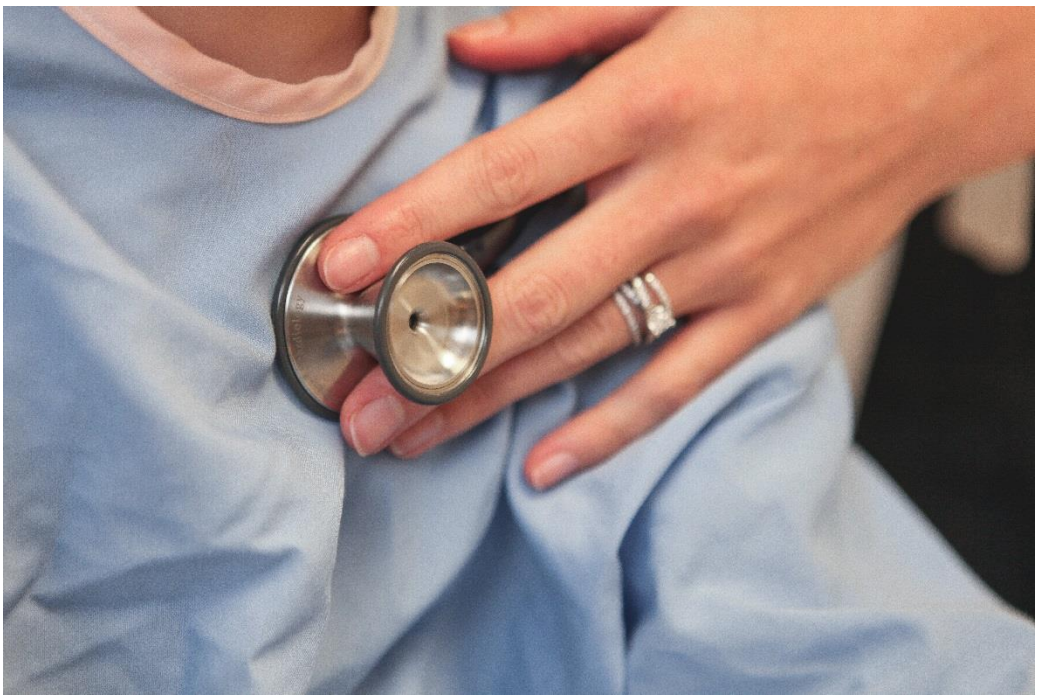
WV CHILD ABUSE MEDICAL PROJECT 2017



2017

Program Evaluation

wvcan

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About WVCAN

The West Virginia Child Advocacy Network (WVCAN) is a statewide alliance of Child Advocacy Centers (CACs) dedicated to helping local communities respond to allegations of child abuse in ways that are effective and efficient – and put the needs of child victims first. WVCAN provides training, support, technical assistance and leadership on a statewide level to local CACs and communities throughout West Virginia responding to reports of child abuse and neglect. Our mission is to better serve children and families when concerns of child abuse arise by supporting the development, growth and continuation of CACs and multi-disciplinary teams in West Virginia. This network is composed of 20 CACs officially serving 36 of West Virginia's 55 counties, and providing courtesy services to almost every county in the state. WVCAN is a 501c3 organization governed by a Board of Directors composed of CAC directors and public citizens of West Virginia.

WVCAN and its member CACs seek to provide a positive intervention for the children who are served by our network. CACs have two clients—the children who have experienced abuse and the Multidisciplinary Investigative Team (MDIT) that addresses the allegations of abuse. CACs provide a child-friendly facility where the professionals come to the children in a collaborative and coordinated response. CACs facilitate forensic interviews of child victims, provide victim advocacy and court preparation, provide or make referrals to therapy that is trauma-focused, and ensure child abuse medical evaluations occur and are locally-accessible. The CAC manages and tracks a case to its conclusion. Similarly, a CAC facilitates coordination between the MDIT professionals (prosecuting attorney, medical and mental health providers, CPS workers, Law Enforcement Officers, and victim advocates) who meet at least monthly to review open cases and make decisions about them. This process eliminates multiple interviews of the child and facilitates the sharing of information among the different professionals and agencies.

WV-CHAMP History

Since early 2011, WVCAN has led an initiative to improve the quality and accessibility of specialized child abuse medical care throughout the state. All children who are reported or suspected victims of child abuse deserve timely and high-quality medical evaluation regardless of where they live or their ability to pay. The evaluation should be from a specially-trained medical provider who partners with local CACs and MDITs to provide a compassionate and comprehensive response to abuse. Having this service available is part of a CAC's operating standards and the vast majority of child abuse medical providers in the state have been recruited and trained by their local CAC. However, a child's access to specialized medical care after a report of abuse is still greatly determined by where he or she lives.

To identify and address barriers to CAC-served children receiving specialized medical care, WVCAN convened a group of stakeholders and partner agencies who shared an interest in improving the quality and accessibility of these services. Grants from the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation supported the early development of this program, now called the WV Child Abuse Medical Program (WV-CHAMP). In the initial phase of this project, the group assessed West Virginia's existing resources, built a structure to support and develop child abuse medical expertise in the state, and developed medical protocols to move toward standardization of child abuse medical care.

Past Work

WV-CHAMP met with early success, and continues operation, across many activities.

- A structure was developed to deliver ongoing child abuse medical education and professional support—over 50 individuals have received direct benefit.
    - WVCAN's annual child abuse conference's medical track offers continuing medical/nursing education credit focused on the identification and medical treatment of child abuse
    - Quarterly online medical educational case reviews offer an informal networking of specially-trained providers to learn and discuss de-identified cases
    - WVCAN provides access to a national resource, myCasereview, for online, double-blind, HIPAA-secure expert medical review of sexual abuse exams per best practice standards
- The child abuse medical protocols developed by this program were either adopted or used to amend existing protocols in 26 WV emergency departments. This accomplishment received national acknowledgment with the American Academy of Pediatrics.
- A web resource was developed to house WV-specific child abuse medical information, training opportunities, and educational resources.
- Sub-grants to two local CACs provided for the training of three new medical professionals in two counties where the nearest provider was previously more than an hour away.
- The WV-CHAMP Directory was developed and disseminated to CACs and participating child abuse medical providers, with annual updates, solidifying a network of over 30 specially-trained child abuse medical providers serving WV children.
- With WV Bureau for Public Health funding, WVCAN published a toolkit of resources to assist local communities working toward an excellent standard of child abuse medical care.

Purposes of a Child Abuse Exam, Current Practices/Availability in West Virginia

Although very few, less than 5%[1], of child sexual abuse medical exams are 'positive' or 'diagnostic' for abuse, the service is a critical component of the holistic community response to child abuse. The child abuse medical exam is a head-to-toe evaluation of that child's overall well-being, and is not about proving or disproving that the reported abuse occurred. According to the 2017 National Children's Alliance Standards for Accredited Members, the goals of a medical evaluation as part of the multidisciplinary CAC response to abuse are:

- Help ensure the health, safety, and well-being of the child
- Evaluate, document, diagnose, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family
- Refer for therapy to address trauma related to the abuse/assault, if not provided by another member of the MDIT/CAC.

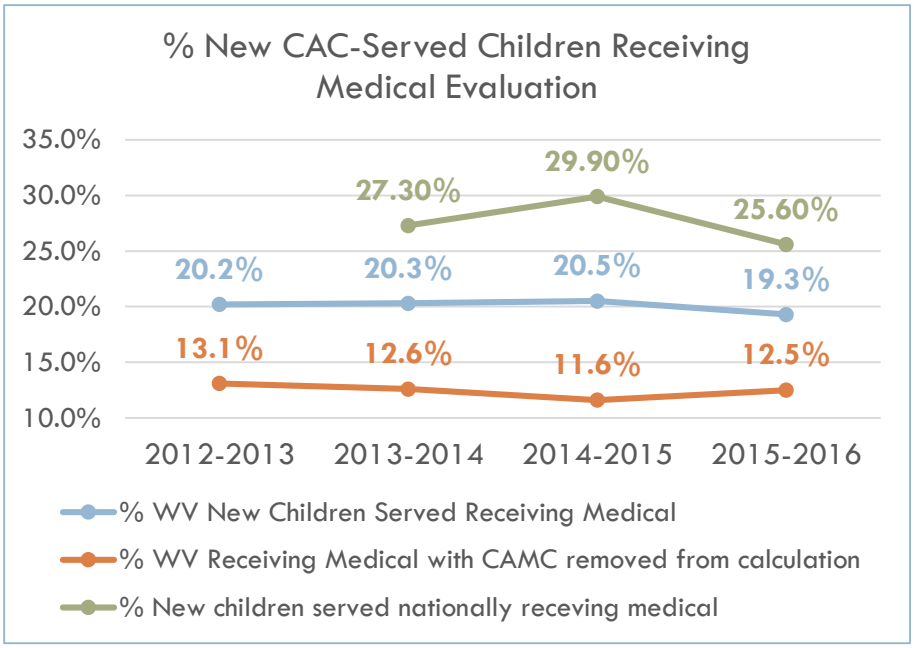
[1] Heger, A., Ticson, L., Velasquez, O., & Bernier, R. (2002). Children referred for possible sexual abuse: medical findings in 2384 children. Child Abuse & Neglect, 26(6-7), 645-659

As a part of their operations, CACs partner with medical providers with pediatric experience and specialized training in the identification and treatment of child sexual abuse. CACs must also ensure that local protocols and MDIT practice facilitate the receipt of medical services, when necessary, for any child served regardless of his or her ability to pay. The medical professionals who work with CACs and MDITs to serve children must also commit to ongoing education, expert review, and fidelity to the MDIT practice and local protocols. This specialization is critical as training, ongoing education, and expert review are well-established predictors of diagnostic reliability in child abuse medical evaluations; providers without this unique training and support are more likely to mistake normal anatomical variations as diagnostic of abuse.[2] Before WV-CHAMP, local programs and professionals were both disconnected from one another and had no centralized information on where to find the professional support they needed to deliver the highest quality of child abuse medical care.

For this reason, WV-CHAMP's programming has primarily focused on workforce development of the specialized providers themselves. This "build it and they will come" mentality has been successful in engaging medical professionals and their teams/communities in ongoing education and development. When this initiative first began, there were approximately 20 or fewer of these specially-trained professionals providing care to WV children, leaving large gaps in care due to generalized unavailability of services close to a child's home. Today there are around 60 known providers available to provide this care, most of whom have engaged with WV-CHAMP programming at some point. Communities are working hard to make sure the workforce is there, but gaps in accessibility of care for children persists.

Continued Need – Gaps in Accessibility to Child Abuse Medical Care for WV Children

The early work of WV-CHAMP addressed many issues surrounding quality of child abuse medical care in WV by ensuring that the necessary professional supports were in place to ensure best practices in the medical community and for the specialized providers themselves. However, WV still falls well behind national averages in getting children child abuse medical evaluations. Around 26% of CAC-served children nationally receive an evaluation, compared to 19% in WV. When the one hospital-based CAC (labeled CAMC in the chart) is removed from the calculation, that falls to 13%. This proportion has been relatively consistent year-to-year, despite the enhanced supportive programming to the specialized providers and programs. This difference is



[2] Adams, J. A., Starling, S. P., Frazier, L. D., Palusci, V. J., Shapiro, R. A., Finkel, M. A., & Botash, A. S. (2012). Diagnostic accuracy in child sexual abuse medical evaluation: Role of experience, training, and expert case review. Child Abuse & Neglect, 36(5), 383-392.

troubling because we know that more children could benefit from this care than are currently receiving it.

Despite the fact that as of 2017, WV's child abuse medical providers are more numerous and supported than ever, the proportion of children receiving specialized care as part of the CAC-MDIT response has remained level. Current development made it possible for children to receive care that meets best practice standards, but still too few children are getting that care in the first place. Accessibility of care heavily depends on non-medical members of the MDIT prioritizing the medical evaluation as a valuable part of the therapeutic and investigative response to child abuse. The team decision to make a referral is the primary driver of children's access to child abuse medical evaluations, although it is not the only area in which roadblocks exist. Analysis of what prevents a child from either being referred to or ultimately receiving a child abuse medical evaluation will steer future programming to ensure that the greatest number of children who may benefit from care can receive it.

2017 CAC Case Review Project

Background

In partnership and with funding from the WV Bureau for Public Health, a key component of WV-CHAMP's work in 2017 was a CAC case review project. The purpose of this activity is to use real de-identified CAC client data to pinpoint and evaluate any common themes that prevent children from being referred to and/or ultimately receiving a child abuse medical evaluation. The outcomes of this analysis was brought before a group of CAC staff, child abuse medical providers, and other stakeholders to evaluate and make recommendations for future programming with WV-CHAMP to increase the accessibility of child abuse medical care statewide.

Methods

An online survey was developed to collect relevant information for each case entered. All 20 WV CACs were invited to participate in this project. Those who opted in sent a de-identified list of case numbers for a 9-month period (January 1, 2016 – October 31, 2016) to WVCAN. In partnership with Dr. Maggie Stone at Marshall University, 10 case numbers were randomly selected and sent back to the CAC. From there, the CAC pulled the case file for these 10 clients and entered responses into the online survey. Ultimately, data from 126 children's cases were collected from13 CACs.

Variables

In our effort to understand the most important factors going into a team's decision to refer a child to treatment and for the child to receive that care, we selected variables that we believed would have the most impact.

Child Demographic Information

CACs were asked to submit de-identified demographic information about children – age and gender. Race/ethnicity was not selected as a variable due to the small sample size and relatively homogenous population of WV – it would be unlikely to show patterns. However, it was hypothesized that girls may be more likely to receive exams than boys as the majority of victims served by CAC are female and a very large proportion of child abuse medical training focuses on female anatomy. Additionally, we wanted to evaluate whether or not age played a factor. 75% of CAC-served children are age 12 or younger. With the possibility of increased reluctance and autonomy of older children, we wanted to

determine whether or not they may be less likely to be referred to and receive medical care after a report of abuse.

Caregivers and Proximity to Care

The most-discussed obstacle to care is drive time. As CACs both in WV and nationally move toward co-located services, it would be important to know the extent to which the child's distance from care influenced the team's decision to make a referral and the child's ability to access that care. We also wanted to evaluate the child's living situation as a possible predictor for these outcomes. Would a child in the foster care system, either prior to or as a result of the report of abuse that brought them to the CAC, have a significantly higher or lower likelihood of receiving an exam? We could see this going two ways - Since there are so many involved professionals and monitoring requirements, we believed foster children may stand out as models for receipt of care. However, we could also see the opposite scenario due to the child's receipt of a comprehensive medical exam prior to entering the system – would the MDIT and caregivers feel that the child shouldn't "go back to the doctor" for this specific concern?

Abuse Experienced

It is important to note that information about the abuse experienced by these children can be broken into three overarching categories – alleged abuse, disclosed abuse, abuser-victim contact/physical findings. Alleged abuse is what brought the child to the attention of authorities and to the care of the CAC in the first place. CACs also collect information about disclosed abuse – what the child reveals in the forensic interview. The disclosure may or may not match the allegation, and is only one part of the full investigation of abuse. Sometimes a child may not disclose all that is known to have happened (like when there is video evidence) or the child may be too young to interview. For the purposes of this study and for these reasons, we also asked CACs about specific abuser-victim contact (such as whether or not the abuser's genitals at any time was thought to have touched the child's genitals) and other physical findings (such as 'patterned' bruises).

All CAC-served children have the right to medical care should it be indicated. However, the underlying assumption of this study is that there are barriers embedded in that team decision-making and/or the child's access to the child abuse medical exam. It is important, therefore, to know if children experiencing particular types of victimization are more or less likely to access care. Additionally, we wanted to evaluate whether or not polyvictimization, a child's experience of multiple forms of violence, played a factor – would the overlap of adversities in and of themselves be more likely to influence a child's access.

Summary Data[3]

CAC Name	Counties Officially Served	Program Structure	New Children Served	Medical Evaluations Received	Location of Provider*
Child Protect of Mercer County	Mercer	Stand-alone 501c3	324	44	Inside official service area
Cornerstone CAC	Boone, Lincoln	Umbrella Organization	68	5	Outside official service area
Child and Youth Advocacy Center	Greenbrier, Monroe, Pocahontas	Stand-alone 501c3	168	13	Inside official service area for Greenbrier, outside for other counties served
Harmony House	Ohio, Marshall	Stand-alone 501c3	190	36	Outside official service area, but geographically close
The Lighthouse CAC	Wetzel, Tyler	Stand-alone 501c3	22	0	Outside official service area
The Logan CAC	Logan, Mingo	Stand-alone 501c3	163	17	Inside official service area
Monongalia County CAC	Monongalia	Stand-alone 501c3	147	39	Inside official service area
Mountain CAP CAC	Upshur, Lewis	Umbrella Organization	39	9	Inside official service area
REACHH CAC	Summers	Umbrella Organization	66	4	Inside official service area
Randolph-Tucker CAC	Randolph, Tucker	Stand-alone 501c3	152	43	Inside official service area
Safe Haven CAC	Berkeley, Jefferson, Morgan	Umbrella Organization	220	8	Outside official service area
SARAH's House	Mineral, Hampshire	Umbrella Organization	203	19	Outside official service area, but geographically close
CAMC Women and Children's CAC	Kanawha	Hospital-based	459	292	Co-located at CAC

*** For the time period covered in this study. Several participating CACs have had rapid local development in recent months to improve access to care.**

[3] All statewide percentages are from Fiscal Year 2015-2016 data collected by all CACs in West Virginia. It represents the proportion of all new children served indicated in any given category. For some categories, such as age, a child can only fall into one category. For others, such as disclosed abuse, a child may fall into multiple categories. If a statewide percentage is not reported, it is because the indicator is one not collected on the statewide level.

Child Demographic Summary Data

Gender			
	# In study	% In study[4]	% Statewide
Male	42	33%	36%
Female	84	67%	64%
Other*	0	0%	<1%
* It's WVCAN's policy is to record a child's self-identified gender. For example, if a trans boy visits the CAC (was born female and identifies as male), he would be recorded as a boy. The "other" category is intended for children who do not self-identify as either male or female, or identify as both.			

Age			
	# In study	% In study	% Statewide
0-6 years	45	36%	35%
7-12 years	50	40%	40%
13-18+ years	31	25%	25%

Child's Living Situation		
	# In study	% In study
Child remained in home of origin	86	68%
Child was in foster care when brought to the CAC and has remained there	12	10%
Child's living situation changed as a result of team investigation/CAC visit	16	13%
Unknown	12	9%

Reported Abuse Summary Data

Alleged Abuse			
	# In study	% In study**	% Statewide**
Alleged Sexual Abuse	91	72%	70%
Alleged Physical Abuse	26	21%	18%
Alleged Drug Endangerment	13	10%	13%
Alleged Neglect	11	9%	7%
Alleged Witness to Violence	13	10%	12%
Alleged Exposure to Pornography*	3	2%	-
Alleged Depiction in Pornography*	0	0%	-
Alleged Other	12	10%	2%
* Not available on the statewide level for the time period covered in study ** Child may be represented in multiple categories – this column will not add up to 100%			

[4] Unless otherwise specified, "% In Study" refers to the proportion of children out of the 126 for whom case data was entered.

Disclosed Abuse			
	# In study	% In study**	% Statewide**
Not Applicable – Child not interviewed OR did not make any disclosures in interview	42	33%	42%
Disclosed Sexual Abuse	55	43%	35%
Disclosed Physical Abuse	24	19%	12%
Disclosed Drug Endangerment	14	11%	7%
Disclosed Neglect	4	3%	4%
Disclosed Witness to Violence	8	6%	9%
Disclosed Exposure to Pornography*	6	5%	-
Disclosed Depiction in Pornography*	1	1%	-
Disclosed Other	4	3%	2%

* Not available on the statewide level for the time period covered in study
** Child may be represented in multiple categories – this column will not add up to 100%

Specific Considerations that may Influence Referral to and Receipt of Medical Exam		
	# In study	% In study
Contact of abuser's mouth with child's genitals or anus at any time	9	7%
Contact of abuser's genitals with child's genitals or anus at any time	21	17%
Contact of abuser's hand or fingers with child's genitals or anus	29	23%
Contact of child's mouth with abuser's genitals or anus	7	6%
Any of the above types of contact, having occurred within the past 72 hours and thus likely requiring forensic evidence collection (rape kit)	0	0
Contact of the abuser's mouth, hand/fingers, and/or genital's with child's breast at any time	7	6%
Emergent medical needs such as pain, bleeding	2	2%
Patterned bruises, lacerations, burns, scars	7	6%
Not applicable – None of the considerations above were present	59	47%
Unknown	5	4%
Other physical injuries/symptoms, please specify	11	9%

Medical Referral and Examination Summary Data

Medical Referrals and Exams Received			
	# In study	% In study	% Statewide
Children referred for medical evaluation by MDIT	30	24%	18%
Children receiving child abuse medical evaluation	32	25%	19%

Approximate driving time from home for child to receive medical care from CAC's provider		
	# In study	% In study
Not applicable – child presented to medical care prior to being served at the CAC	10	8%
Less than 30 minutes	49	39%
30 – 59 minutes	53	42%
1 – 2 hours	13	10%
Greater than 2 hours	1	1%

Reason child was not referred to child abuse medical evaluation		
	# In study	% Of kids not referred (96)
Not indicated based on team protocol	65	68%
Child had already received a child abuse medical evaluation from a provider with special child abuse training (e.g. the MDIT provider or one from another community)	8	8%
Child had already received a child abuse medical evaluation from a provider without special child abuse training	5	5%
Other	18	19%

Time lapsed between referral to and receipt of child abuse medical evaluation		
	# In study	% of kids who received medical (32)
Less than 1 week (0-6 days)	12	38%
1 week to a month (7-30 days)	13	41%
Greater than 1 month (31+ days)	4	13%
Unknown	0	0%
Not applicable – child received an exam prior to or without team referral	3	9%

Regression Models

The log-odds regression models presented below take all the case information into consideration to show what is significantly related to a child's ability to access CAC medical services. Each variable takes into account all other variables' significance in whether or not a child accesses care. What we want to understand is, with all things taken into account, what factors most impact a multidisciplinary team's decision to refer a child to a medical evaluation and, ultimately, a child's receipt of care.

NOTE: Regressions were run both including and excluding CAMC Women and Children's CAC since that program performs so many more medical exams than others in the state. However, this did not make a significant difference in the data.

Medical Referrals

The models indicate that specific types of abuse had a statistically-significant effect on the likelihood of a medical referral being issued, but that the total number of abuse types alleged did not. Drive time was added to each model both as a single, near-interval variable and as five separate dichotomous variables. This data did not impact the log odds of medical referral in either case.

Table 1: Log Odds of Medical Referral in Two Models		
Variable	*Model 1*	*Model 2*
Child's gender (RG=Male)	-0.652	-0.612
Child's age in years at time of service (Infants Coded as 0)	-0.113	-0.087
Child remained in home of origin?	1.223	0.321
Child was in foster care when brought to CAC?	0.906	0.127
Child's living situation changed as a result of CAC intervention?	1.302	0.759
Drive Time By Category	0.055	0.031
Abuser-Victim Contact and Physical Symptoms Variables		
Contact of abuser's mouth with child's genitals or anus at any time	0.878	0.484
Contact of abuser's genitals with child's genitals or anus or mouth at any time	2.905*	2.533**
Contact of abuser's hand or fingers with child's genitals or anus	1.717	1.768**
Contact of the abuser's mouth, hand/fingers, and/or genitals with child's breast at any time	-0.386	-0.006
Contact of child's mouth with abuser's genitals or anus	-1.095	-1.878
Emergent medical needs such as pain, bleeding	24.045	3.029
Patterned bruises, lacerations, burns, scars	1.909	1.466
Alleged Abuse Variables		
Sexual Abuse Alleged	-1.286	
Physical Abuse Alleged	0.414	
Drug Endangerment Alleged	-1.707*	
Neglect Alleged	1.254	
Witness to Violence Alleged	2.807	
Depiction in Pornography Alleged	--	
Exposure to Pornography Alleged	-22.089	
Other Abuse Alleged	-20.132	
Polyvictimization Scale (Alleged)		-0.288
Disclosed Abuse Variables		
Sexual Abuse Disclosed	1.051	
Physical Abuse Disclosed	-0.773	
Drug Endangerment Disclosed	1.373	
Expose Porn Disclosed	4.293*	
Depiction Porn Disclosed	-23.712	
Witness Violence Disclosed	-2.783	
Other Abuse Disclosed	-18.947	
Neglect Disclosed	-21.792	
*p≤.05 **p≤.01 NOTE: No children presented with alleged depiction in pornography.		

Medical Exams Received

In the next two regressions, we focus on the odds of receiving a medical evaluation. As in our analysis of the odds of receiving a referral, "Contact of abuser's genitals with child's genitals or anus or mouth at any time" was the most statistically-significant factor analyzed. The polyvictimization scale constructed from all alleged varieties of abuse was, once more, not statistically-significant.

Table 2: Log Odds of Receiving Medical Evaluation in Two Models		
Variable	*Model 1*	*Model 2*
Child's gender (RG=male)	0.103	0.241
Child's age in years at time of service. (Infants coded as 0)	-0.122	-0.086
Child remained in home of origin?	0.786	0.928
Child was in foster care when brought to CAC?	1.759	1.548
Child's living situation changed as a result of CAC intervention?	-0.084	0.467
Drive Time By Category	-0.302	-0.252
Abuser-Victim Contact and Physical Symptoms Variables		
Contact of abuser's mouth with child's genitals or anus at any time	2.378	1.234
Contact of abuser's genitals with child's genitals or anus or mouth at any time	3.393*	2.989***
Contact of abusers hand or fingers with child's genitals or anus	1.767	1.485*
Contact of the abuser's mouth, hand/fingers, and/or genitals with child's breast at any time	0.668	1.381
Contact of child's mouth with abuser's genitals or anus	-0.164	-2.185
Emergent medical needs such as pain, bleeding	-15.914	-18.016
Patterned bruises, lacerations, burns, scars	3.562	2.251*
Alleged Abuse Variables		
Sexual Abuse Alleged	0.341	
Physical Abuse Alleged	-0.702	
Witness to Violence Alleged	2.835	
Drug Endangerment Alleged	-0.595	
Neglect Alleged	1.624	
Exposure to Pornography Alleged	-19.224	
Depiction in Pornography Alleged	--	
Other Abuse Alleged	-19.025	
Polyvictimization Scale (Alleged)		0.042
Disclosed Abuse Variables		
Sexual Abuse Disclosed	-0.059	
Physical Abuse Disclosed	0.251	
Witness Violence Disclosed	-2.506	
Drug Endangerment Disclosed	0.478	
Neglect Disclosed	-19.667	
Expose Porn Disclosed	0.842	
Depiction Porn Disclosed	-27.728	
Other Abuse Disclosed	-19.998	
*p≤.05 **p≤.01 ***p≤.001 NOTE: No children presented with alleged depiction in pornography.		

Referral to and Receipt of Services – Focus on Polyvictimization

In two final regressions, two additional polyvictimization scales were constructed to include all types of specific abuser-victim contact/physical symptoms and all types of disclosed abuse, respectively, to match the alleged abuse polyvictimization scale used in the prior regression models. These three scales, along with the same demographic and housing information from the other models, were taken into account. These analyses demonstrate that not only specific types of abuser-victim contact/physical symptoms increase both the likelihood that a child has received both a referral to medical care and the exam itself, but that the total number of these types of contact has an effect as well. In other words, when a child has more than one of these known and/or disclosed types of abuser-victim contact and/or physical symptoms, he or she is more likely to be directed to medical care.

Table 3: Log Odds of Receiving Referral and Receiving Evaluation, Emphasis on Demographics & Polyvictimization Scales

Variable	*Medical Referral Received*	*Medical Evaluation Received*
Child's age in years at time of service (Infants coded as 0)	-0.049	-0.058
Child's gender	0.466	-0.448
Child remained in home of origin?	-0.231	0.357
Child was in foster care when brought to CAC?	-0.12	1.299
Child's living situation changed as a result of CAC intervention?	0.33	0.264
Drive Time By Category	-0.042	-0.408
Polyvictimization Allegation Scale	-0.663	-0.147
Polyvictimization Victim-Abuser Contact/Physical Symptom Scale	0.543*	1.038***
Polyvictimization Disclosure Scale	0.213	-0.142

*p≤.05 **p≤.01 ***p≤.001

Cross-Tabulations for Medical Referrals and Receipt of Exams

What the summary and regression data do not tell us is the overlap of services with specific types of abuse. For example, were *any* children who disclosed 'witness to violence' referred to an exam? Even though the regression data may demonstrate that, for this sample, this particular victimization was not significantly tied to a child's access to services, we want to know if it was tied to a child's access to care at all. Disclosure is the focus here, rather than allegation/reports, because we are interested in the team's decision-making based on the information that came from the child's story in the interview.

The significance of the relationships between abuse types and services received presented in the cross-tabulations did not stray from those of the regression models. However, understanding the overlap between disclosure categories and services is an important part of the discussion.

Cross-Tabulation of Child's Disclosure and Referral to Exams

Sexual Abuse Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Sexual Abuse Not Disclosed	63	8	71
Sexual Abuse Disclosed	33	22	55
Total	96	30	126

Physical Abuse Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Physical Abuse Not Disclosed	78	24	102
Physical Abuse Disclosed	18	6	24
Total	96	30	126

Witness to Violence Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Witness to Violence Not Disclosed	89	29	118
Witness to Violence Disclosed	7	1	8
Total	96	30	126

Drug Endangerment Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Drug Endangerment Not Disclosed	84	28	112
Drug Endangerment Disclosed	12	2	14
Total	96	30	126

Neglect Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Neglect Not Disclosed	92	30	122
Neglect Disclosed	4	0	4
Total	96	30	126

Exposure to Pornography Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Exposure to Pornography Not Disclosed	93	27	120
Exposure to Pornography Disclosed	3	3	6
Total	96	30	126

Depiction in Pornography Disclosed / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Depiction in Pornography Not Disclosed	95	30	125
Depiction in Pornography Disclosed	1	0	1
Total	96	30	126

No Disclosure* / Referral to Exam			
	No Medical Referral	**Medical Referral Made**	**Total**
Child Made Disclosure	58	26	84
Child Did Not Disclose Abuse	38	4	42
Total	96	30	42

* This captures children who, regardless of the allegations for which they were brought to the CAC and/or evidence that abuse occurred, made no disclosure during a forensic interview. Additionally, this variable captures children who were unable to be interviewed. In other words, the multidisciplinary investigative team would have no piece of the child's story directly influencing their decision to make a medical referral.

Polyvictimization* / Referral to Exam				
		Did the MDIT and/or CAC make a referral for the child to have a child abuse medical evaluation?		
		No	**Yes**	**Total**
Number of different categories of abuse disclosed by victim	**No Disclosure**	38	4	42
	One type of abuse disclosed	44	21	65
	Two or more types of abuse disclosed	14	5	19
	Total	96	30	126

* Here, a child is described as a poly-victim if he/she reported 2 or more types of victimizations. This is not meant to describe the severity or impact of what any victim has experienced, merely the overlapping types of abuse they described in the interview.

Cross-Tabulation of Child's Disclosure and Receipt of Exams

Sexual Abuse Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Sexual Abuse Not Disclosed	61	10	71
Sexual Abuse Disclosed	33	22	55
Total	94	32	126

Physical Abuse Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Physical Abuse Not Disclosed	77	25	102
Physical Abuse Disclosed	17	7	24
Total	94	32	126

Witness to Violence Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Witness to Violence Not Disclosed	88	30	118
Witness to Violence Disclosed	6	2	8
Total	94	32	126

Drug Endangerment Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Drug Endangerment Not Disclosed	82	30	112
Drug Endangerment Disclosed	12	2	14
Total	94	32	126

Neglect Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Neglect Not Disclosed	90	32	122
Neglect Disclosed	4	0	4
Total	94	32	126

Exposure to Pornography Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Exposure to Pornography Not Disclosed	89	31	120
Exposure to Pornography Disclosed	5	1	6
Total	94	32	126

Depiction in Pornography Disclosed / Child Received Medical Exam			
	Exam Not Received	Exam Received	Total
Depiction in Pornography Not Disclosed	93	32	125
Depiction in Pornography Disclosed	1	0	1
Total	94	32	126

No Disclosure* / Child Received Medical Exam			
	Exam Not Received	**Exam Received**	**Total**
Child Made Disclosure	57	27	84
Child Did Not Disclose Abuse	37	5	42
Total	94	32	126

* This captures children who, regardless of the allegations for which they were brought to the CAC and/or evidence that abuse occurred, made no disclosure during a forensic interview. Additionally, this variable captures children who were unable to be interviewed. In other words, the multidisciplinary investigative team would have no piece of the child's story directly influencing their decision to make a medical referral.

Polyvictimization* / Child Received Medical Exam				
		Did the child receive a child abuse medical evaluation from your MDIT's medical provider or a similarly qualified provider meeting NCA standards?		
		No	**Yes**	**Total**
Number of different categories of abuse disclosed by victim	**No Disclosure**	37	5	42
	One type of abuse disclosed	42	23	65
	Two or more types of abuse disclosed	15	4	19
	Total	94	32	126

* Here, a child is described as a poly-victim if he/she reported 2 or more types of victimizations. This is not meant to describe the severity or impact of what any victim has experienced, merely the overlapping types of abuse they described in the interview.

Discussion and Recommendations

The outcomes of the research, the implications for current practice, and other needs in the field were discussed by the research team to develop the discussion and recommendations below.

Service Delivery Rate

Summary: The ability of CACs to strengthen their local child abuse medical component depends on the program's capacity, especially staffing.

As noted on page 4, West Virginia still falls behind national averages for CAC-served children receiving medical evaluations:

> *"Around 26% of CAC-served children nationally receive an evaluation, compared to 19% in WV. When the one hospital-based CAC (labeled CAMC in the chart) is removed from the calculation, that falls to 13%. This proportion has been relatively consistent year-to-year, despite the enhanced supportive programming to the specialized providers and programs. This difference is troubling because we know that more children could benefit from this care than are currently receiving it."*

This is also one area in which the sample differed noticeably from West Virginia's statewide averages for referral to and receipt of medical services – 24% of children in the sample were referred to medical evaluations compared to 18% statewide, and 25% of children in the sample received a medical evaluation compared to 19% statewide. This, in and of itself, speaks to a CAC's capacity to engage in deepening of services. The CACs with the staff capacity to participate in this research also, most likely, have the resources and programmatic duration to have more enhanced service delivery than smaller, newer centers. Continued investment in CAC capacity is anticipated to increase the likelihood for robust delivery of therapeutic services, including child abuse medical evaluations.

Clarifying CAC Protocols' Referral Criteria

Summary: The primary barrier to children's access to child abuse medical care is the referral being made in the first place. CACs and MDITs should clarify their local referral criteria to encompass the additional children who would benefit from care, particularly for those with no disclosure or incomplete disclosures.

The logistic regression models (pages 11-13) illuminated the circumstances under which a child was *most* likely to receive medical care as part of the CAC response, but the majority of children in this sample (76%) were never even referred. For these 96 children for whom medical care was not recommended as part of the team response, 68% was due to it not being indicated based on the team's protocols. In fact, very few children who disclosed certain categories of abuse were referred. For example, referencing the cross-tabulations of disclosed abuse and medical referrals (pages 14-15), it is shown that none of the four children who disclosed neglect were referred to a medical evaluation and only two of the 12 disclosing exposure to drugs were referred.

Although this study is limited by lack of details to these disclosures, best practice would support a higher rate of referrals for children. Additionally, CAC Directors participating in this research team noted that feedback from their recent re-accreditation site visits from the National Children's Alliance included recommendations for broader medical referral criteria.

Based on the data and team discussion, it is recommended that CACs in West Virginia clarify their protocols such that medical evaluations would be recommended for a greater number of children who would benefit. Understanding that the offender-to-victim contact is an important determinant, it is likely

that CACs and MDITs are more likely to seek medical care for kids disclosing more severe types of contact (e.g. genital-to-genital, anus-to-genital, etc.). This could prevent children who made no disclosure and/or incomplete disclosures, especially about sexual abuse, from being referred to and receiving an exam even though it may be highly beneficial to them. Therefore, it is further recommended that CACs reference the **West Virginia CAC Referral Guidelines** for guidance as to which children, beyond the more egregious and obvious cases, would benefit from a medical evaluation. Noted by the team as areas of need/interest:

- Another scenario not taken into account in this study, but of importance, is understanding the circumstances under which a sibling should be referred to a medical evaluation based on a disclosure of abuse for another child in the home. CAC protocols should include, or be edited to include, clear guidance.
- As is well-known in the field, disclosure is a process rather than an event. Just because a child is unable to tell the interviewer what is happening, there may still be enough evidence and/or concern to warrant a medical referral and exam for these children. Additionally, children may come to a CAC or MDIT who are unable to disclose in an interview – particularly the youngest and most vulnerable children. Four of 42 children in this study who did not disclose abuse were referred to a medical evaluation, and five of 42 children who did not disclose abuse in the interview received an exam. In these cases, it may be the findings of the medical exam, as opposed to the child's story, that keeps them safe. Protocols should take into consideration the wide variability of the information beyond the interview that may warrant a medical referral.

Team Dynamic and Education

Summary: The purposes and benefits of a child abuse medical evaluation, and the broad circumstances in which it may benefit victims, must be understood by the MDIT and made more routine in MDIT practice. This will be accomplished through ongoing education and concerted effort to change team culture around the medical component of child abuse investigation and treatment.

In addition to the MDIT education and planning that would go into expanding local medical protocols, more must be done to address team dynamics around child abuse medical evaluations. The purpose, limits, and process of medical evaluations is important knowledge for MDIT members to have, but the purpose of medical evaluations must also be elevated in importance and made more routine the overall team practice. Much of this work will come in the form of 'myth-busting' and making a medical referral a more routine part of MDIT practice.

This study dispels some of the myths around a child's access to care. Participants in the research team were largely surprised by the fact that a child's driving time (distance) from the CAC's medical provider did not significantly contribute to the child ultimately receiving the service. That is not to say that distance is never a challenge, but it is also not the great stumbling block the research team anticipated it to be. Similarly, a child's living situation does not have a significant impact on their access to care. Children who are in their home of origin, have to go into foster care as a result of their case, or are already in foster care all have about the same chance of being referred to or receiving care. The insignificance of these variables is, largely, a positive thing as it relates to a CAC's role in facilitating a child's access to care – CACs cannot always control drive time or living situations, but CACs can influence the team's decision-making and processes.

To dispel the myths around what the child abuse medical evaluation is like, WVCAN also has a technical assistance document covering the **Myths and Facts** as well as a **Template PowerPoint** to help CACs and

their medical providers educate non-medical team members without having to start from the ground up. The participating CAC Directors also recommended the creation of a one-pager to present to team members comparing current and best practices, as well as rationale for the recommended changes.

Forensic Interview Details

Summary: Abuser-victim contact and physical symptoms are the most significant determinants of whether or not a child will be referred to and ultimately receive specialized medical care as part of the MDIT/CAC response. Careful attention to sensory details in the forensic interview will open the door to more referrals for more children.

Understanding that the types of victim-abuser contact and physical symptoms were such significant determinants of a team's decision to connect a child to care, it is recommended that forensic interviewers explore relevant sensory and contact details with the child. This is standard procedure for forensic interviews, but each interview is challenging in its own right. Best practice would be to have the team's medical provider present at the interview to ask the interviewer to expand and clarify as details relate to the necessity for an exam, but this is unlikely in most West Virginia communities. As non-medical MDIT members become familiar with broader reasons for a medical referral, they can ask for clarifying and follow-up questions when a medical team member is not present at the interview.

Assisting Caregivers and the Role of Advocates

Summary: Advocates are the primary person to educate children and caregivers about the exam and assist them in accessing it. Therefore, advocates need ongoing training and support as it relates to educating children and caregivers, setting appointments as soon after the forensic interview as possible, and accompanying families to the medical evaluation.

Advocates also play a tremendous role in removing obstacles to a child's receipt of child abuse medical care. Particularly, when the medical provider cannot be at the post-interview family meeting, the Advocate will be the primary person explaining the reasons for the referral, purposes of the exam, and process to the child and caregiver. WVCAN has resources, including the **Medical Exam Handout for Caregivers** to assist Advocates in the process of educating caregivers. Additional and uniform education on this role to CAC Advocates is recommended by the research team.

The team also discussed the importance of the advocate allaying a child and family's reluctance to receive the medical evaluation by helping to schedule the appointment as quickly as possible and by accompanying the child and caregiver to the exam itself. Particularly for medical care that is not co-located with the CAC (18/20 programs in the state), having the familiar face of the Advocate may encourage more families to keep their appointments. The team recommended the creation of an additional technical assistance document outlining the importance of advocate accompaniment to exams and how to establish that practice in the local community.

Informing the Medical Community at Large

Summary: Child abuse medical providers serving West Virginia children are more numerous, well-connected, and supported than ever. However, other medical providers who may encounter abuse or suspect that a child is a victim still do not know about the specialized services and multidisciplinary team processes there to serve them. It is recommended that, both on the statewide and local level, the medical community at-large be educated about the availability of these services and how to access them when a patient needs this care.

Emerging from in-the-field practice as opposed to the data in this study, the team identified the medical community's unfamiliarity with CACs, MDITs, and specialized child abuse medical providers as a barrier to children receiving timely and appropriate care when abuse is reported or suspected.

Measurement of Change

It is recommended that this study be duplicated at a later date to measure changes in children's access to child abuse medical care in West Virginia.

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