. It's additional corroboration for evidence for us cuz if they make that same outcry to them, then that corroboration—their outcry is more credible. As well as [that] medical personnel can testify to things that we can't testify to in court, say things that we're not allowed to say."

His colleague in the same community goes on to say:

"That's the biggest benefit for—obviously, for the safety of the kid to have medical personnel look at them. That's a huge benefit, but in terms of prosecuting someone, [the medical] team can get in there and ask the leading questions and then testify to a court and it's all admissible, whereas if we mess up and ask something leading in our forensic interview, then we're damaging the case. That's the biggest part there."

In short, motivation to seek medical evaluations increased when doing so helped MDT members in their jobs.

Knowledge. Medical providers who have the knowledge to explain, evaluate, and document child abuse cases in a way that assists law enforcement, CPS, and prosecutors in case investigation and prosecution were able to help increase the effectiveness of the overall MDT in conducting medical evaluations, particularly when the medical professionals were willing to testify. Mentoring by a more seasoned medical MDT member can be invaluable in developing this skill set. Additionally, prosecutors may need to provide training to medical professionals on how to testify as an expert witness, present information in court, and manage difficult questions from the defense.

What medical evaluation involves. When MDT members were asked what would make them hesitate to get a medical evaluation, one of the most common answers was fear of re-victimizing the child. Some participants even talked about how the evaluations “violate” the child. This suggests a lack of knowledge about what actually does and does not happen during a medical evaluation. Such misunderstandings were fairly common among law enforcement, prosecutors,

and CPS workers, and occurred most often in communities without a strong medical presence on the MDT. Fears about the medical evaluation potentially re-victimizing children were often compounded by uncertainty about how to talk to victims and families about the medical evaluation and how to help the victims and families feel safe during the evaluation process.

Managing medical evidence at trial. Several aspects of presenting medical evaluations can pose difficulties for prosecutors. First, few medical evaluations result in positive physical findings and this needs to be explained to the jury. Medical professionals can help with this. As one law enforcement officer talked about cases of his that have been presented with no physical findings:

"A lot of times ... there's no medical findings, but they can explain to the jury where there's no medical findings, which is very good. I thought that was very beneficial for me, so I can only imagine as a jury how important that is, why there's no medical findings."

Second, it is likely that children may tell the story of the abuse incident somewhat differently at different times and defense lawyers may try to suggest this is due to "not being able to keep their story straight." So prosecutors need to explain how trauma and developmental stage may impact how children recount incidents of abuse. Third, not all medical providers can be certified as expert witnesses. Therefore, prosecutors need to be able to frame questions to them to avoid expert opinions, but still get in all relevant facts. Finally, many prosecutors talked about "the CSI effect," including how television crime shows have shaped jury members' ideas about how evidence is gathered, the amount of scientific resources that should be devoted to a case, how cases will proceed, how likely it is to have positive findings, etc. So prosecutors need to be able to address this issue effectively and explain discrepancies between television and the real case before the jury. On the other hand, several prosecutors also said that the CSI effect made them more likely to want a medical evaluation because juries expect that evaluations will be done and, when they are not, juries may see that as a significant gap in the case investigation.

The billing "black box." Several study participants expressed confusion about CVC procedures. The system of paying for medical evaluations and getting compensated can be confusing in several ways:

1. CVC is unavailable for physical abuse and neglect cases, so few MDT members knew how to obtain medical services for those cases.
2. There is significant variation in compensation based on the particular hospital's rates, the SANE's or CAP's rates, types of services provided, etc. This variation in rates made it difficult for MDT members to plan or budget for medical evaluations.
3. There is often disconnect between those who request the medical evaluation, those who handle the money and those who request services. One law enforcement officer told about getting "pressure from above" to limit the number of medical evaluations and not understanding this was because the department was paying significantly more for the evaluations than CVC compensates. Such a disconnect may be inevitable, particularly in larger systems, but it may limit the actions of those MDT members who do not have decision-making authority regarding medical evaluations.

Relationships between the MDT members. MDTs with stronger relationships between members seemed to be more effective at assessing the need for a medical evaluation and then obtaining one if needed. In these situations, several factors existed, including:

1. MDT members had good strategies for working through differences of opinion about when a medical evaluation was needed.
2. MDT members knew where to go to advocate for an evaluation.
3. Those MDT members who had decision-making authority about evaluations were open to input from others, including CPS or CAC staff who may be left out of this decision-making process.
4. MDT members shared the burden of getting evaluations completed (e.g., sometimes CPS would transport for LE when LE could not free up an officer).

When asked about how MDT functioning could pose barriers to obtaining medical evaluations, one CPS worker stated:

"It's just hard to see it from our perspective, simply because we do work very well together. I know I can call the DA that's sitting outside. We've brought cases to the DA here at the MDT, which is not something commonly that CPS actually does. It's usually from criminal. But we've come forward where there's criminal cases, but we feel like these need to be brought to the forefront, whatever, and we can bring 'em. That kind of relationship, it's hard to build, I think, but once you have it, it makes a very, very big difference."

MDT FUNCTIONING AND NEEDS

MDT functioning and needs have a direct impact on how medical evaluations are obtained in a community. Thus, the study also asked a number of questions about the MDT itself. Out of these discussions, participants spent the most time discussing two overarching themes: 1) building a team/culture for collaboration; and 2) training needs.

Building a team/culture for collaboration. MDT member organizations have different organizational cultures and work contexts that can create significant challenges to building an effective collaboration. Study participants addressed a number of issues that directly impact the effectiveness and cohesiveness of the team. The primary themes addressed included: MDT leadership, getting everyone "to the table," developing protocols and making sure all members understand them, developing communication networks, building respect and understanding between members, developing accountability, and having a strategy to address staff turnover.

CAC leadership. Several CAC staff members discussed the challenges of trying to coordinate the MDT while having no official administration over the other MDT members. Yet, despite this, many CACs were able to foster effective, well-functioning teams. Those CACs that struggle with building the collaboration could possibly benefit from mentoring relationships with a CAC in a similar type of community.

Getting everyone “to the table”. Fundamental to an effective MDT is the team’s willingness to participate in collaboration. Study participants identified the following tasks critical to this effort, which are discussed below:

- Building relationships between individuals across organizations,
- Building motivation to collaborate,
- Engaging the reluctant organization or individual,
- Addressing tension between organizations,
- Keeping the mission forefront, and
- In some cases, co-locating services.

Building relationships between individuals across organizations. MDT members need to work with each other regularly for the MDT to function as effectively as possible. Many study participants noted that monthly case review meetings are insufficient to create an efficient collaboration and that it is important for individual relationships to be developed across organizations. Several participants also noted that while the collaboration requires individual-level relationships across organizations, continued collaboration needs to also be supported by agency-level agreements so that when there is staff turnover, the collaboration does not falter. In short, although relationship-building is an individual-level process, effective collaboration requires that relationships between organizations not be dependent on particular individuals.

Building motivation to collaborate. MDT participation takes time and effort and thus requires a certain level of organizational and personal commitment. In some cases, though, this could put significant demands on MDT members. For example, in a small community with few personnel in a particular job, one participant reported that “an unreal level of commitment” was required to be as accessible as the MDT needed. However, there are also ways the MDT can actually reduce burdens on its members by sharing responsibility for tasks. For example, CAC and CPS staff often reported that they would transport alleged victims for medical evaluations even when law enforcement had requested the evaluation. Additionally, several participants noted that motivation to collaborate was often greatly increased as member organizations and individuals saw participation in the MDT process improving the response to victims, assisting with case investigation and prosecution, and achieving other important outcomes. For example, one CAC staff member talked about building the MDT in a community:

“You have to prove yourself and prove your value to them. When you’ve done that, then you get some real loyal support.”

Engaging the reluctant organization or person. Often MDTs encountered either an organization or person who was key to achieving MDT goals, but who was reluctant to fully participate or support MDT activities. Engaging these individuals can be difficult and CACs must find effective ways to involve all partners.

Addressing tension between organizations. Tension was often noted between various MDT member organizations, and this can impede MDT functioning. The most common source of tension was between LE and CPS. These two organizations both conduct investigations, but have very different investigation timeframes and levels of evidence required. Several participants noted that these differences often led to misunderstandings and that high turnover at each organization can compound difficulties in coordinating between the two organizations.

Some communities had found effective ways to meld the needs of the both LE and CPS. For example, in one community, CPS became aware that LE worried that if CPS interviewed the perpetrator first, this might alert the person that they were being investigated and lead to them fleeing or giving a biased account. In response, CPS set up a system where such interviews were done jointly with representatives from both organizations present. Another factor that seemed useful in addressing CPS/LE tension was that a fair number of CPS study participants were formerly with LE. These individuals often served as natural bridges between the two organizations. A final strategy some participants used to address CPS/LE tension was doing a great deal of cross-training. Once individuals understood the differences between organizational timelines, requirements, etc. and the reasons for such differences, the individuals often found the differences easier to respect.

Building a shared mission and keeping that mission forefront. Collaboration can be difficult and personalities can get in the way. Many participants made some statement about how keeping a focus on the MDT mission to help children often diffused tensions when they arose. For example, a CPS worker discussed how their MDT handled it when CPS saw a need for a medical evaluation and LE did not:

"That's where your partners help out, because a lot of times it'll be like, okay, maybe they don't see it, but if we feel that it's urgent or critical need, that's where the team works together. You can definitely get things done. Obviously, it's in the best interest of the children."

Co-locating services. To facilitate collaboration, some MDTs had co-located some member organizations. In some cases, participants saw this as useful in that it often streamlined services and created tighter connections between organizations. However, other communities reported difficulties with this because it could diffuse appropriate boundaries between organizations.

The role of food. As something of an aside note, it was interesting how frequently food was mentioned as integral to effective collaboration. For example, one CPS unit reported the following about healing a strained relationship with law enforcement,

"CPS has to be consistent and flexible, but God, I guess the bottom line is that you really frigging have to work at [building the relationships]. I mean you really do. You have to know what your detective's favorite flavor of ice cream is, or if chili cheese fries are his favorite thing to eat."

Developing protocols and being sure everyone understands them: Participants frequently reported an evolution in MDT protocols as team members tried different approaches to determine what worked best. They also reported a need to regularly review protocols to ensure protocols match current needs, particularly for communities experiencing significant growth. Some participants suggested that it can be helpful for MDTs to have a mechanism to regularly review procedures to assess the match between protocols and the needs of the MDT and community.

Developing both formal and informal communication networks: Participants frequently discussed the evolution of MDT communication networks as both formal (as established by protocols) and informal. Participants often reported improved collaboration when communications did not always have to go through formal networks (e.g., the CPS hotline), and when members could informally brainstorm about cases, ask for help, get advice about how to proceed on a case. One participant described it as:

"Communication, talking to them. Know who they are. Present yourself. Build alliances, build teamwork in the field. It doesn't matter, if you only meet once a week, and that's the only time you're communicating—like if a detective and I work with CPS, and the only time I talk to him about the case is on Thursday, then there's no point. You gotta build that relationship. You gotta have phone numbers. You gotta call them. You gotta trust each other. They're gonna call you. You gotta do things. Obviously, nothing, I'm not talking about anything that's away from policy. I'm saying, you gotta scratch each other's back. 'Regarding this, have you talked to them?' 'No.' 'Well, look, I'm gonna talk to them. Is that okay?' 'Yes.' 'Alright, well what I get, I'll give you the information.' That kind of open communication. That's what I feel that we have here, and that's why I think we're successful. Again, are we perfect? Absolutely not. I think we're very successful, because people are able to talk. I have the DA's number and I've called her at two in the morning, and she doesn't get mad."

Building respect and understanding between team members: This topic came up frequently in the focus groups. Participants offered a number of strategies that may help in developing respect and understanding between MDT members. Included in these were the overarching themes of:

1. Understanding the roles, limitations, restrictions, and job expectations specific to each job or organization.
2. Developing strategies to resolve conflicts and find solutions despite differing agendas.
3. Ensuring all members on the MDT participate actively, have a voice, and no one person or organization dominates the group.
4. Addressing, and hopefully minimizing, power differentials between organizations or individuals.

On the latter point, a couple of sub-themes emerged. One was that "power equals purse strings," a topic which arose most often when discussing how LE generally controls requests for medical evaluations because LE is the only entity that can be compensated for them. In most cases, when

a CAC, CPS, or medical person thought an evaluation was needed, but law enforcement disagreed, the evaluation would not be done. For example, one CAC staff member said:

"Well, really it's not our choice. It's law enforcement's decision, so even if we say, 'Well, I think a medical exam would be a good idea, it's up to them whether or not that happens."

Another sub-theme arose around power differentials between LE and CPS in that some CPS workers reported feeling like they needed to do what LE told them to. One CPS worker explained how this complicated her doing her job:

"Yeah, we'll call [law enforcement] if it's a severe case or sexual abuse. They'll tell us from the beginning, 'Don't interview anybody until we get involved, until we talk to everybody.' We have to hold off. Then they'll go and interview everybody and not tell us. Then we end up needing to get a disc of the interview. It's just a lot of extra stuff that we could avoid if we just did it jointly."

When MDT members felt like they had unequal power on the MDT, this sometimes seemed to cause other problems. Specifically, participants reported outcomes such as feeling less motivated to participate fully in the MDT process, feeling like they did not have the ability to truly advocate for victim needs, or believing they had to compromise their agency's policies to facilitate or appease another organization.

Developing accountability: Several participants reported that it was critical to effective MDT functioning for members to hold each other accountable for doing their jobs as best as possible, but to do this in a way that was not, as one participant put it, "blaming or shaming." At the same time, participants also focused on a need to approach problems with a case as opportunities for team problem-solving, rather than an individual organization's problem.

Addressing turnover: Some organizations tend to have high turnover and/or movement of staff within the organization. High turnover rates were reported most commonly with CPS and with LE patrol officers. When coordination between MDT organizations was predicated on relationships between individuals in an organization, turnover in those positions could disrupt agency coordination. Thus, it is important for MDTs to avoid relationships between organizations being overly dependent on relationships between single individuals within those organizations. As one respondent put it:

"You gotta find, as they say, the pillars that are gonna be there. If you keep assigning new people all the time, you need to find at least two stable from each agency that are going to be there long-term, and they've shown the interest."

Training needs. MDT members frequently discussed three main themes related to training: needs for topical training, need for cross-training, and challenges in obtaining training.

More training. Overall, MDT members wanted more training on a variety of topics. Participants from nearly all MDT groups, including some medical professionals without specialized training in child abuse, thought more training would be helpful. Requested topics included:

- Child abuse investigation.
- The medical evaluation process.
- Working with victims and their families.
- Crime Victims Compensation (CVC) processes and requirements.
- Cultural competence

Not only did participants identify a desire for advanced training, but they also often mentioned the need for ongoing basic training to address staff turnover and provide “refreshers” to existing team members.

A significant number of LE officers were not conversant with current standards for medical evaluations in sexual abuse cases. This was most apparent with the Texas statute “96-hour rule,” which states that if a victim presents to the hospital within 96 hours of the alleged incident, hospitals are required to provide an evaluation. Since many law enforcement entities use this statute to guide decision-making about whether to request an evaluation, it is important that they know the correct timeframe. Many officers thought the timeframe was shorter: 72, 48, or even 24 hours. Additionally, many officers thought an outcry of penetration was required for an evaluation.

Cross-training. Many study participants identified a need for MDT members to understand MDT organizations other than their own. This was seen as critical to effective collaboration across agencies. Specific topics mentioned as important included:

- Each organization’s mission, requirements, timeframes, limitations
- What a typical day looks like for an MDT member from that organization.
- Who to call and under which circumstances.

Participants discussed different models for such cross-training. Although comprehensive trainings might provide a more complete picture, such intensive training requires more funding and greater time commitments. Therefore, many participants saw this approach to cross-training to be less feasible than other approaches. Two other cross-training models seemed to work in several communities. The first of these was including short trainings as a portion of the regular MDT case review meetings in which each MDT organization presented something about their specialty or about what other organizations need to know to understand their work context. The second effective model was “ride-alongs” where individuals from one agency would follow an MDT member from another agency as that member went about their workday.

Training challenges. Although additional training was seen as very important, participants noted several challenges in implementing trainings. Larger trainings can be very hard to schedule given the multiple schedules that need to be coordinated. Further, it can be difficult to free up personnel from small departments or organizations to attend these trainings. For example, several participants referenced the CACTX yearly conference and many stated that they had not

ever been able to attend due to either scheduling difficulties or the need to provide coverage in their organization. Participants also frequently mentioned ongoing struggles in obtaining resources to pay for trainers, travel, etc.

SURVEY FINDINGS

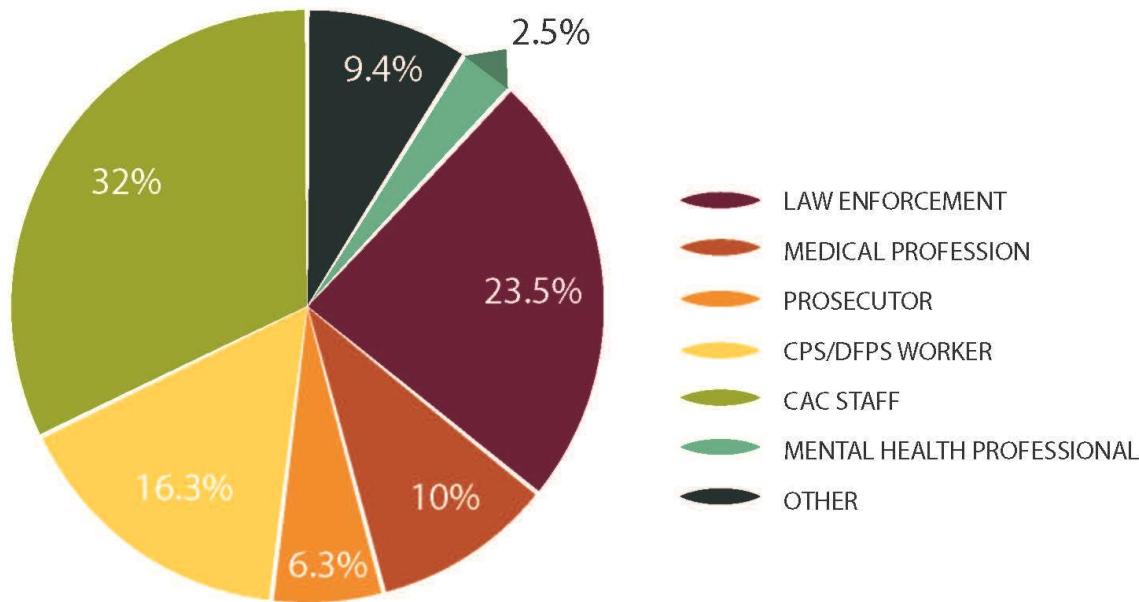
In addition to the findings from the focus groups, responses from the online survey yielded valuable information about medical evaluations for child abuse victims. A total of 319 professionals from 47 MDTs completed the survey.

SURVEY PARTICIPANTS

Before discussing content related to medical evaluations, a description of survey participants is presented.

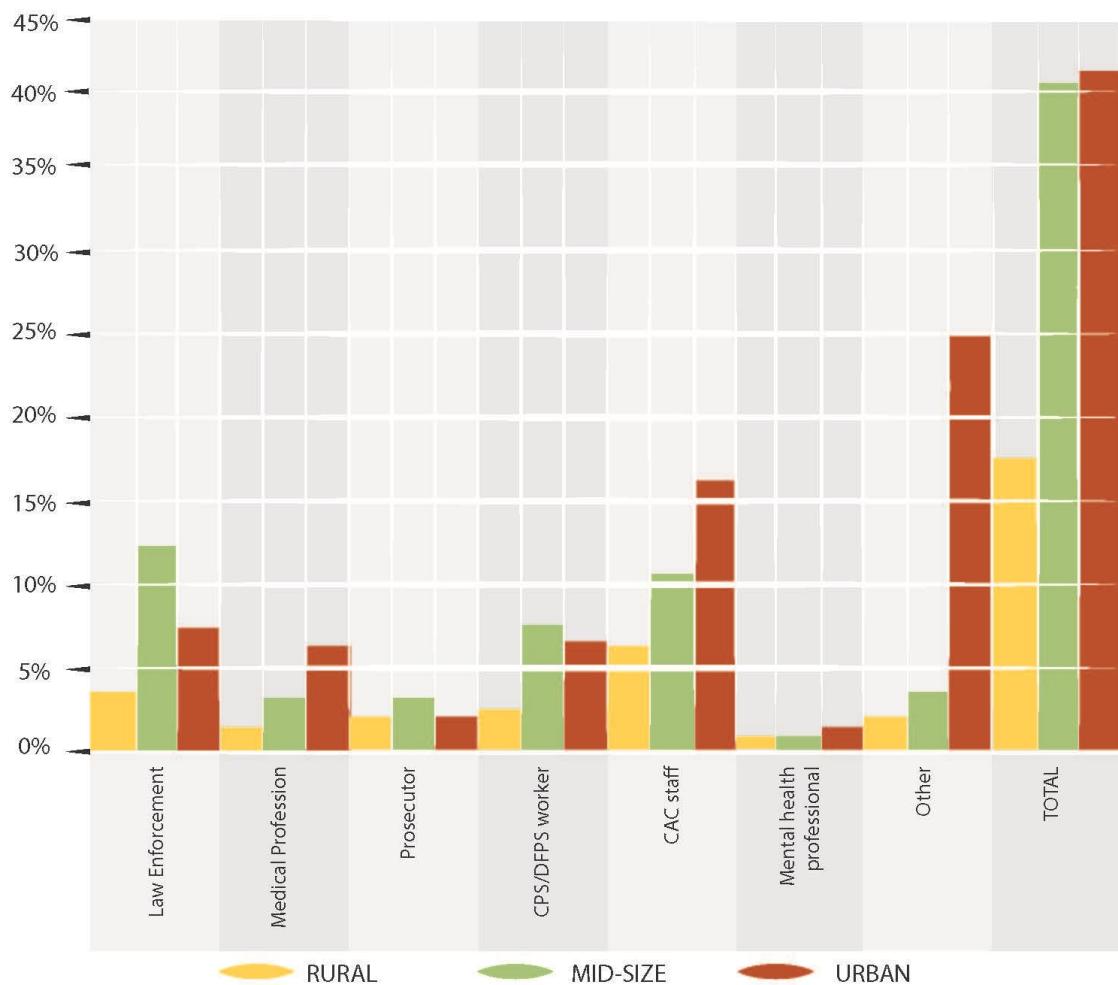
Professional background. As part of the survey, participants were asked to select their primary profession. At least one participant from each of the professions participating in MDTs was represented in the findings. Most of the participants (32%) were CAC staff. An additional 24% of participants were law enforcement professionals. The remaining groups of professionals had lower rates of participation: 16% were CPS workers, 10% were medical professionals, 6% were prosecutors and 3% were mental health professionals not on the CAC staff. An additional 9% of professionals identified as “other” and primarily noted that they were victims’ advocates or mental health professionals employed with a CAC. Figure 4 below categorizes the professions of participants.

Fig. 4 // Participation by professional background (N=319)



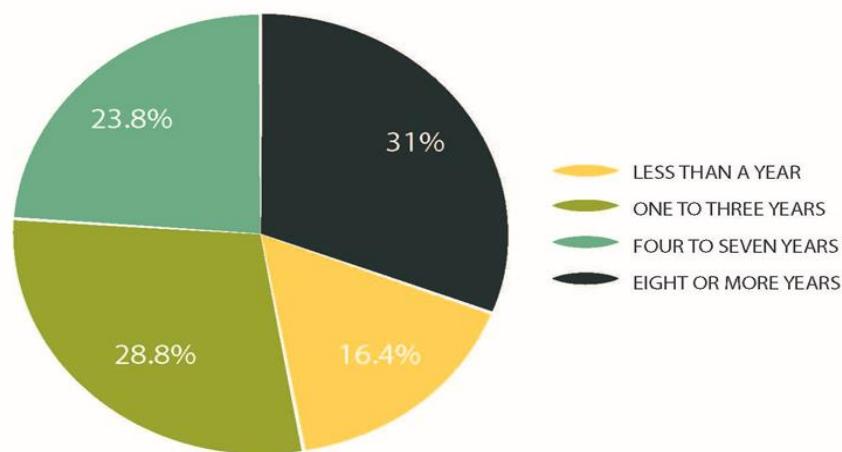
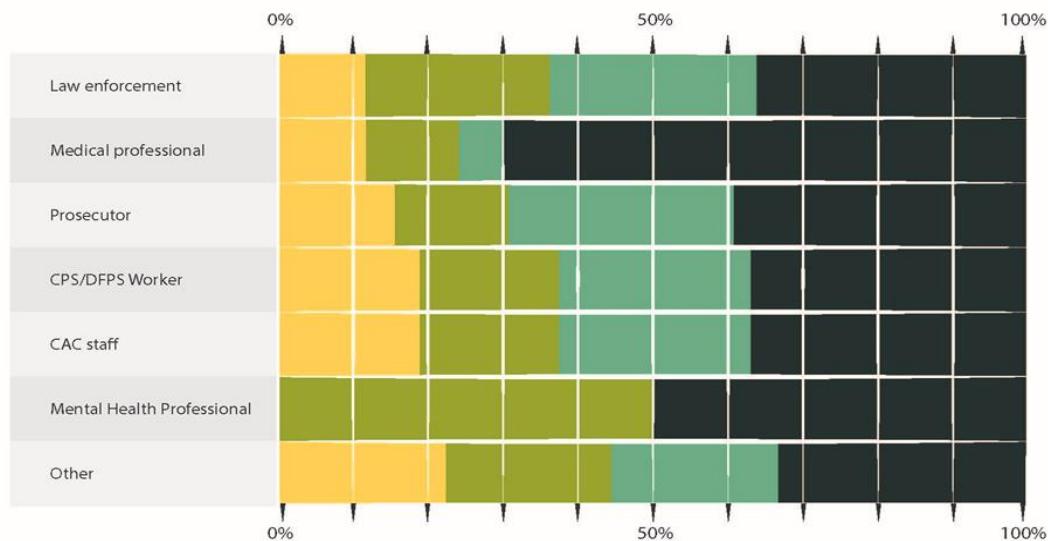
Community type and profession. Participants identified their MDT, which was cross-referenced with a list provided by CACTX (see Appendix B) to classify their community type as small/rural, mid-size or large/urban. A fairly equal number of participants were from large/urban (42%) and mid-size (41%) areas. Only 17% of participants were from small/rural areas. The largest percentage of participants (16%) was CAC workers from large/urban areas. The second largest percentage of participants (12.5%) was law enforcement professionals from mid-size areas. Groups with the some of the smallest percentages of participants include medical professionals from small/rural areas (1.3%) and mental health professionals from both small/rural and mid-size areas (0.6%). Figure 5 below shows the community types where participant's MDTs are located.

Fig. 5 // Participation by community type and profession



Length of time in profession. Figure 6 below details the amount of time members of the MDT had been in their current position. In general, participants reported having multiple years of experience in their current position. Only 16.4% of participants reported having less than one year of experience and 28.8% of participants had one to three years of experience in their current positions. The majority of participants (54.8%) had four or more years of experience in their current positions. Based on Figure X below, medical providers had the most years of experience in their current positions as 69.7% of medical providers had eight or more years of experience. Mental health professionals not employed by the CAC also indicated substantial experience as 50% had eight or more years of experience. The remaining professionals had relatively similar distributions in terms of years of experience.

Fig. 6 // Length of time in current position by profession



Law enforcement characteristics. If a participant indicated they were a law enforcement professional, they were asked additional questions specifically related to their position and agency. Of the 75 law enforcement professionals, 14.7% were from small/rural areas, 53.3% were from mid-sized communities and 32.0% were from large/urban areas. Figure 7 below details the various positions/titles of law enforcement professionals. Figure 8 on the following page details the types of law enforcement agencies of participants. The majority (65%) of law enforcement professionals were detectives. In terms of type of law enforcement agency, the majority (58.7%) were from city police departments while 36.0% were from Sheriff's Departments. Only 1.3% of participants identified as being from constable's offices and 4.0% identified as being from "other" agencies. Those from other agencies primarily noted they were from juvenile probation agencies. Of those responding, only 8% worked in agencies with a sexual assault unit and 13.3% had a specialized child abuse unit.

Fig. 7// Law enforcement profession by community type (N=75)

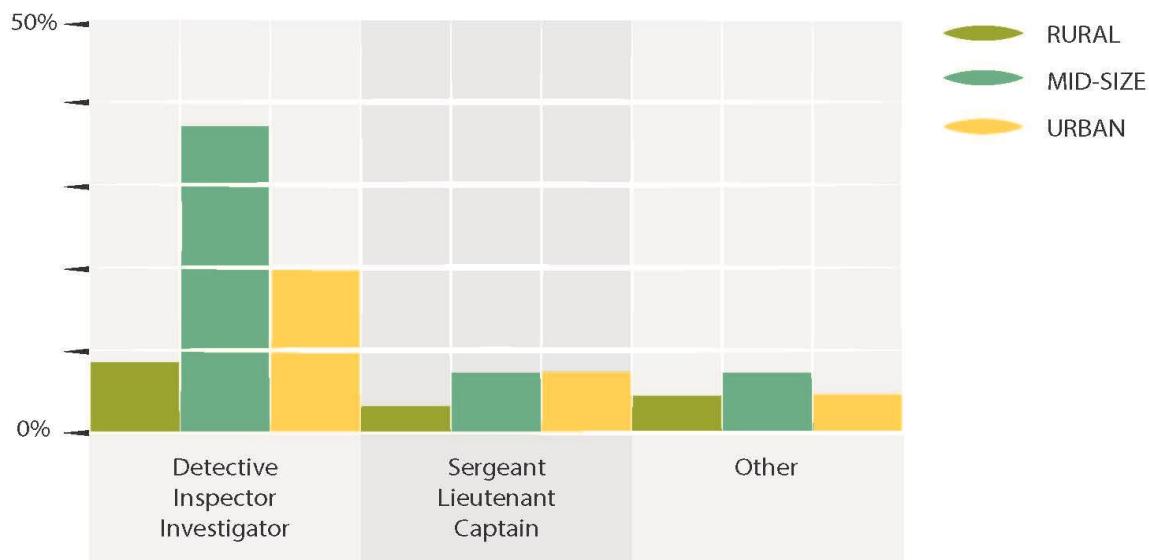
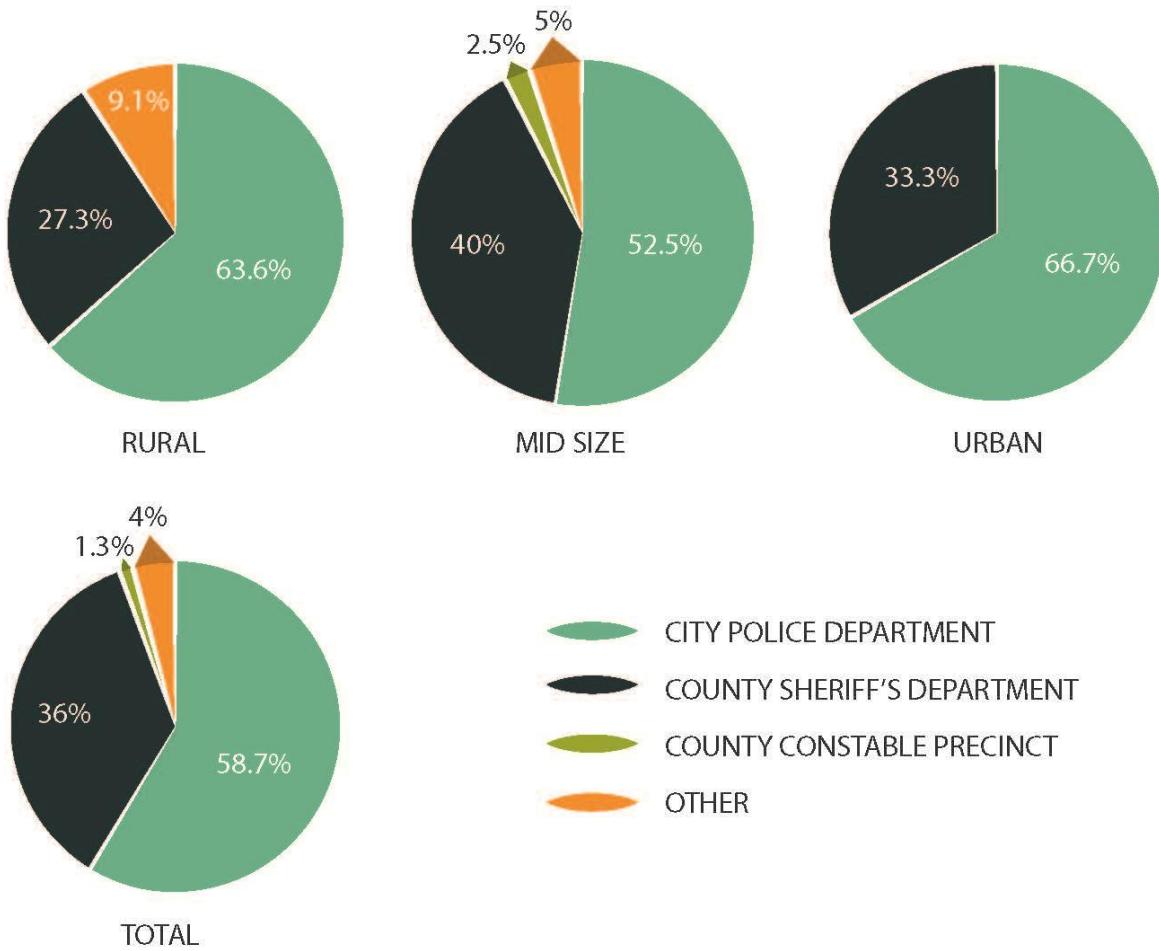
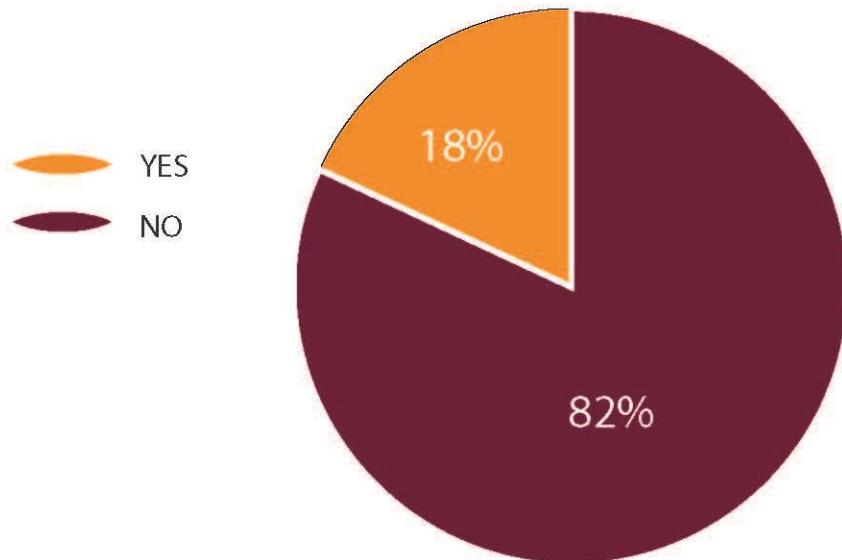


Fig. 8 // Type of law enforcement agency by community type



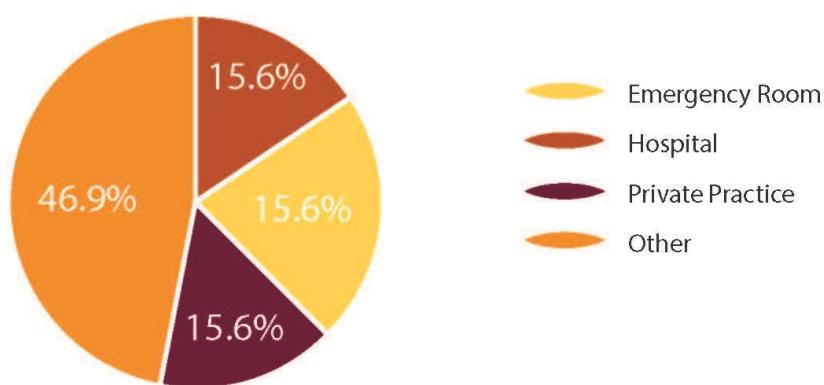
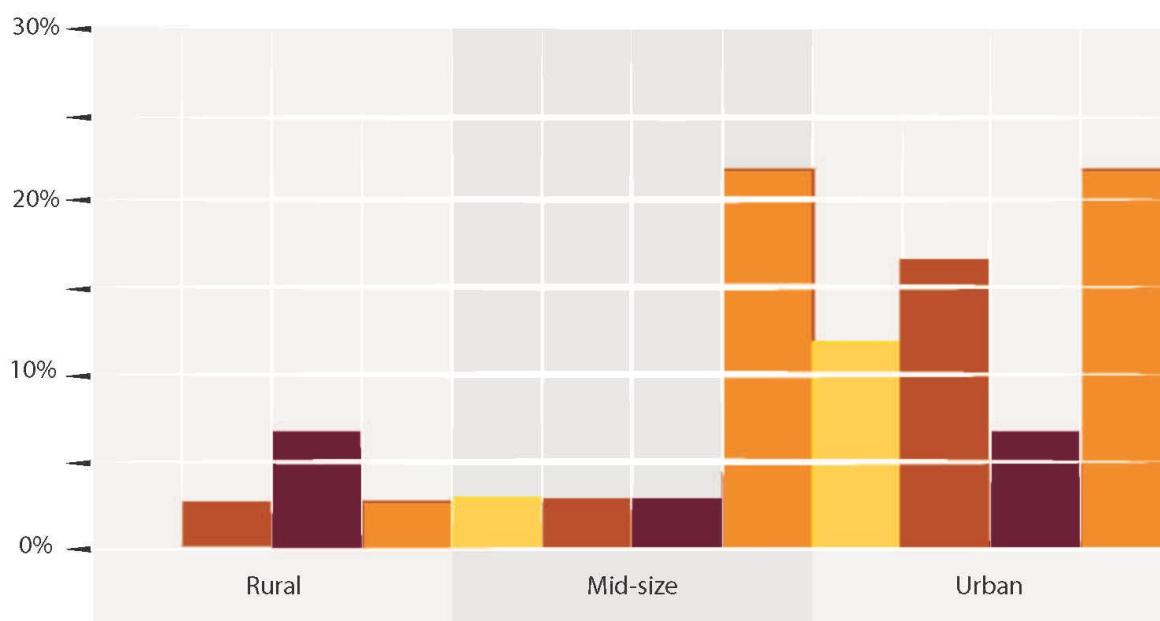
Child welfare worker characteristics. The 51 professionals who indicated they were child welfare workers were asked additional questions regarding their positions within their agency. Of those, 47.1% were caseworkers, 29.4% were supervisors and 5.9% were program directors. One regional director also completed the survey. Of these professionals, 15.7% indicated they had “other” positions noting that they were investigators or program administrators. Child welfare workers were also asked if they worked within a specialized sexual abuse unit. Only 18.4% of workers were part of a specialized sexual abuse unit and according to Figure 9 below, most of these workers were in large/urban areas and none were in rural areas.

Fig. 9// CPS specialized sexual abuse unit by community type



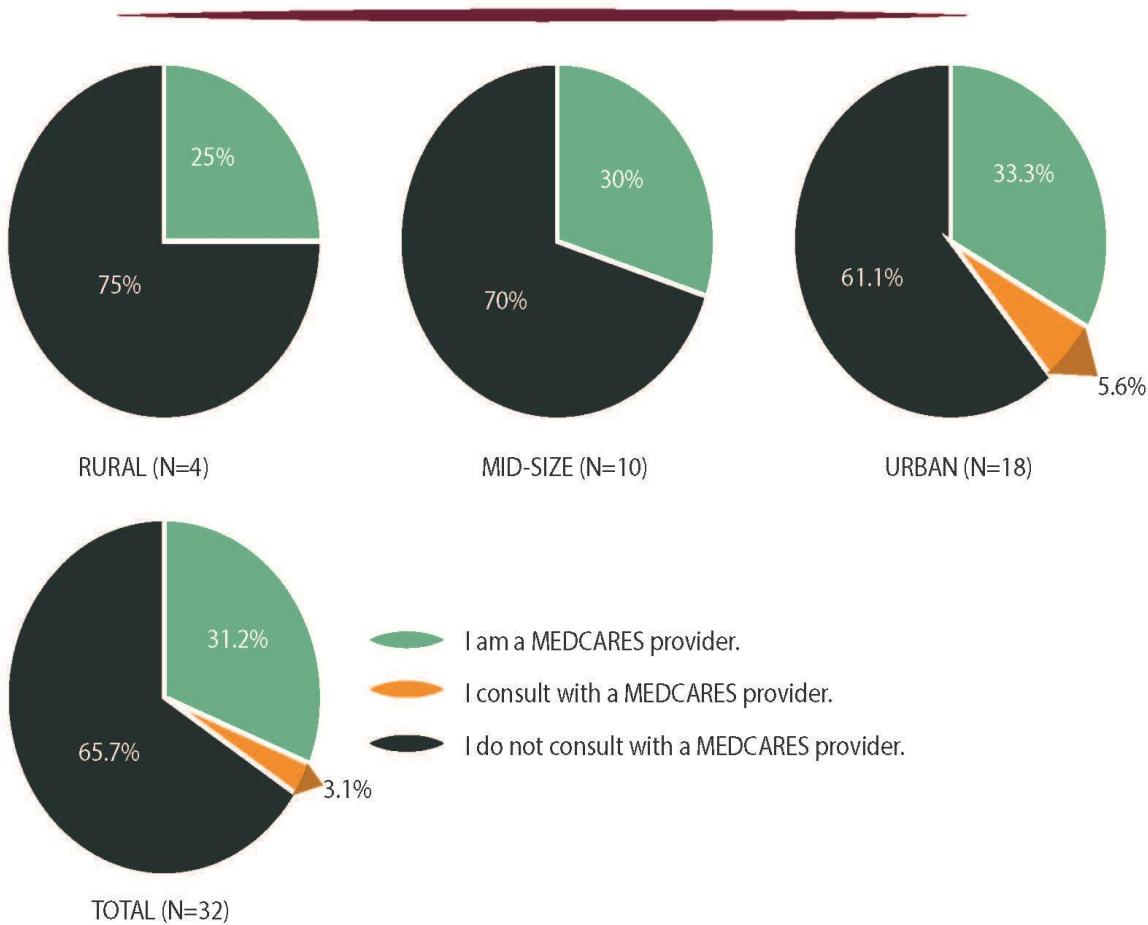
Medical providers. Thirty-two medical professionals completed the survey. The majority of participants were nurses (56%) or doctors (25%). The remaining 19% indicated that they were nurse practitioners. Of the doctors, only 12.5% had a child abuse specialization. Figure 10 below indicates the primary practice setting by community type. The largest number of medical professionals (56.2%) was from large/urban areas. Most of the professionals indicated that their practice setting was “other,” which included a CAC or clinic based setting (21.9% in both mid-sized and large/urban areas). In terms of affiliation with a local hospital, 65.6% of medical professionals indicated they were affiliated with a hospital.

Fig. 10// Medical professionals: Primary practice setting



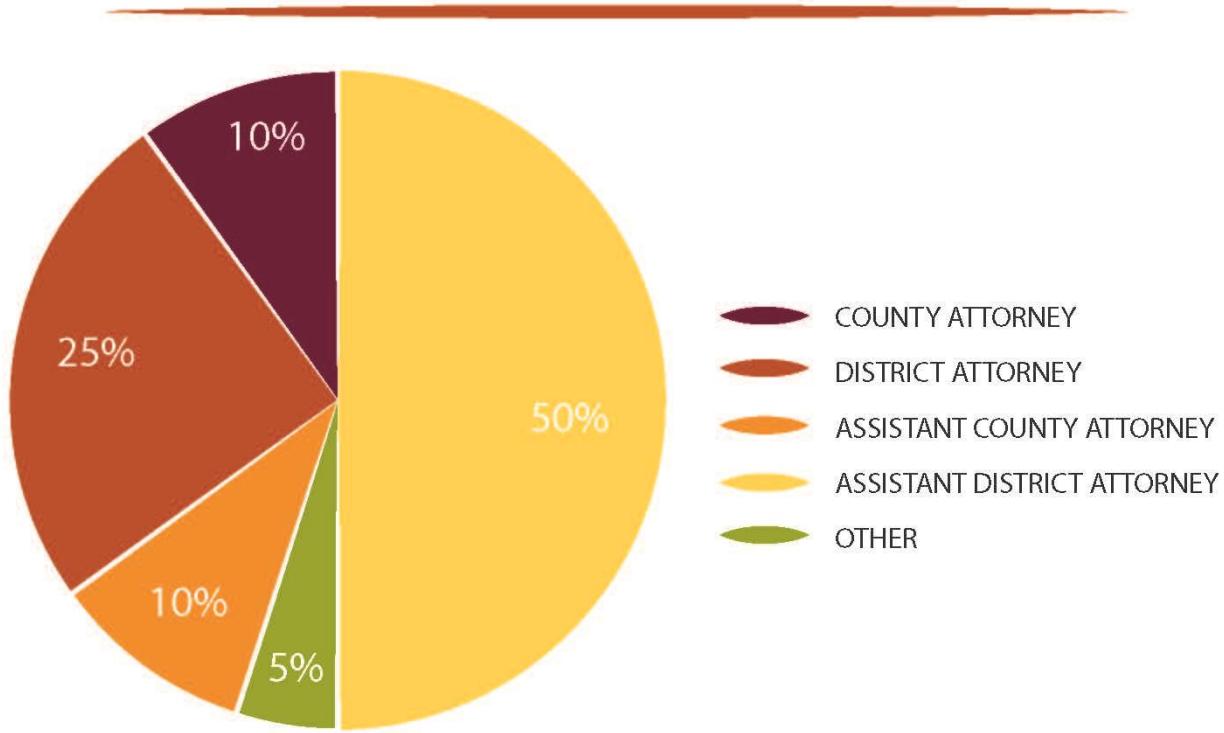
Medical professionals were also asked about MEDCARES. Approximately 31% indicated they were MEDCARES providers. Only 3.1% of medical providers said they consult with a MEDCARES provider while 65.7% said they do not consult with a MEDCARES provider. As seen in Figure 11 below, most of the MEDCARES providers worked in large/urban areas while only one MEDCARES provider indicated they worked in a rural area.

Fig. 11// Medical Professionals: Consultation with MEDCARES medical provider



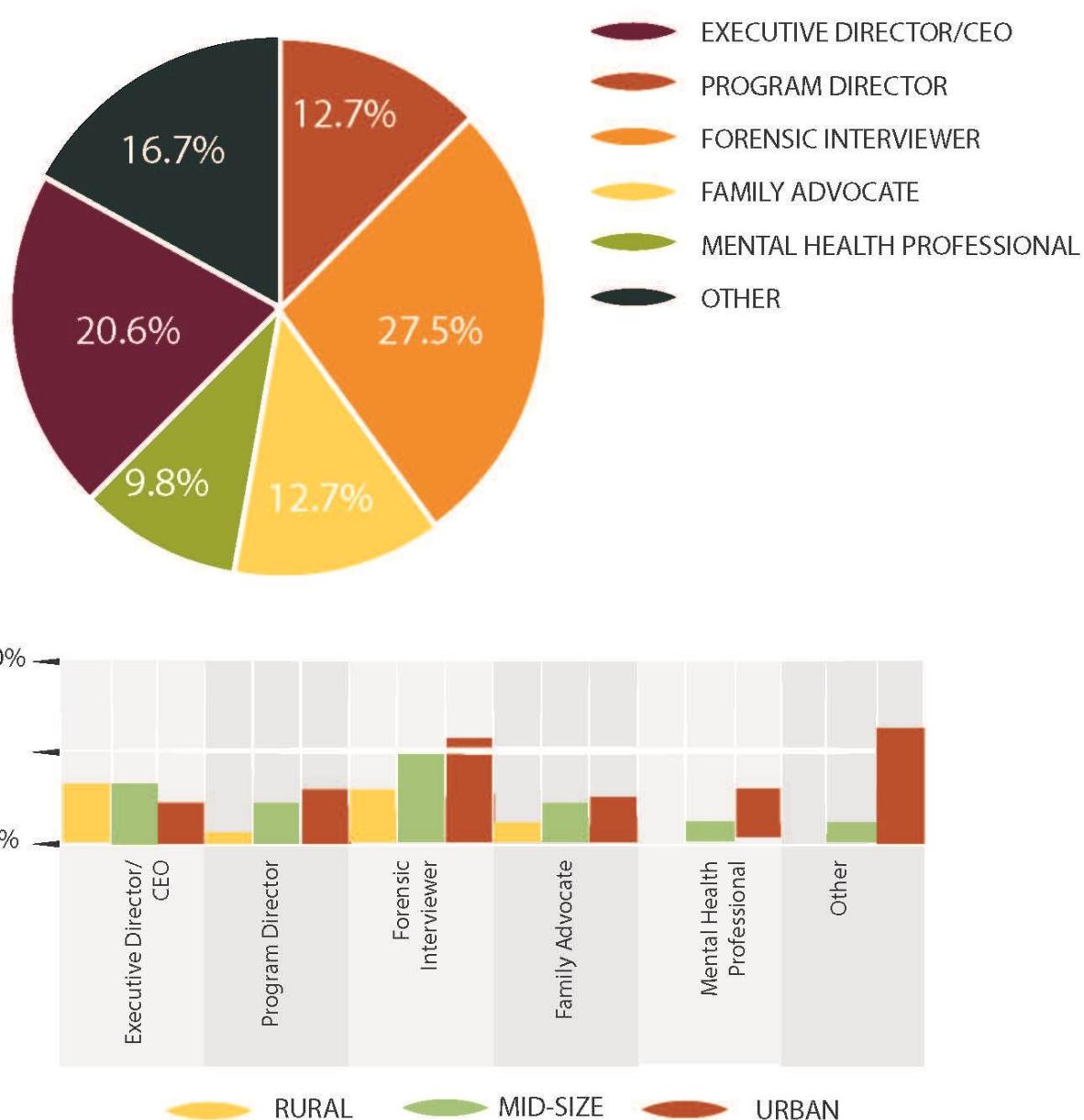
Prosecutors. Prosecutors were the least represented group among survey participants. Of the 20 prosecutors who completed the survey, 50% were Assistant District Attorneys and 25% were Assistant County Attorneys. Figure 12 below indicates the breakdown of prosecutor positions. Half of the prosecutors were from mid-sized areas while 25% were from small/rural and large/urban areas. Only 20% of the prosecutors were part of a specialized child abuse unit.

Fig. 12 // Prosecutors' titles (N=20)



Child Advocacy Center staff. Staff from CACs were the most represented group of participants. A total of 102 staff completed the survey. Half of the staff was from large/urban areas, 32.3% were from mid-sized areas, and 17.7% were in small/rural areas. Of the participating CAC staff, 27% were forensic interviewers and 20% were executive directors. Figure 13 below provides a detailed breakdown of CAC staff by agency position.

Fig. 13 // Current profession within the CAC by community type (N=102)



MEDICAL EVALUATIONS: WHO CONDUCTS AND WHERE?

The online survey was designed to gather information about how medical evaluations are being conducted across the state. Based on the qualitative data collected, there appeared to be varying procedures and protocols for evaluations. Survey findings confirmed some variation in how evaluations are conducted.

Acute sexual abuse evaluations. Figure 14 below details who conducts medical evaluations in different community types, while Figure 15 illustrates where evaluations occur. According to participants, regardless of community type, SANEs conduct most medical evaluations for child abuse victims whose abuse occurred within the previous 96 hours. Eighty-six percent of participants reported that SANE nurses perform these evaluations in their communities. Only a small percentage (6%) of acute evaluations are conducted by forensic nurse examiners (the more general title for nurses doing forensic work, who may or may not have SANE training), emergency room doctors (8%) or private doctors (4%). Doctors with a child abuse specialization conduct 10% of evaluations, but nearly all of these were in large/urban areas.

Fig. 14// Who conducts medical evaluations reported within the 96-hour timeframe?

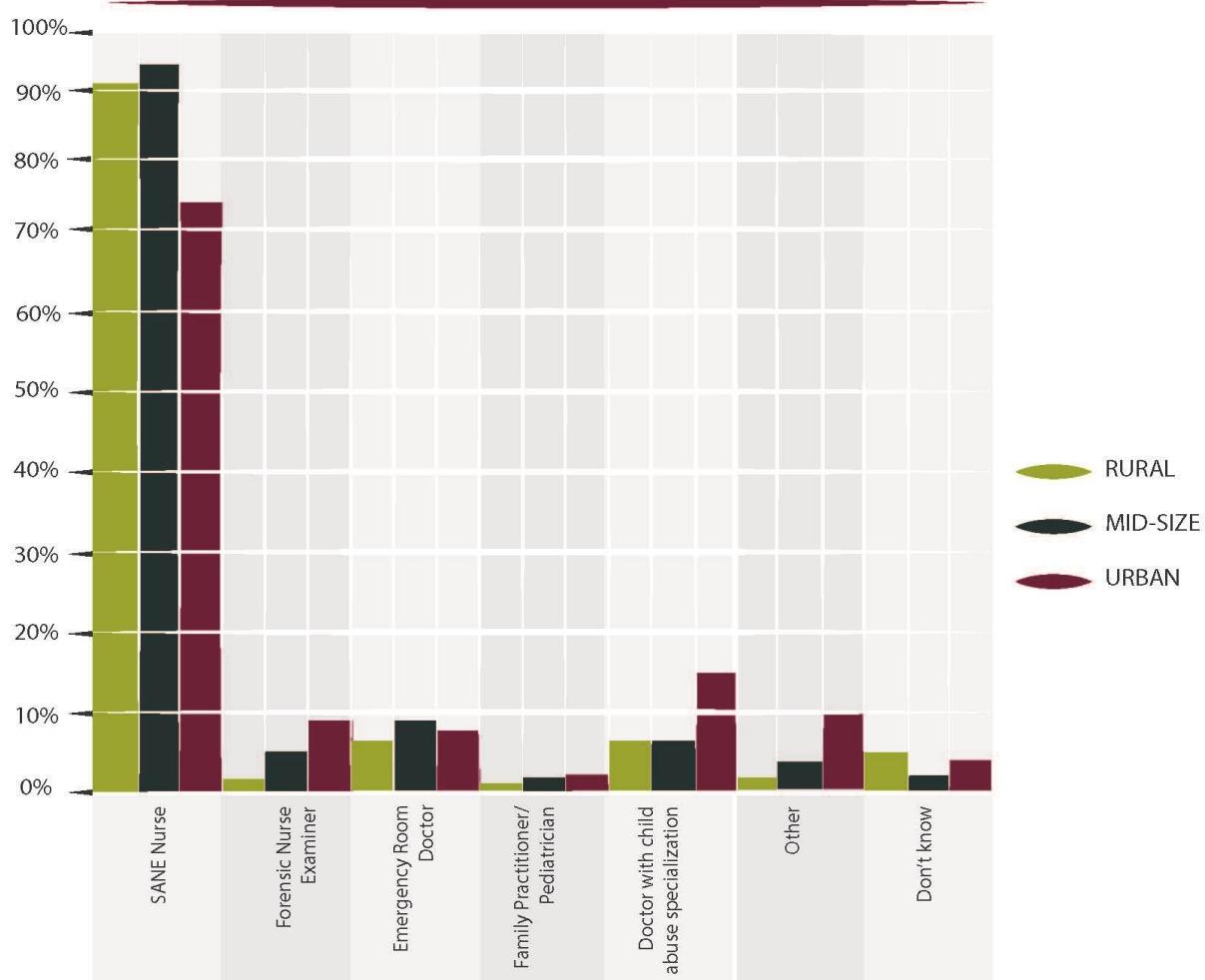
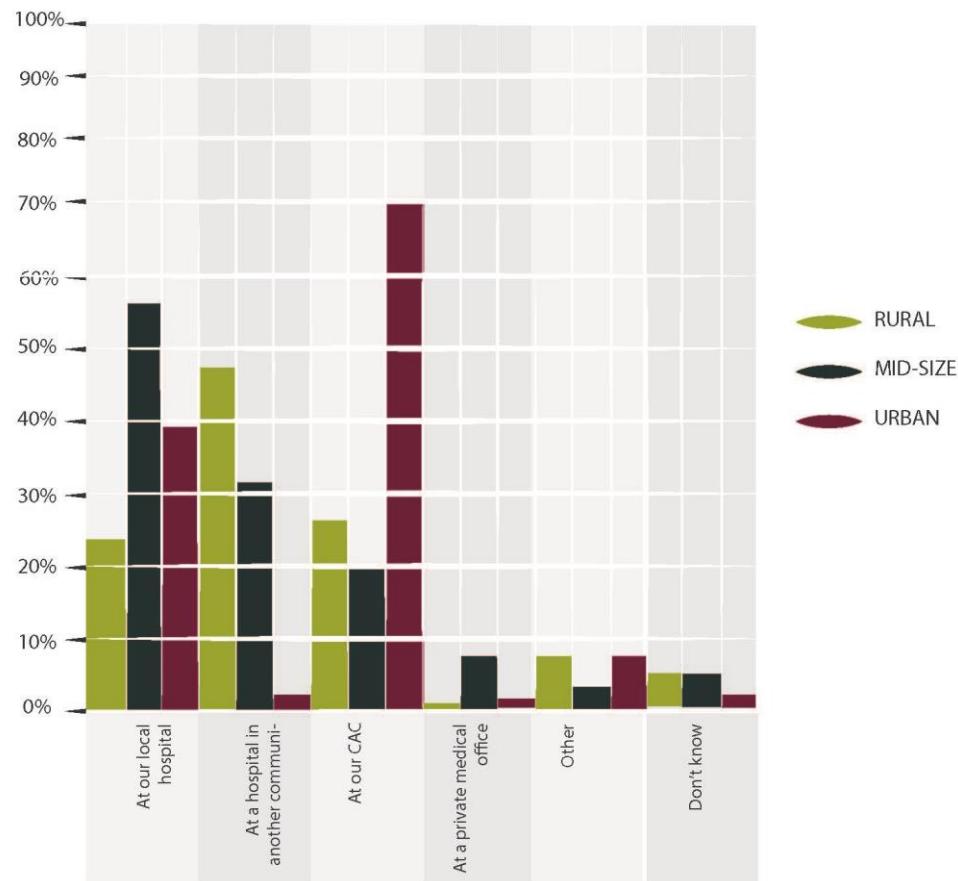


Fig. 15 // Where are sexual abuse medical evaluations conducted when they are reported within 96-hour timeframe?



In large/urban areas, the majority of acute sexual abuse evaluations are conducted at local hospital while in small/rural areas, the majority these evaluations are conducted at hospitals in another community. In terms of evaluations conducted at CACs, large/urban areas appear to have the most capacity for conducting medical evaluations at their CACs.

Non-acute sexual abuse evaluations. In addition to acute sexual abuse evaluations, participants were asked questions regarding non-acute evaluations for sexual abuse victims. Figure 16 on the following page details who conducts medical evaluations in different community types while Figure 17 illustrates where exams occur. As with acute evaluations, medical evaluations for child abuse victims whose abuse occurred after 96 hours are primarily conducted by SANE nurses regardless of the community type; 69% of participants reported that SANE nurses perform non-acute evaluations in their communities. Unlike with acute evaluations, fewer non-acute evaluations in large/urban areas are conducted by SANEs (54%) because doctors with child abuse specialization conduct 29% of these evaluations.

In urban areas, non-acute evaluations appear to primarily occur at CACs. Evaluations in suburban areas occur at local hospitals and evaluations in rural areas occur at hospitals in other communities.

Fig. 16 // Who conducts medical evaluations reported after the 96-hour timeframe?

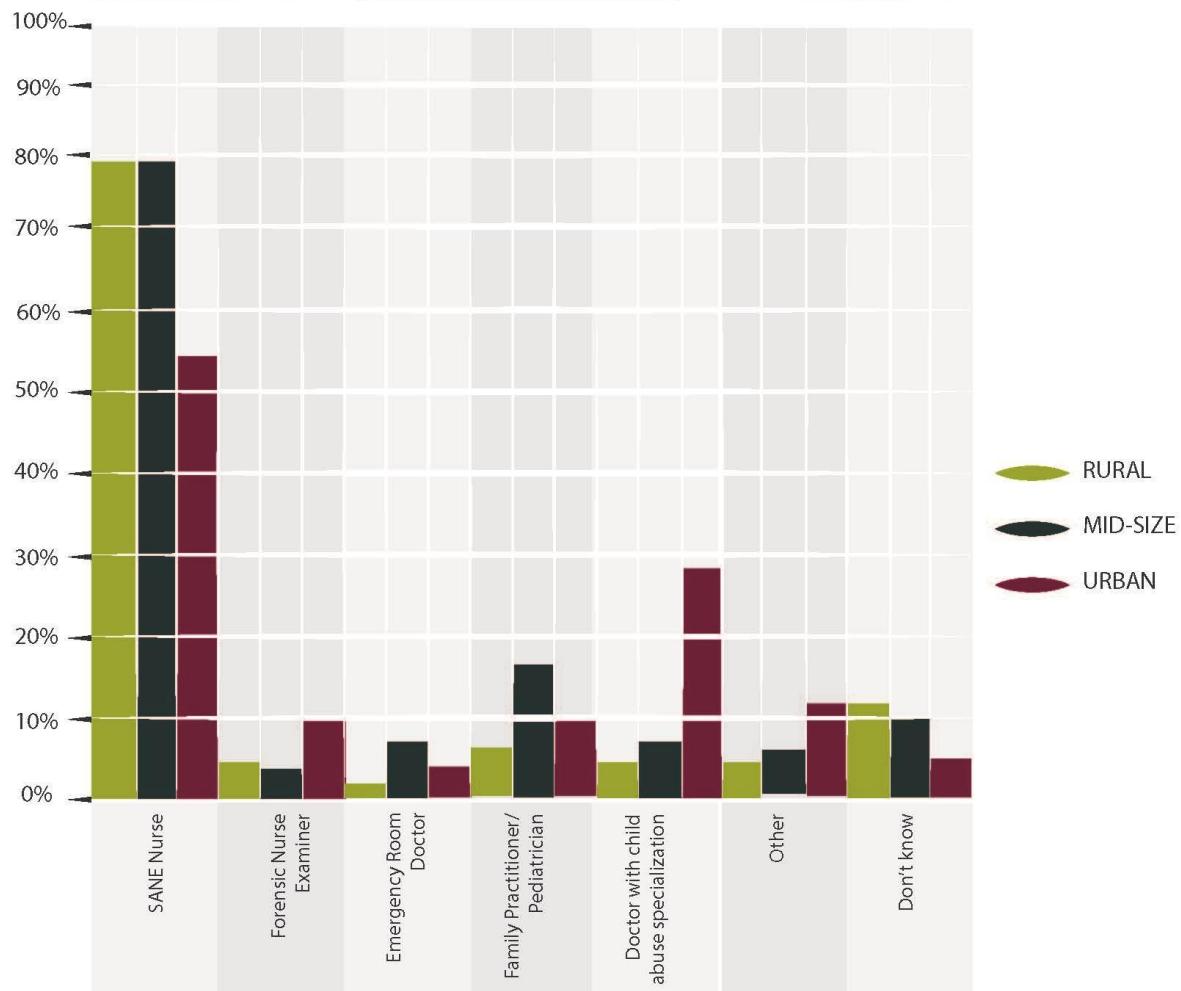
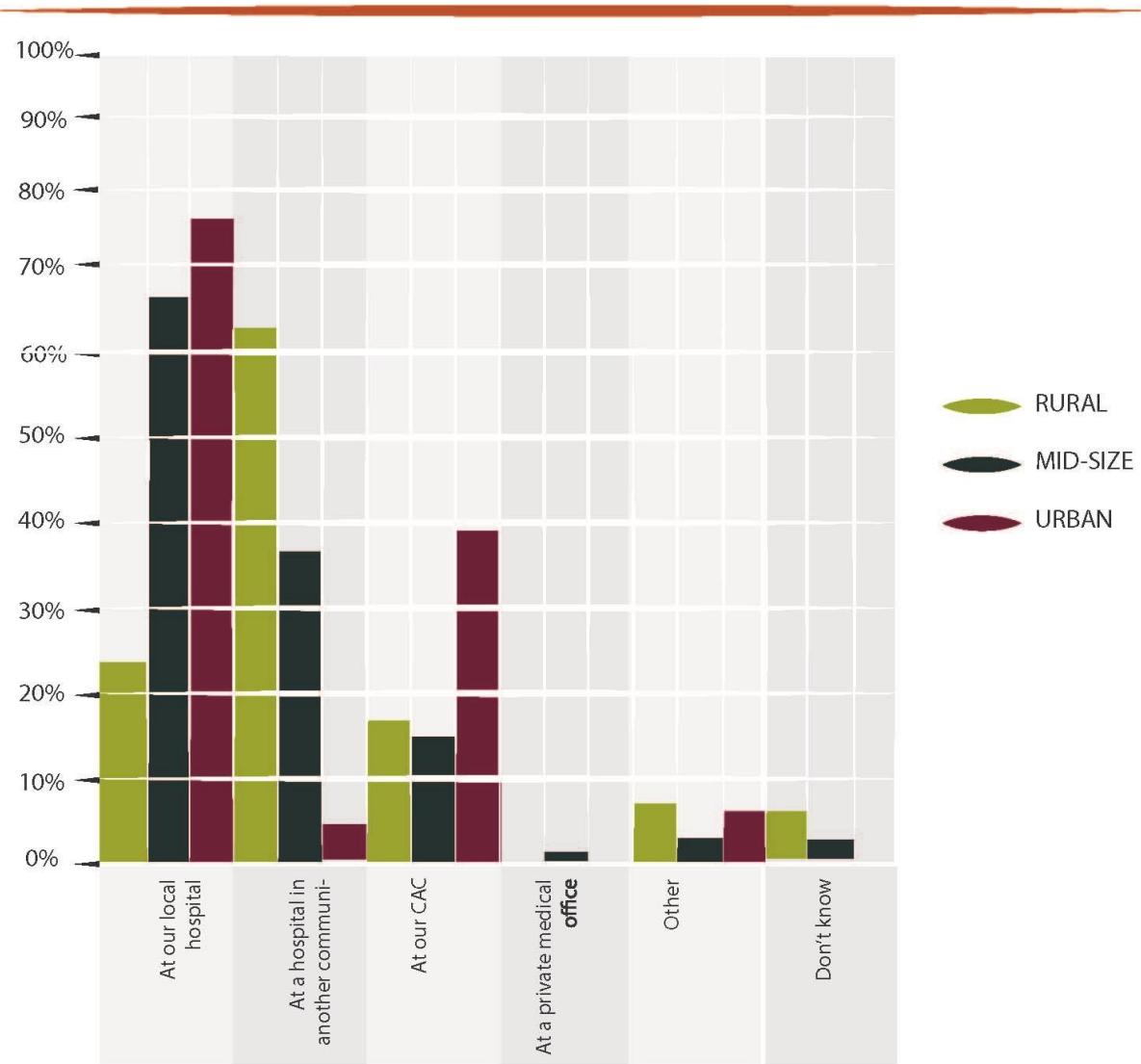


Fig. 17// Where are medical evaluations conducted after the 96-hour timeframe?



Physical abuse evaluations. Despite the fact that focus group participants discussed evaluations for physical abuse victims much less frequently, the online survey asked participants where physical abuse victims received evaluations. There was some variation among participants regarding who conducts evaluations, but the variation does not appear to differ greatly by community type. For instance, 49% of physical abuse evaluations are conducted by emergency room doctors. In small/rural areas, 63% of these evaluations are conducted by emergency room doctors while 41% are conducted by private doctors. Perhaps the most surprising finding was that 17% of respondents did not know who conducted physical abuse evaluations in their areas.

In terms of where these evaluations are conducted, the majority are conducted at local hospitals regardless of community type. Similar to the findings discussed above for sexual abuse evaluations, large/urban areas appear to have the most capacity to conduct evaluations at their CACs.

Fig. 18// Who conducts medical evaluations for reported physical abuse?

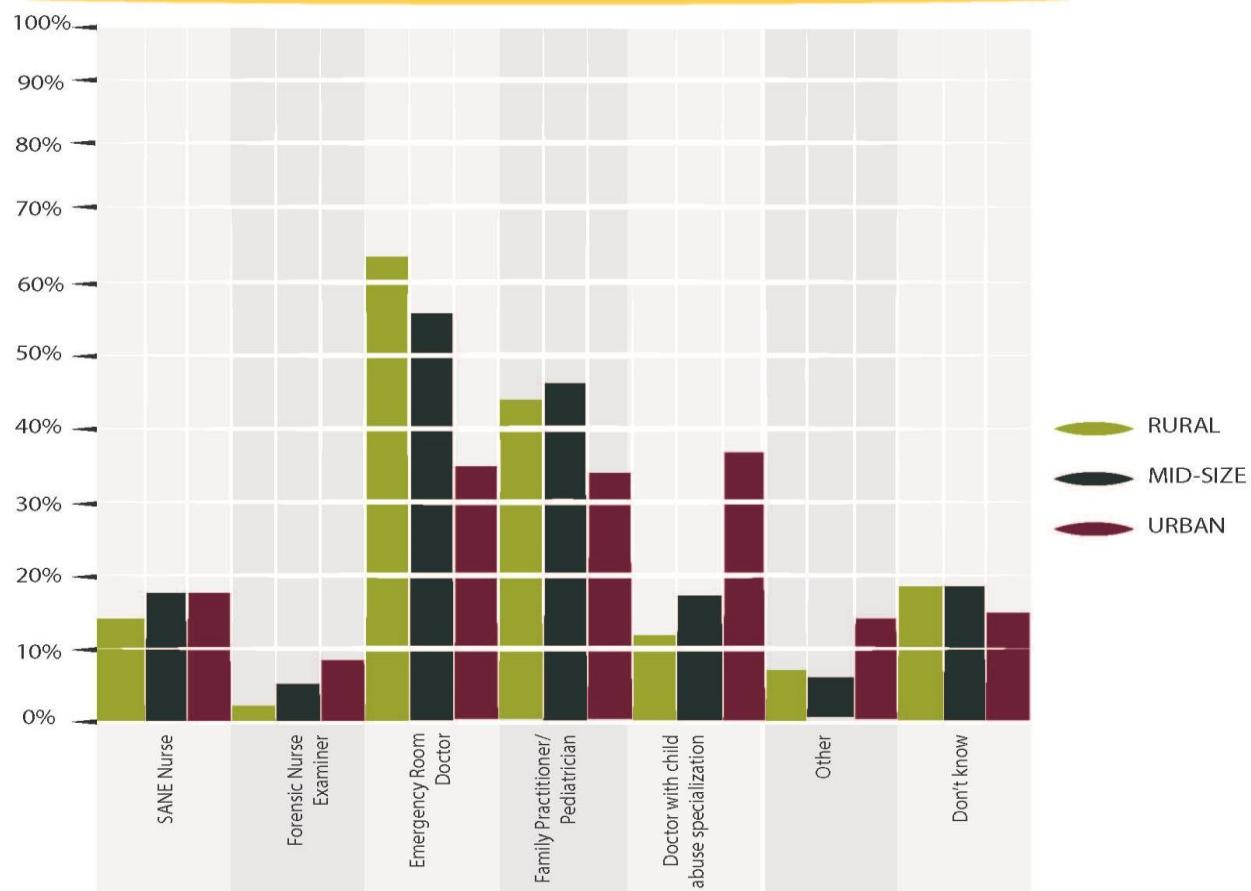
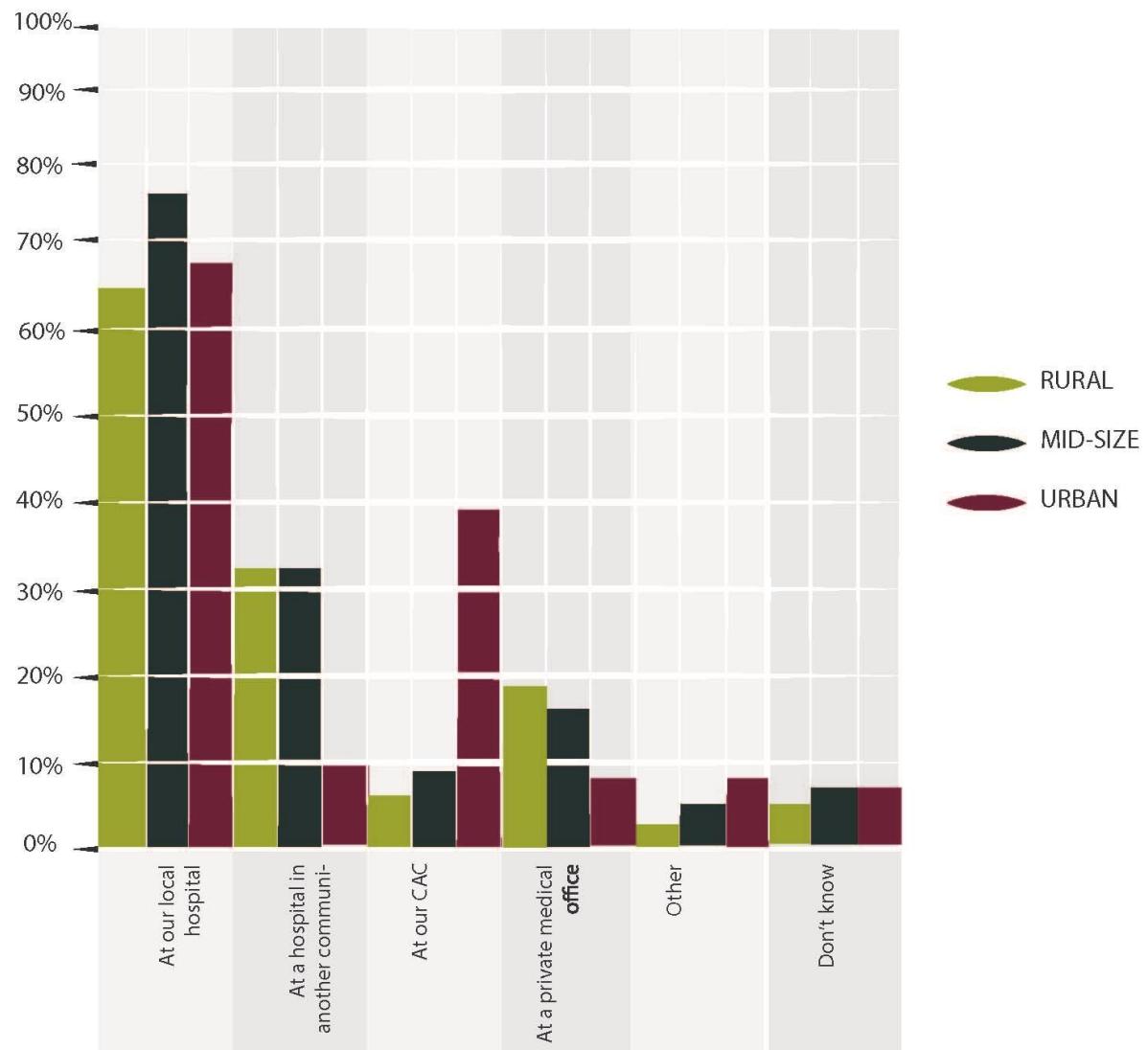


Fig. 19// Where are medical evaluations conducted for reported physical abuse?

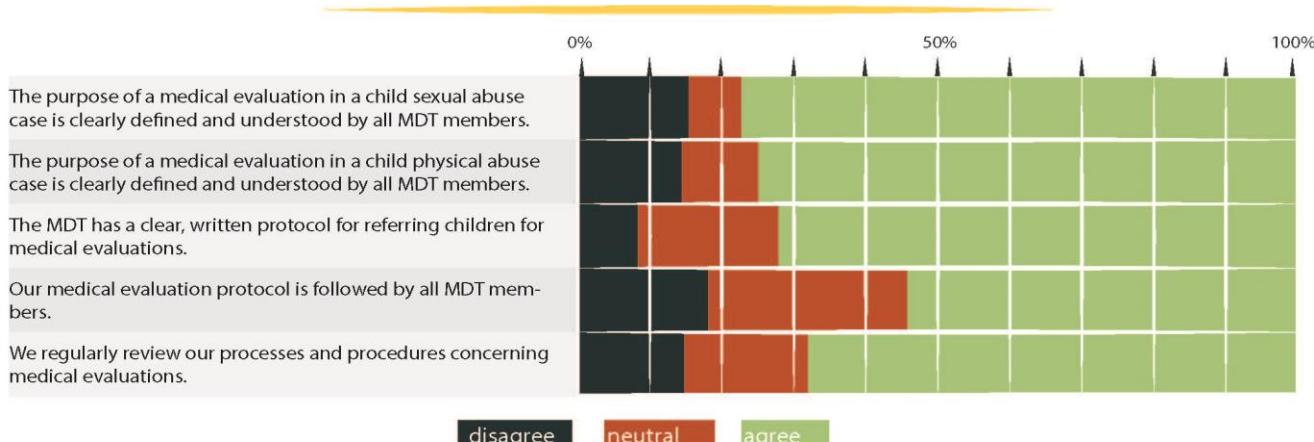


MEDICAL EVALUATIONS & THE MDT

Additional questions were asked of participants to understand how their MDTs make decisions and process case information related to medical evaluations.

Medical evaluation protocols. Figure 20 below illustrates participant responses to questions related to medical evaluations. Participants were asked to read statements and rate their level of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree. For the purposes of presenting these findings, responses were collapsed into three categories: disagree, neutral and agree. Most participants responded that they agreed that their MDT has a written protocol for medical evaluations (71.7%) and that they understand the purpose of evaluations for physical abuse victims (75.3%) and sexual abuse victims (77.7%). However, just over half of the participants agreed that their MDT has a protocol that is followed by all members (54.9%).

Fig. 20// Medical evaluations: Purpose and procedures



Importance of medical evaluations. Figures 21 and 22 illustrate participant responses to questions about the importance of medical evaluations. Because focus group participants tended to discuss the importance of medical evaluations differently based on their professional background, several survey questions addressed the reasons MDT members think evaluations are important. Figure 21 below presents the top response categories by community type. This Figure shows that while small/rural and mid-sized areas frequently cited additional outries as an important reason for medical evaluations, this was not so in large/urban areas.

Fig. 21// Medical Evaluations: Importance by community type

RURAL

- Additional outcries or disclosures may be made by a child during the evaluation. (98.1%)
- Children get tested for sexually transmitted diseases. (94.2%)
- Children are reassured that their bodies are okay. (92.2%)

MID-SIZE

- Additional outcries or disclosures may be made by a child during the evaluation. (96.4%)
- Children get tested for sexually transmitted diseases. (94.6%)
- Evaluations assist with forensic evidence gathering. (96.4%)
- Information obtained during the evaluation is not considered hearsay in criminal proceedings. (94.6%)

URBAN

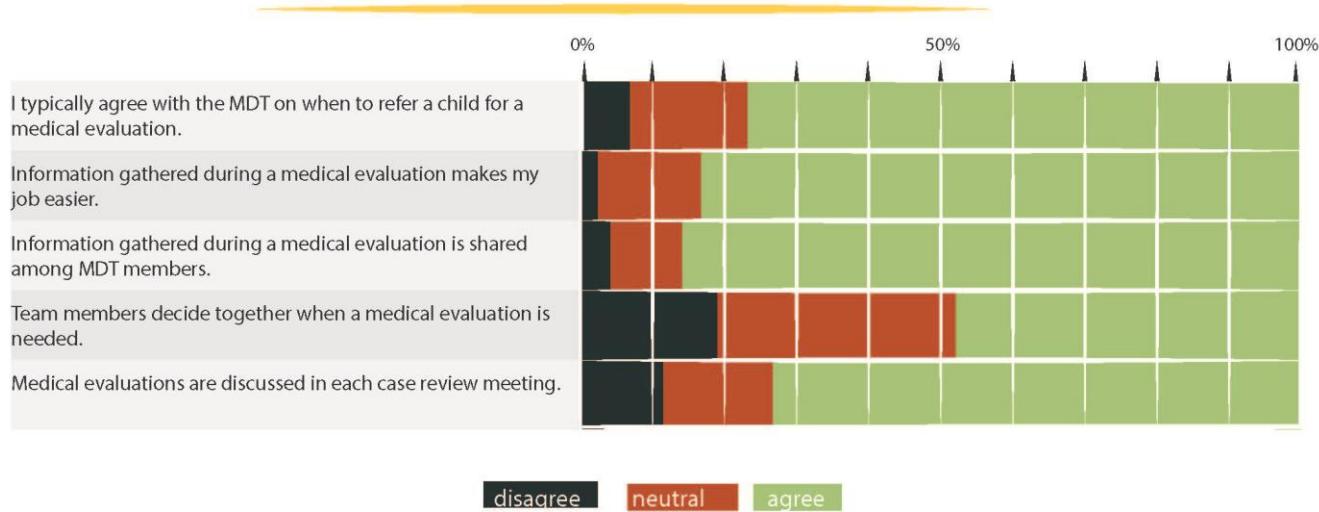
- Evaluations assist with forensic evidence gathering. (97.2%)
- Children get tested for sexually transmitted diseases. (93.6%)
- Children are reassured that their bodies are okay. (97.2%)

Fig. 22// Medical evaluations: Importance



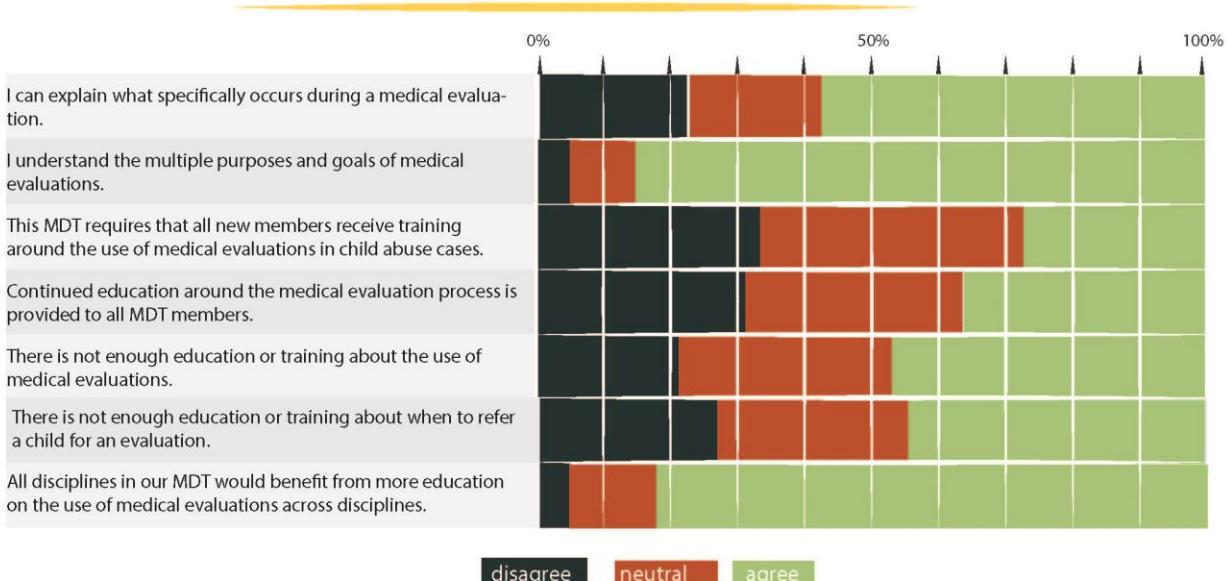
Collaboration regarding medical evaluations. Figure 23 below illustrates participant responses to questions related to how their MDT works together to obtain medical evaluations and make use of the data gathered. Most participants responded that medical evaluations make their jobs easier (81.8%) and that the information from medical evaluations is shared with the MDT members (86.0%). While most participants said they agreed with their team members about when an evaluation was necessary (77.6%), only 48.3% said that the MDT decides together who should get a medical evaluation.

Fig. 23// Medical evaluations: Collaboration



Training regarding medical evaluations. Figure 24 on the following page illustrates participant responses to questions related to training and education regarding medical evaluations. Interestingly, most participants said they understood the purpose of a medical evaluation (87%); however, only 58.2% believed they could describe what happens during an evaluation. Furthermore, most participants (81.7%) felt their MDT would benefit from additional training and only 35.8% agreed that training on medical evaluations was available to all MDT members.

Fig. 24// Medical evaluations: Education and training

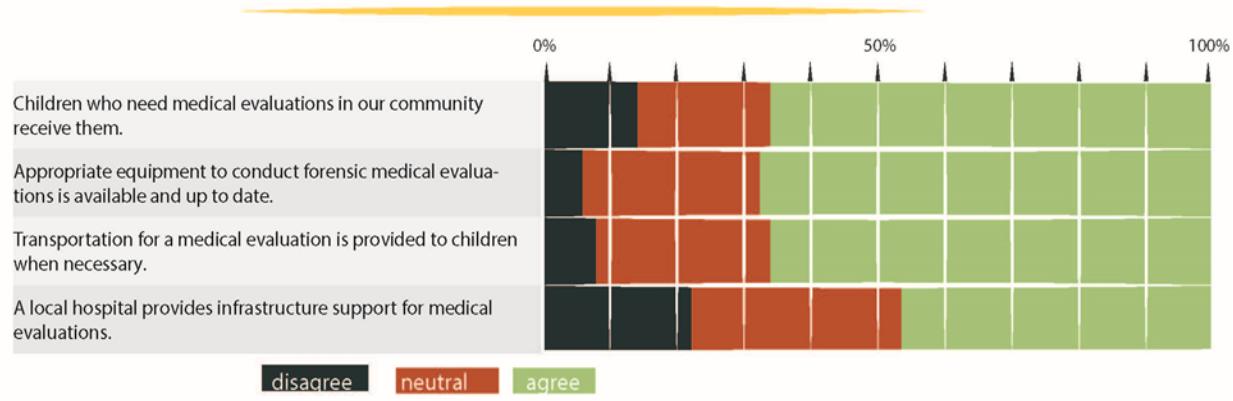


BARRIERS TO MEDICAL EVALUATIONS

Because the primary purpose of this study is to understand factors contributing to the low rates of evaluations in the state, information from focus groups was used to develop questions to obtain information about barriers to medical evaluations. Participants were asked to read statements and rate their levels of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree.

Access to medical evaluations. Figure 25 below illustrates participant responses to questions related to medical evaluations and issues of access. Less than half of participants (47.2%) agreed that their community had a local hospital that provides infrastructure support for medical evaluations. Most participants agreed that transportation (66.2%) and appropriate medical equipment (68%) was available in their area. In general, 66.7% of participants agreed that children who needed medical evaluations were receiving them.

Fig. 25// Medical evaluations: Access



Medical evaluation barriers. Figures 26 and 27 illustrate participant responses to additional questions related to barriers to medical evaluations. Unlike results discussed above, these questions were negatively phrased as a reliability check on the positively-phrased questions. Figure 26 below summarizes the barriers highlighted by participants in differing community types. In all areas, lack of hospital support was one of the top three barriers as was law enforcement not authorizing medical evaluations. In small/rural areas, specifically, lack of qualified medical professionals was often noted as a barrier.

Fig. 26// Medical evaluation barriers: Top responses by community type

RURAL

The local hospital is not supportive of a SANE program (34.0%).

Qualified medical professionals are not available to provide evaluations (21.6%).

Law enforcement does not want to authorize an evaluation (20.0%).

MID-SIZE

The local hospital is not supportive of a SANE program (22.1%).

The local hospital is not supportive of child abuse programs (15.8%).

Law enforcement does not want to authorize an evaluation (14.2%).

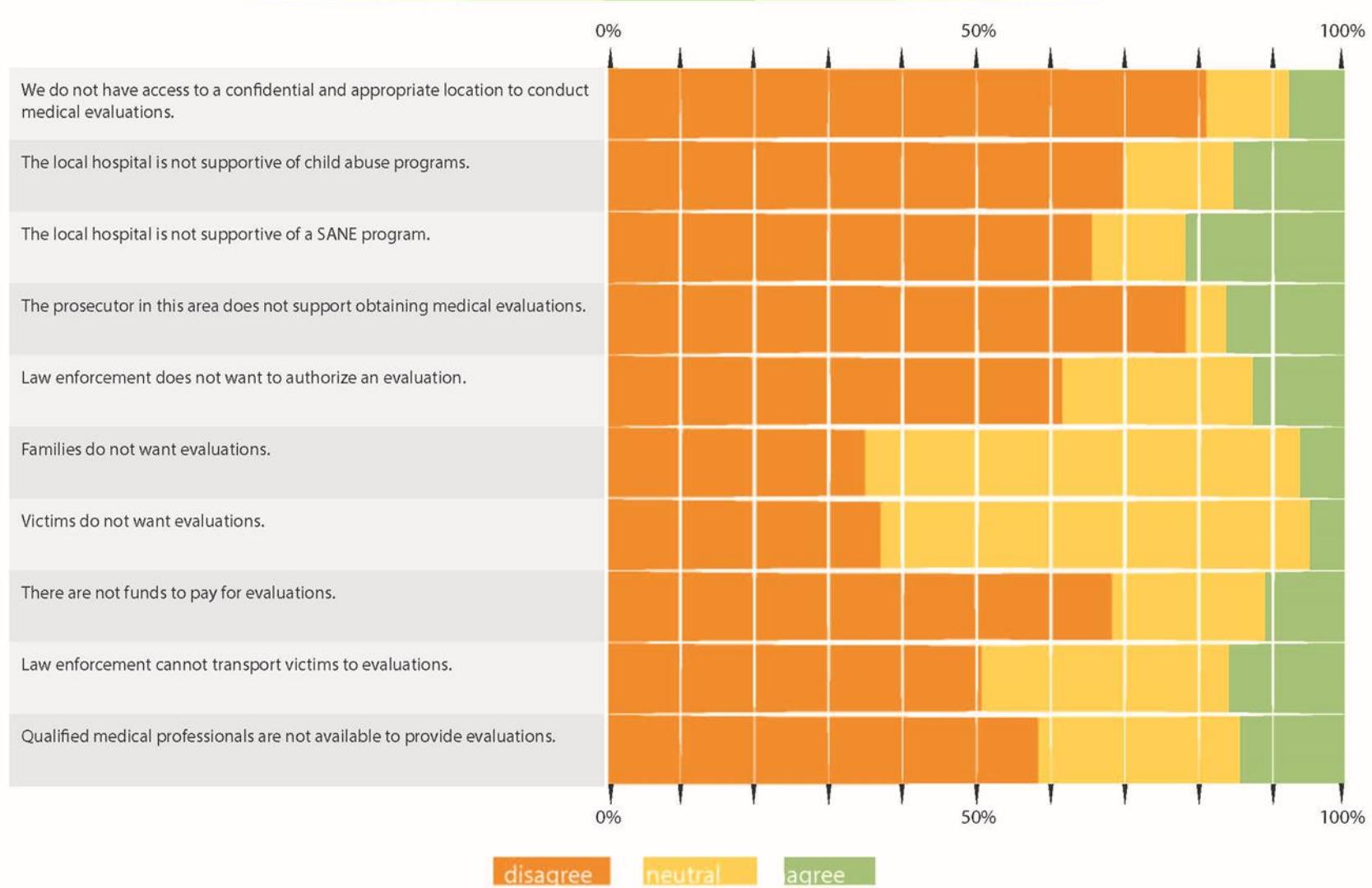
URBAN

Law enforcement does not want to authorize an evaluation (15.2%).

The local hospital is not supportive of a SANE program (14.8%).

There are not funds to pay for evaluations (13.9%).

Fig. 27// Barriers to getting medical evaluations



Improvements to medical evaluations. Figure 28 summarizes participant responses to questions about ways to increase rates of medical evaluations. The most common responses appear to be related to payment structure and the top recommendation is that hospitals should not charge more than the reimbursement rate for evaluations. Additional recommendations are that hospitals should offer more support to SANE programs and communities should have more qualified providers to conduct evaluations. Finally, training is needed regarding medical evaluations.

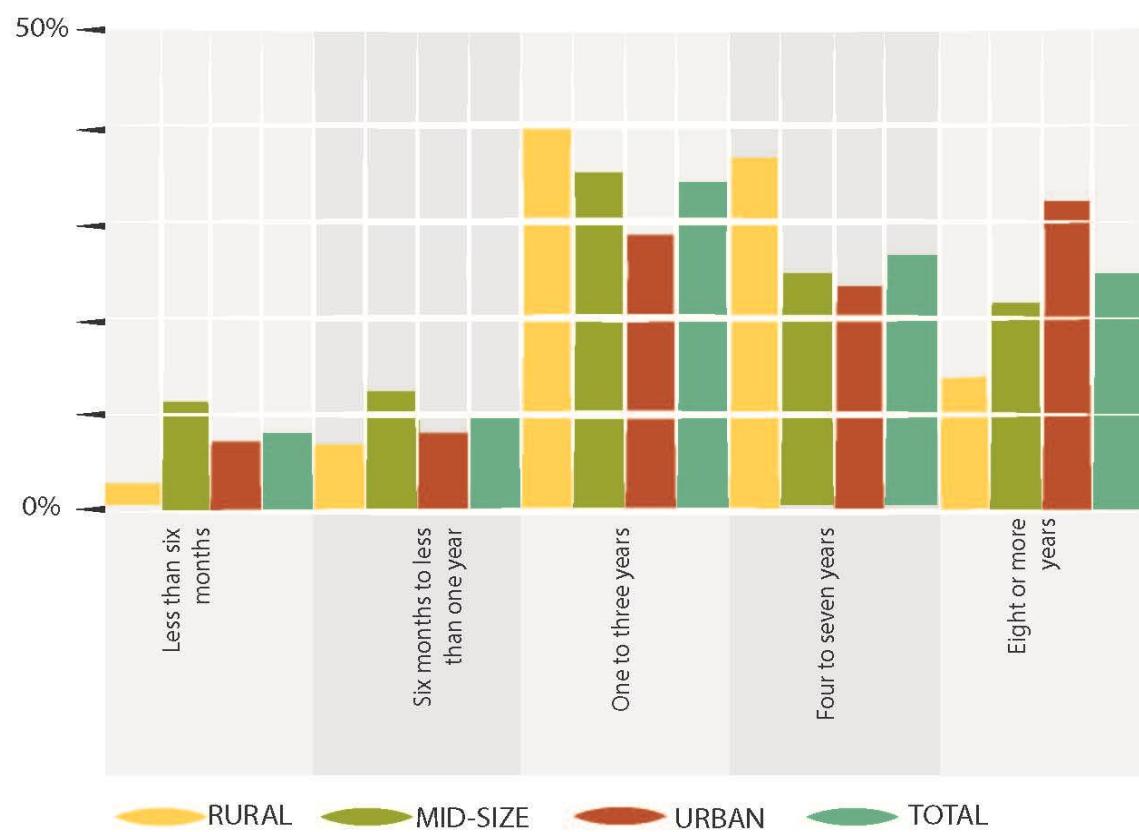
Fig. 28// How important are the following factors in improving medical evaluations for child abuse?



MDT COMPOSITION

Survey participants were asked information about their MDT and their participation in the MDT. Of those participants who responded, the majority had been participating in their MDT for one or more years. Figure 29 below shows the amount of time survey participants had been participating in their MDT.

Fig. 29// Length of time participating in the MDT by community type



Child abuse training. Survey participants were also asked if they had received any training or education regarding child abuse issues prior to participating in their MDT. Overall, most participants indicated they had training and/or education in child abuse issues. However, only 60% of prosecutors indicated they had prior training on child abuse issues.

MDT Case Review Facilitation. Survey participants were asked who facilitated their MDT case reviews. The majority of participants (84.5%) responded that their CAC staff facilitated their case reviews. Some participants indicated that their MDT was facilitated by prosecutors (13.4%), law enforcement (5.2%), medical providers (1.0%) or CPS workers (3.3%). Participants could choose more than one option as a response to this question. Thus, percentages do not add up to 100% and suggest that MDTs may be co-facilitated by different professionals.

Law enforcement participation. All survey participants were asked to identify who participated in their MDT case review meetings. Table 2 below indicates law enforcement positions represented on the MDT by community type. In terms of law enforcement, detectives from either police or sheriff's departments were the most represented professionals. Small/rural areas were more likely to have professionals in upper management positions participate in MDTs as indicated by higher participation by police chiefs, police chief deputies and Sheriffs in these areas. Representation from constable's offices was rare across all community types. Some participants indicated other law enforcement agencies participated in their MDTs, such as school district police, district attorney investigators, juvenile probation officers, Texas Rangers, and Department of Public Safety officers.

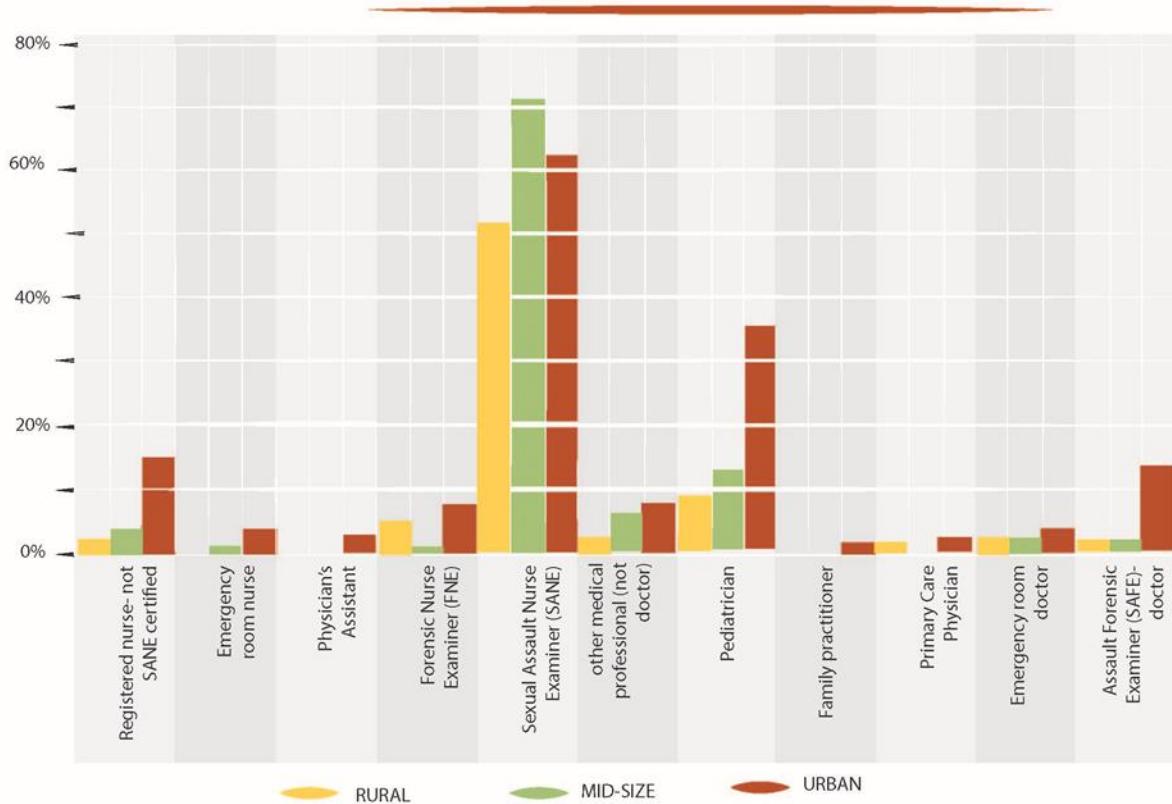
Table 2// Law enforcement MDT participation by community type

	% Rural	% Mid-size	% Urban	% Total
Police Officer, Deputy, or Corporal	33.3	32.5	27.6	30.6
Police Detective, Inspector, or Investigator	82.4	90.2	89.8	88.7
Police Sergeant, Lieutenant or Captain	41.2	43.9	44.1	43.5
Assistant or Deputy to the Chief of Police	23.5	7.3	4.7	9.0
Chief of Police/Police Commissioner	45.1	9.8	8.7	15.3
Sheriff's Officer, Deputy, or Corporal	25.5	27.6	14.2	21.6
Sheriff's Detective, Inspector, or Investigator	74.5	78.9	67.7	73.4
Sheriff's Sergeant, Lieutenant or Captain	11.8	29.3	21.3	22.9
Sheriff's Assistant	3.9	2.4	0	1.7
Sheriff	11.8	10.6	5.5	8.6
Constable's Officer, Deputy, or Corporal	7.8	0	2.4	2.3
Constable's Detective, Inspector, or Investigator	0	0.8	0.8	0.7
Constable's Sergeant, Lieutenant or Captain	0	0	0	0
Constable's Assistant	0	0	0	0
Constable	0	0	0.8	0.3

*Amounts represent the percent of respondents who indicated they had specific law enforcement professionals participating on their MDT

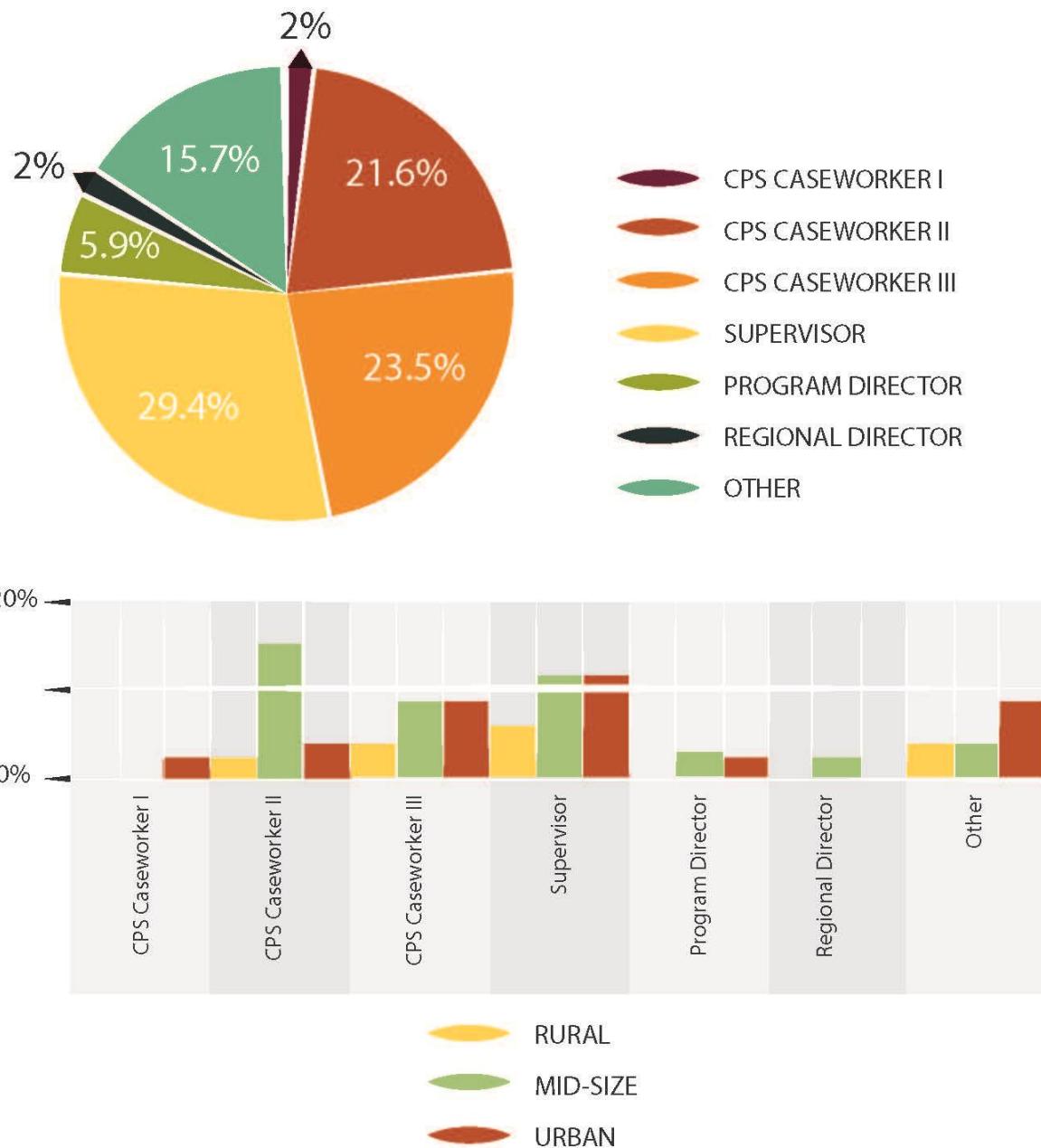
Participation by medical professionals. Figure 30 below shows the percentage of respondents who noted that specific medical professionals participate in their MDTs. Across community types, SANEs were the group with the highest reported rates of participation on MDTs. A higher percentage of pediatricians participated in large/urban MDTs compared to mid-sized and small/rural areas. Participants who indicated that “other” medical professionals participated on their MDT noted that these professionals were pediatric nurse practitioners, hospital representatives and medical social workers.

Fig. 30// Medical professional MDT participation by community type



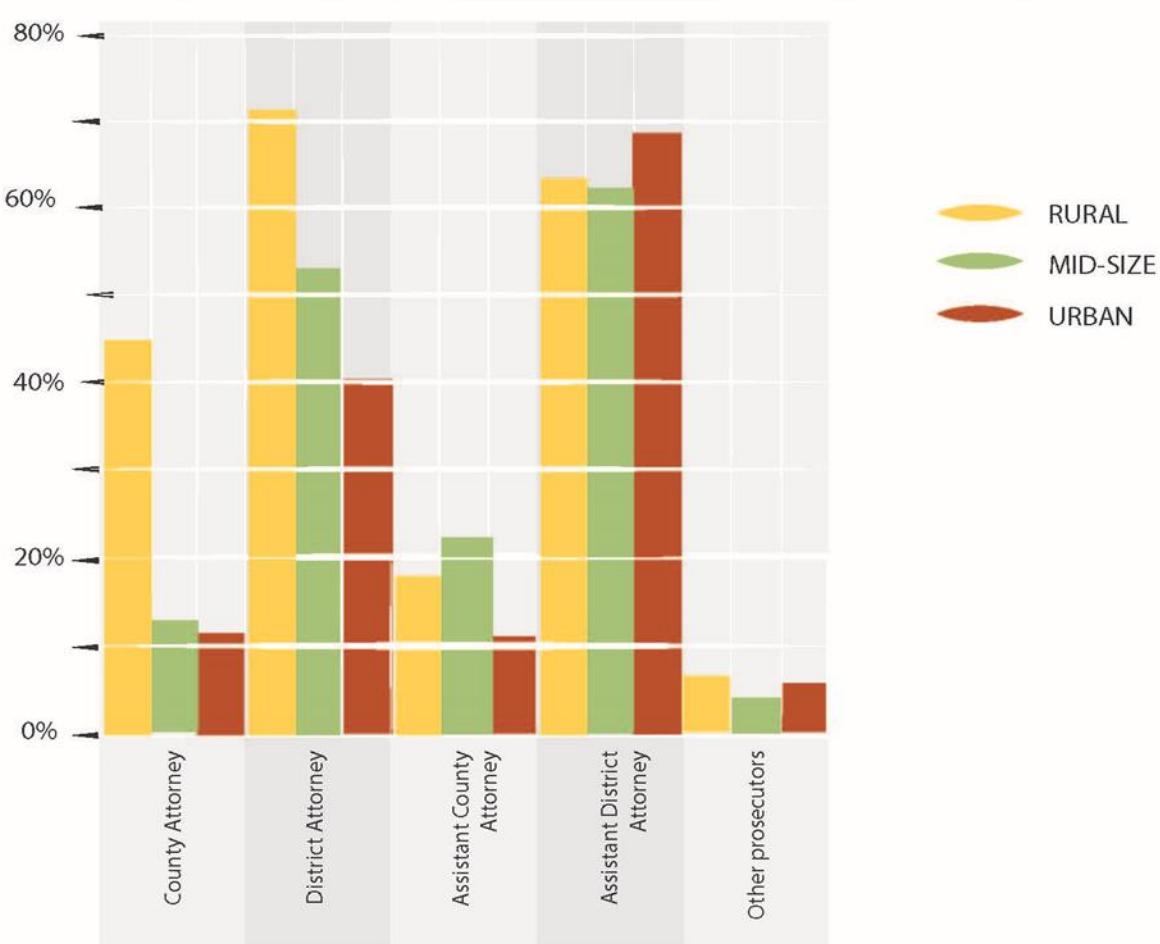
Child Protective Services participation. Figure 31 on the following page shows the percentage of respondents who noted that specific CPS workers participate in their MDTs. CPS caseworkers participated in MDTs in all community types. As areas increased in population, they had higher percentages of upper level administrators participating in MDTs. For instance, 4.7% of participants from large/urban areas indicated that a regional director participated on their MDT and 35.4% indicated that a program director participated in their MDT. These rates of supervisory participation were lower for mid-sized and small/rural areas where caseworkers might be more accessible to the MDT. Other CPS staff who participate in MDTs included investigators, conservatorship workers and/or family-based services workers.

Fig. 31 // CPS MDT participation by community type



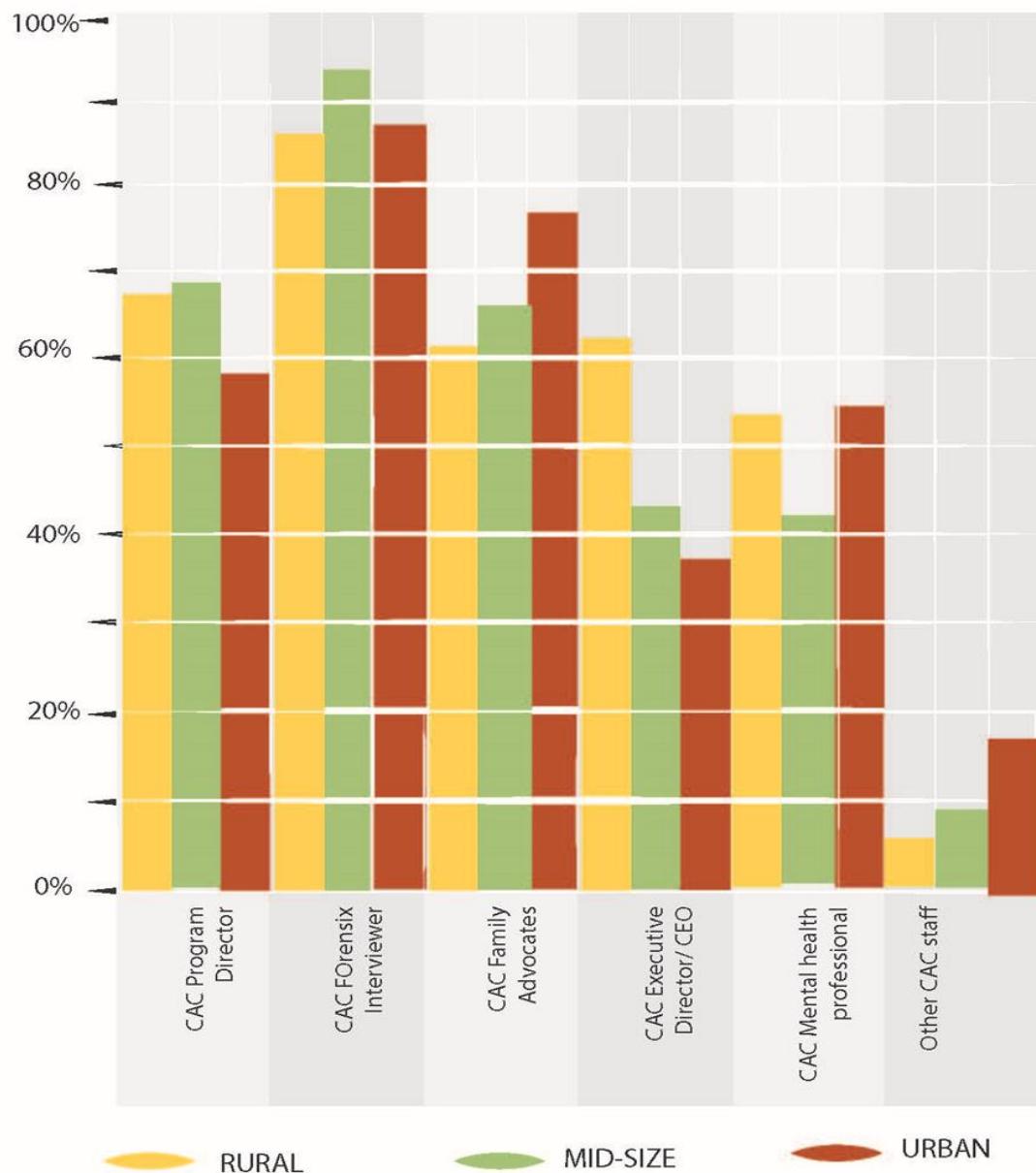
Prosecutor participation. Figure 32 below shows the percentage of respondents who noted that specific prosecutors participate in their MDTs. Across community types, participants identified high percentages of District Attorneys and Assistant District attorneys who participated in their MDTs. County Attorneys and Assistant County Attorneys were more likely to participate in rural areas. In the “other” category, participants noted that CPS prosecutors, victim’s assistance coordinators and other agency representatives participated in their MDTs.

Fig. 32// Prosecutor MDT participation by community type



CAC staff participation. Table 33 below shows the percentage of respondents who noted specific CAC staff participate in their MDT. Participants reported high percentages of forensic interviewers who participate in their MDTs. Program directors were also frequently reported as MDT participants. Participants who listed “other” staff indicated that CAC interns and coordinators also participated in their MDT. In addition to CAC mental health professionals, 20% of participants indicated that mental health professionals not employed by the CAC participate in the MDT.

Fig. 33// CAC MDT participation by community type

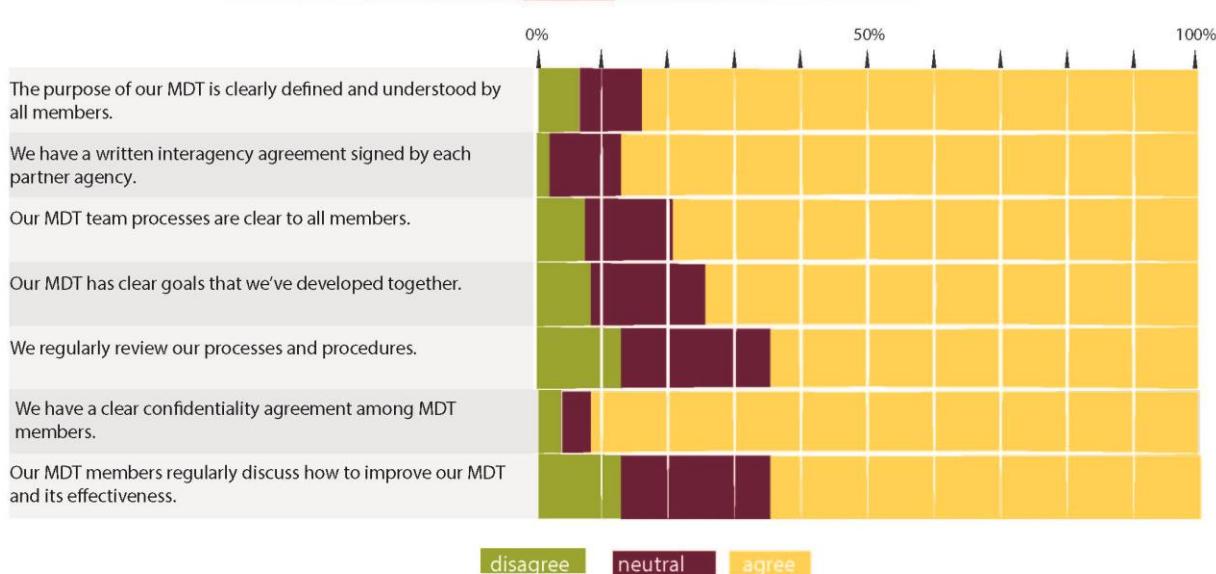


MDT TEAM FUNCTIONING

Survey participants were asked a series of questions about their MDT's functioning. The primary purpose of these questions was to understand how the functioning of the MDT may impact the completion of medical evaluations. Participants were asked to read statements and rate their level of agreement on a five-point Likert-type scale ranging from strongly agree to strongly disagree. For the purposes of presenting these findings, responses were collapsed into three categories: disagree, neutral and agree.

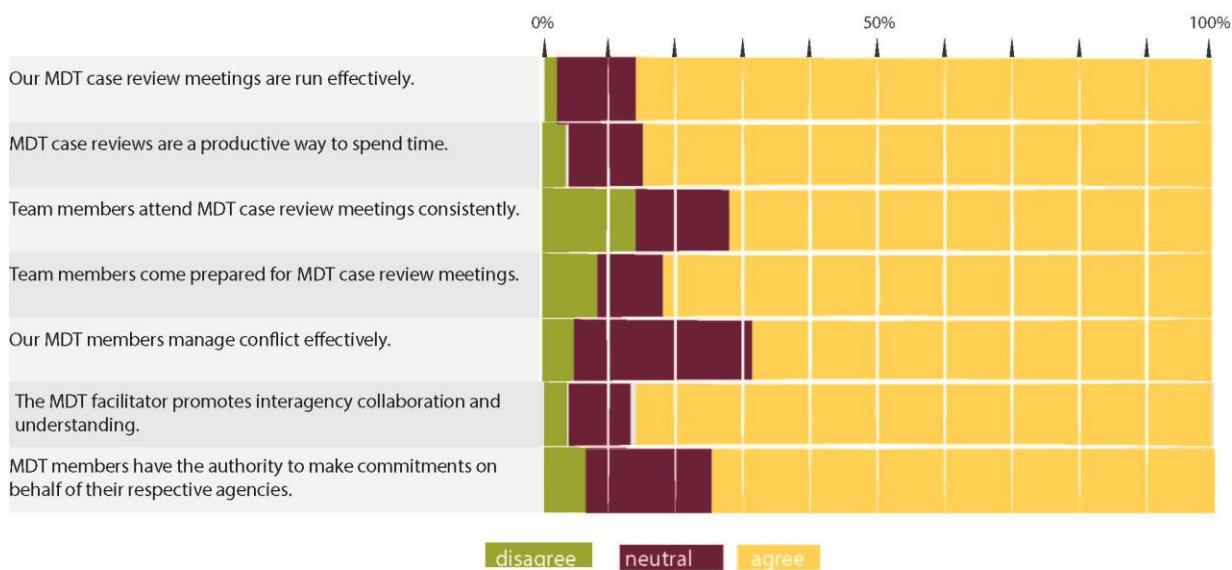
MDT Purposes and Procedures. Figure 34 below shows the percentage of responses related to MDT purposes and procedures. In general, participants agreed with statements suggesting that their MDTs have clear purposes and procedures. A large percentage of participants (90.6%) agreed that their MDT had clear confidentiality agreements while 87% agreed that written interagency agreements were in place. However, only 64.5% of participants agreed that the MDT regularly reviewed its processes and procedures.

Fig. 34// MDT purpose and procedures



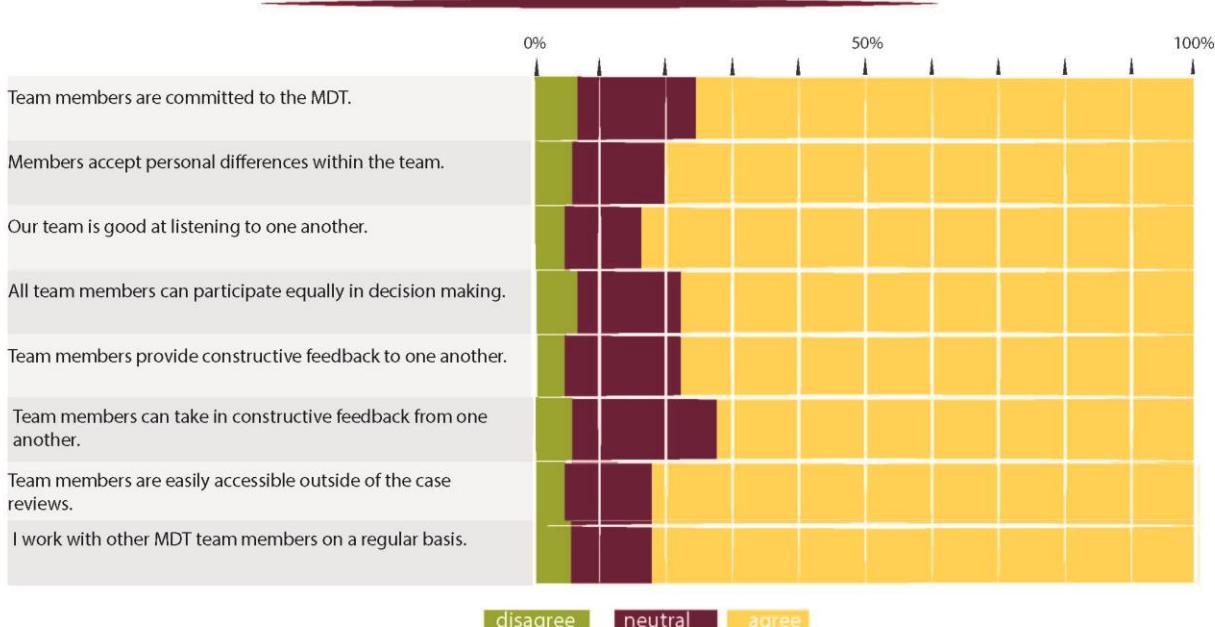
MDT leadership and participation. Figure 35 on the following page shows the percentage of responses related to MDT leadership and participation. In general, participants agreed with statements suggesting that MDTs have clear leadership and strong participation. Participants agreed that the MDT facilitator promoted collaboration (87.2%) and that the MDT meetings were run effectively (86.5%). However, only 70.6% of participants indicated that members attended MDT meetings regularly.

Fig. 35// MDT leadership and participation

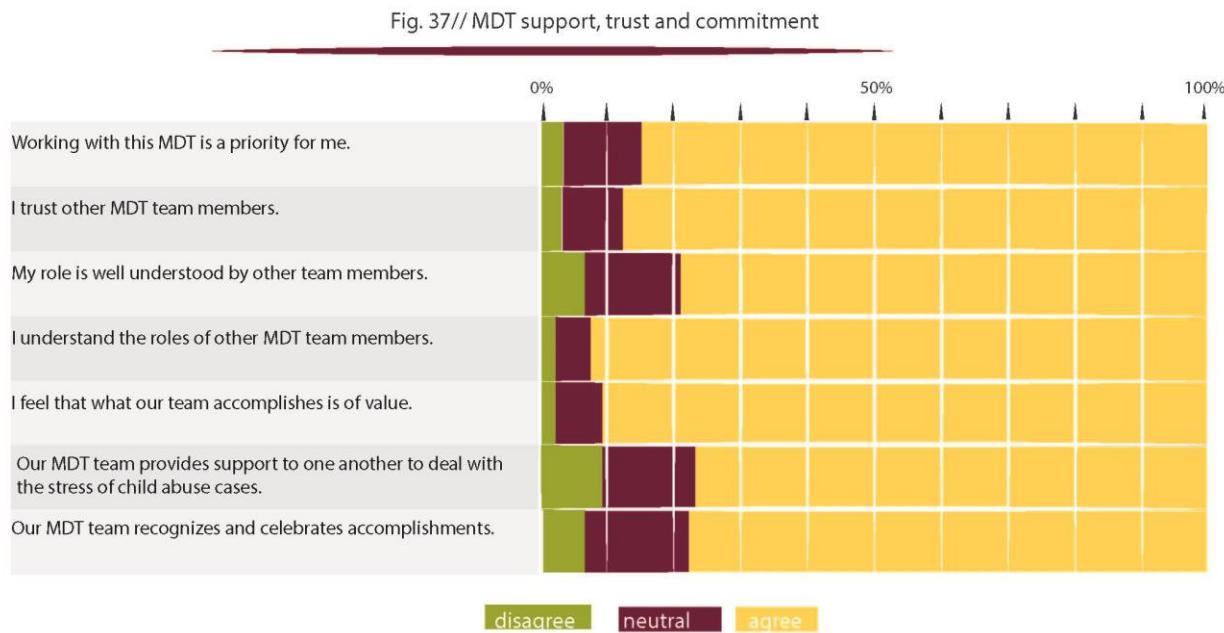


MDT communication. Figure 36 on the following page shows the percentage of responses related to MDT communication. As with the prior sections, participants generally agreed that their MDT had effective communication. Participants agreed that they work with other team members regularly (81.6%) and that team members are accessible outside of case reviews (81.7%). Participants also tended to agree that members could accept feedback (71.8%), listen to each other (83.9%) and participate in decision-making (79.2%).

Fig. 36// MDT communication

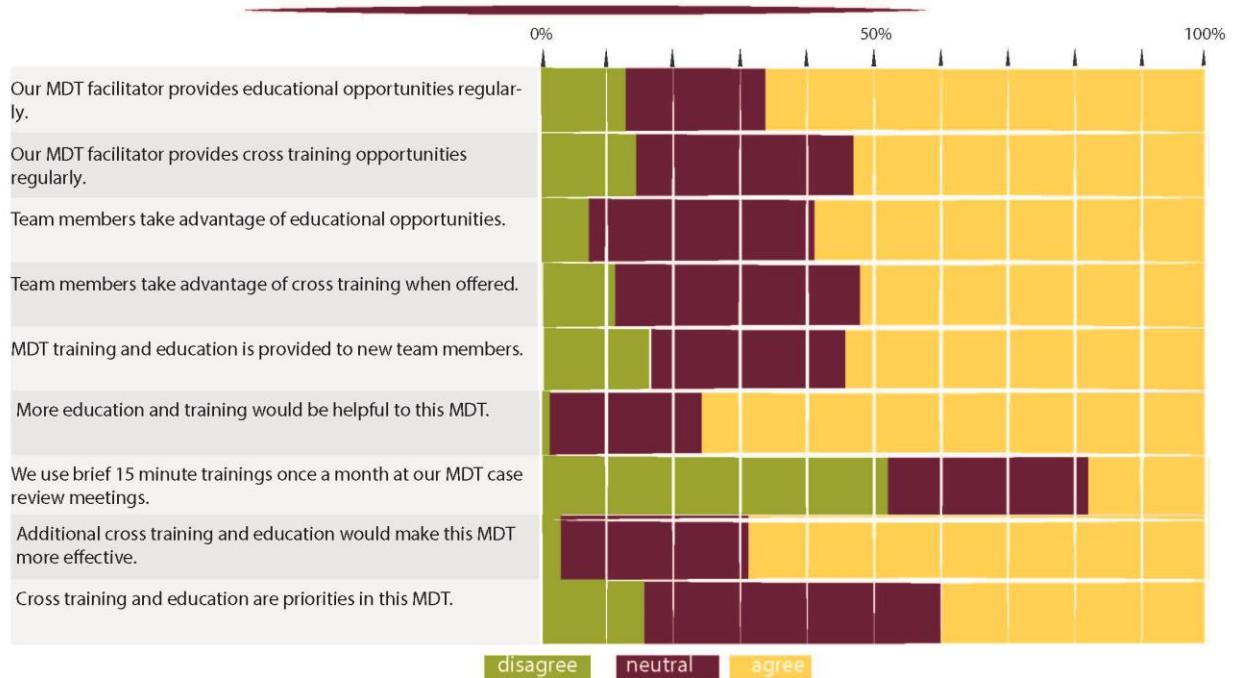


MDT support, trust and commitment. Figure 37 shows the percentage of responses related to MDT support, trust and commitment. The vast majority of participants reported that the work of the team is valuable (90.6%) and they understood the roles of the MDT team members (91.8%). Participants also agreed that the work of the MDT was a priority for them (84.7%) and that they trust other team members (88.0%).



MDT education and training. Figure 38 on the next page shows the percentage of responses related to MDT education and training. While the aspects of MDT functioning discussed above suggest strong agreement about MDT functioning, there was less agreement about education and training. The majority of respondents were either neutral or disagreed that training was important to their MDT. As a result, 70.9% felt that more training was needed to improve their MDT effectiveness and 75.5% responded that more training would be helpful. Participants' responses also indicate that MDTs vary in their use of training opportunities. More than half of MDTs do not use the suggested 15-minute monthly trainings at their case review meetings. These trainings, which are recommended by CACTX, provide an opportunity for brief cross-training and networking at meetings. However, 54% of participants said that their MDTs provide opportunities for other types of cross-training regularly and 66.4% said their MDTs provided regular educational opportunities.

Fig. 38// MDT education and training



RECOMMENDATIONS

Based on the findings from focus groups and the online survey, it is recommended that CACTX and CACs work to improve the rates of medical evaluations for child abuse victims in Texas by taking the actions described below.

OPEN THE BILLING BLACK BOX

Billing for medical evaluations is a convoluted process that few members of MDTs appear to understand, yet the process greatly influences the rates of medical evaluations in their areas. The status quo procedures are that acute and non-acute sexual abuse evaluations may be compensated by the Attorney General's Office through the Crime Victim's Compensation Fund. For forensic purposes, law enforcement agencies are charged with initially paying for the evaluations and are therefore the agencies that authorize them. Law enforcement agencies then receive reimbursement for the evaluation from the Attorney General's Office. While a seemingly logical process, there are many unintended consequences to these procedures. First, law enforcement agencies must have a system in place to cover the cost of medical evaluations until they receive reimbursement. For smaller agencies, covering the cost of medical evaluations puts an undue burden on their agency, particularly if the full amount of an evaluation is not reimbursed. In fact, there is no standard rate for medical evaluations. The Attorney General's Office reimburses for evaluations at a standard rate, but hospitals and SANEs may charge more than the reimbursable rate. Thus, law enforcement agencies may not receive full reimbursement for their expenses. Some participants noted that the reimbursement rate for evaluations had not changed since 1999 and that costs for evaluations are not on par with the reimbursed rate. Even when reimbursement occurs, it may not actually reach the law enforcement agency's budget because reimbursement is made to the local government and may not be passed through to the law enforcement agency.

To open this "black box of billing," actions should be taken to streamline the reimbursement process. Options should be explored to pay hospitals and medical providers directly for evaluations so that complicated issues with law enforcement reimbursement are avoided all together.

INCREASE HOSPITAL SUPPORT THROUGH POSITIVE REINFORCEMENT

Hospitals providing medical evaluations for child abuse cases usually have to make significant investments in the program and often accrue significant costs. Costs and dedicated staff time make it difficult to get hospitals to support SANE or related programs. Many MDTs mentioned that since additional funds are not usually available, they found it important to supply other, non-fiduciary benefits to the hospitals. One CAC actively worked to get items into the local paper about how the hospital helped abused kids. Study participants suggested that it was critical that both CACTX and local CACs explore strategies to increase hospital motivation to invest in child abuse services.

Rather than passively relying on support from local hospitals, CACTX should develop a “CACTX report card” of hospitals who are strongly supportive of child abuse services. Such report cards are common among advocacy groups as they are a way to honor and reinforce positive relationships. CACTX should explore options of having the OAG publicly recognize hospitals active in child abuse services and develop strategies for local CACs to help get a supportive hospital “good press.” A rating system would offer local CACs a starting point for discussing relationship and infrastructure building with their local hospitals.

DEVELOP STATEWIDE GUIDELINES FOR WHEN A MEDICAL EVALUATION IS REQUIRED

In nearly every community, MDT members stated that all child victims received a medical evaluation “if the facts of the case warrant one.” However, the criteria used to decide whether an evaluation was warranted varied significantly across communities and across professions. CACTX should develop protocol recommendations for when medical evaluations are required and explore options for codifying recommendations so that MDTs are required to follow protocols.

INCLUDE PHYSICAL ABUSE AND NEGLECT

Protocols for obtaining medical evaluations in cases of physical abuse and neglect were inconsistent and often non-existent. The lack of consistency exists for two reasons. First, the Attorney General’s Office does not reimburse law enforcement for evaluations for child physical abuse and neglect victims in the same way it reimburses for sexual abuse. In these non-sexual abuse cases, health insurance or crime victim’s compensation as the payer of last resort is used to reimburse for medical costs. Thus, the financial burden lies with families. Second, many communities lack access to a forensic medical examiner for physical abuse and neglect cases. Even though a community may have access to a SANE, many SANEs believe that in-depth assessment of many types of physical abuse and neglect is outside of their scope of practice. CACTX should develop a workgroup to examine this issue in greater detail and develop a plan for how to include physical abuse and neglect medical evaluations within CAC protocols.

EXPAND ACCESS TO MEDCARES

Having ready access to a MEDCARES site and the professional services and consultation these sites provide was strongly predictive of medical evaluation rates. Many MDT members noted that “if Dr. X says to do it, then we do it.” Clearly, the opinions of physicians are highly valued and their recommendations are carried out. However, many small/rural communities lacked access to physicians with child abuse specializations. CACTX should support efforts to expand MEDCARES so that both small/rural and mid-sized communities have easy access to MEDCARES providers that enables them to have regularly scheduled consultations and to develop working relationships.

CHANGE THE CONVERSATION

There is general confusion about medical evaluations for sexual abuse victims. Many non-medical professionals discussed medical evaluations as being similar to well-woman evaluations. Thus, there is a pervasive belief that medical evaluations violate and traumatize children. Given that MDT members are highly motivated to protect children, the inclination is to avoid evaluations if there is no obvious forensic purpose. CACTX should create a campaign to change this conversation to focus less on the forensic aspect of evaluations and more on the medical need for evaluations. As was suggested by one CAC director, medical evaluations should be called “well-child evaluations.” Because well-child checks are a standard part of pediatric medical care, both families and professionals are familiar with the concept of regular exams for their children.

ENGAGE IN DISCUSSION ABOUT FORENSIC MEDICAL SERVICE DELIVERY.

Many Texas communities lack ready access to medical professionals with specialized training in child abuse assessment and treatment, which can create significant barriers to obtaining medical evaluations. There are at least two possible models to address this barrier:

1. Recruit and train more medical professionals in smaller communities to conduct medical evaluations of child abuse; or
2. Provide support services so that smaller communities can more readily access the services available in urban centers.

There seems to be some controversy about which approach to take in Texas. The benefit of the first approach is that it lessens wait times for victims and reduces many burdens on MDT members, such as providing transportation and the time it requires. However, as discussed above, it can be difficult to maintain a cadre of trained medical professionals in smaller communities due to increased demands on their time and increased difficulty meeting the requirements to maintain certifications. Thus, some medical professionals argue that forensic medical services are specialized services that are rightly centralized in urban centers. Resolution of this issue is beyond the scope of this study, but does pose an interesting question for those attempting to gain better access to medical evaluations. This conversation is on-going within the sexual assault community. CACTX should take an active role in this discussion to ensure that the needs of child victims are met.

ENCOURAGE MEDICAL PROFESSIONALS’ REGULAR PARTICIPATION IN THE MDT.

Regular contact with a medical professional trained in child abuse assessment and treatment was one of the largest predictors of medical evaluation rates. In order to encourage the participation of medical professionals in MDTs, CACTX should assist and train CACs to make use of services such as Skype to have medical professionals attend MDT meetings when travel distances are prohibitive. CACs and CACTX should continue to invite medical professionals to participate in

trainings, regional meetings, or other forums where they can interact with other MDT members. CACTX and CACs should support more consistent use of the FACN by CPS workers.

IMPROVE USE OF MEDICAL EVALUATIONS IN CRIMINAL AND CIVIL PROCEEDINGS

When medical evaluations were perceived as helpful to criminal proceedings, law enforcement and prosecutors were usually more motivated to play an active role in encouraging, requiring or requesting medical evaluations. Prosecutors noted the presence of the “CSI effect” where juries expect that cases brought to trial will have some sort of positive physical findings. Because positive physical findings are rare in medical evaluations of child abuse, it is important that MDT members, particularly prosecutors and medical providers, be well-versed in explaining a lack of physical findings. CACTX should assist CACs in developing specialized training for its MDT members and other professionals on testifying and explaining to juries the issues with physical findings. Such training is particularly important for medical professionals who may be new to court proceedings.

DEVELOP AND SUPPORT ADDITIONAL EDUCATION AND TRAINING.

This study highlighted a number of training needs for professionals in the MDT. Figure 39 on the following page highlights some of the more prominent training needs that were identified. In general, very basic information is needed to help professions understand medical evaluations and their importance. However, specific trainings were identified for various professions.

Fig. 39// Suggested training topics by profession

Medical providers

Providing testimony

Working with law enforcement/CPS

Prosecutors

Working with child abuse victims

Basic child development

Assisting medical providers in court

Law enforcement

Basics of medical evaluations

Working with child abuse victims & their families

Child development 101

CPS 101

CPS Workers

Law enforcement 101

Basics of medical evaluations

While training and education are clearly needed, there are barriers to obtaining it. Law enforcement and CPS cited turnover issues as a factor in their lack of knowledge about medical evaluations. Lack of funds, staff and time were also cited as barriers. In order to address these barriers, CACTX should identify creative training solutions. For instance, online trainings could be an effective use of limited training resources and may be useful in reaching MDT members. Further, online courses with attached professional continuing education credits would likely result in greater participation than those without such credits.

Additionally, cross-training should be used if at all possible. To foster collaboration across agencies, many study participants identified a need for MDT members to understand MDT organizations other than their own. Many CACs arranged smaller, more informal cross-trainings and these were often highly effective. Cross-training was also useful in addressing some knowledge gaps that created barriers to medical evaluations and use of the results of evaluations. For example, in communities where medical professionals taught other MDT members about what evaluations do – and do not – consist of, law enforcement and CPS workers seemed more inclined to refer children for evaluations. Also, in communities where prosecutors provided training to medical professionals about testifying, there seemed to be more effective use of the medical evaluation results.

CACTX should also encourage discipline-specific mentoring. Some MDT members may be able to accept training from a member of their own profession more readily than they might accept training from someone from a different profession. Such discipline-specific mentoring can also be an effective strategy to prevent burnout and help in learning how to manage a number of discipline-specific challenges. Although some mechanisms for profession-specific mentoring exist in CAC protocols, both CACTX and local CACs should explore how they could work with other professions to expand mentoring.

PROVIDE SAFE SPACE FOR ALL MDT MEMBERS

While it was not a focus of this study, information about MDT functioning yielded interesting findings related to differing strategies for self-care among MDT members. Those members who lacked specialized child abuse training included law enforcement officers, prosecutors and some medical professionals. They disclosed that working with child abuse victims was overwhelming and that being on the “front line” was incredibly difficult. Because there was little space within their professional discipline or workplaces to process the emotional strain of their work, CACs should strive to encourage open dialogue that allows these professionals to process and disclose personal stress related to their work.

CONTINUE RESEARCH

While this study provided insight into rates of medical evaluations, there are still unanswered questions that CACTX and/or its national affiliate should continue to explore. Primarily, it is not known whether all children who need medical evaluations are receiving them. A significant challenge to assessing the appropriateness of current protocols is that there are no common criteria stating which victims need a medical evaluation. Without such criteria, it is impossible to assess the match between which children need an evaluation and which get them. To truly understand the current status of child abuse medical evaluations in Texas, each of these issues would require future research. Additionally, there is little information available to compare Texas protocols for medical evaluation to those in other states. It would be useful to compare Texas protocols to those of other states with higher rates of medical evaluations as this might help highlight potential best practices that could be adopted here.

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APPENDIX A

Focus Group Guide

Introduction

Script: You are being asked to participate in a research study examining procedures and barriers around obtaining medical examinations for child abuse victims. The research has several goals, including:

- to understand existing procedures for obtaining medical examinations for child abuse victims,
- to understand differences between community types in both procedures and barriers,
- to identify possible barriers to obtaining evaluations,
- and finally, to identify best practices for obtaining medical evaluations.

Participation in this study will consist of attending a focus group and providing input to the research team about the above issues. The research team will keep all input confidential. Specifically, information provided to the research team will be presented only in aggregate form and no input will be linked to any specific participant. Focus groups will last approximately one hour and will be recorded for analysis purposes. Participation in this study is entirely voluntary.

- Review consent form
- Get permission to audiotape
- Answer any questions about the study

Questions

1. Could you describe the MDT in this community?

Possible questions to help explore this topic:

- a. Who is on the MDT?
- b. What is your role on this MDT?
- c. Who leads / organizes the MDT?

2. Could you talk generally about the role of child medical evaluations in alleged abuse cases?

Possible questions to help explore this topic:

- a. Do you think it is important to do medical evaluations? Why or why not?
- b. Are there conditions that would make you more or less inclined to want a medical evaluation done?

- c. Do you feel like you have to justify this component of child abuse investigation / care?
 - d. (If they discuss resistance to medical evaluations in the MDT): In your experience, what is the resistance to obtaining child medical evaluations?
 - e. What concerns do you have about medical evaluations in your community?
 - f. (If they educate about medical evaluations) When it comes to medical evaluations, on what topics do you spend the most time providing education? To whom do you provide education / re-education?
 - g. What is the impact of medical evaluations on case prosecution? (including on juries).
3. How do child abuse victims receive medical evaluations in your community?

Possible questions to help explore this topic:

- a. What are the procedures for medical exam referrals? (Who takes lead, transports, who conducts, etc.)
 - b. In general, how is it decided which cases are referred for evaluations?
 - c. Could you talk about if procedures differ by abuse types and if so, in what ways?
 - d. What are the guidelines for referrals for medical evaluations?
 - i. If there are guidelines, who set(s) them?
 - ii. If there aren't guidelines, reasons for this? Pros/cons to this?
4. What are the barriers in your community to child abuse victims receiving medical evaluations?

Possible questions to help explore this topic:

- a. How does the makeup of your MDT impact getting medical evaluations completed?
- b. What barriers do you think exist to getting evaluations completed?
 - What barriers are there specifically in your discipline (CAC, LE, CPS, Med, Pros)?
 - What barriers are there generally?
- c. Do these barriers vary by type of abuse or other case characteristics (victim age or gender, relationship to the perpetrator, acute/chronic case, etc.)?
- d. Do you think these barriers might differ by community characteristics (population size, state region, dominant culture of the area, etc.)?
- e. What factors might make the barriers worse?
- f. What factors might help overcome the barriers?

- g. How have you seen MDTs successfully address such barriers? Or, how might you imagine MDTs could address such barriers?
 - h. Please describe your idea of the very best practices possible regarding medical evaluations for communities such as yours.
5. Compared to other localities, how well do you think your MDT is doing regarding getting children medical evaluations?

Possible questions to help explore this topic:

- a. Is there anything particular about this community that impacts rates of medical evaluations?
- b. Is there anything particular about this community that impacts MDT composition?
- c. How do you think the issues of this study might be impacted by community type/size
 - large urban, mid-sized, rural?

6. Could you talk about your MDT's functioning, effectiveness, and needs?

Possible questions to help explore this topic:

- a. Are there other professionals you think it would be useful for the MDT to collaborate with? If so, who?
- b. Are there training requirements for MDT members? If so, what are those?
- c. What supports does your organization need from the MDT that it is not currently getting?
- d. Do you think the collaboration positively impacts conviction rates in your community?
- e. What are common barriers to strong MDT functioning? (Either here or in other localities)
- f. How effective do you think this MDT is?
- g. What makes this MDT effective?
- h. What could be done to improve this MDT?

7. What question or questions should we have asked, but didn't, about the issue of medical evaluations for child abuse cases?

Possible questions to help explore this topic:

- a. Are there any other important issues we should know about?
- b. If you were making recommendations to increase the rates of medical evaluations, what would you suggest?

- c. Are there any educational standards you think should be mandated for MDT member continuing education?

APPENDIX B

List of Children's Advocacy Centers in Texas

Community Type	Center
Small/Rural	Eastland
	Gonzales
	Port Lavaca
	Alpine
	Center
	Graham
	Bonham
	Crockett
	Sweetwater
	Livingston
	Corsicana
	Canton
	Paris
	Henderson
	Hondo
	Athens
	Greenville
	Victoria
Mid-size	Granbury
	Kaufman
	Jacksonville
	San Angelo
	Dayton
	New Braunfels
	Bastrop
	Sherman
	Seguin
	Abilene
	Kerrville
	Odessa
	Texarkana
	Lufkin
	Burnet

	Midland
	Waxahachie
	Cleburne
	Wichita Falls
	Longview
	Winnsboro
	San Marcos
	Tyler
Large/Urban	Laredo
	Galveston
	Bryan
	Waco
	Angleton
	Corpus Christi
	Belton
	Lubbock
	Brownsville
	Georgetown
	Amarillo
	Beaumont
	Conroe
	Rosenberg
	Lewisville
	El Paso
	Plano
	Edinburg
	Austin
	San Antonio
	Fort Worth
	Dallas
	Houston