Medical Evaluations for Alleged Victims of Child Abuse
Background

2012
Realization of gap in access to child abuse medical evaluations for Texas children

2013
Research study conducted by the UT School of Social Work to examine barriers and make recommendations

2014
Development and dissemination of “When to Refer” guidelines, endorsed by Texas Pediatric Society and Children’s Hospital Association of Texas (CHAT) and additional resources

2015–2016
Efforts continue to expand access to medical evaluations

2017
Survey of CACs reaffirmed barriers identified in 2013

2018
Recognition of need to identify the gap and the target more specifically
2012: Gap Identified

34%  
Nationally, 34% of children who came to the attention of a CAC/MDT were being referred for medical evaluations.

21%  
In Texas, that number was only 21%, and in rural areas, only 8%.
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Survey of CACs reaffirmed barriers identified in 2013

2018
Recognition of need to identify the gap and the target more specifically
2013: Research Study by UT School of Social Work

Findings:

▪ Lack of consistency in decision-making around when to refer children for medical evaluations; lack of statewide guidelines/recommendations

▪ Reluctance among law enforcement personnel to refer children for medical evaluations
  ▪ Education/training
  ▪ Complicated billing structure

▪ Lack of hospital support for SANE/child abuse programs

▪ Lack of qualified medical professionals to conduct evaluations
2013: Research Study by UT School of Social Work

Highlighted Recommendations:

- Develop statewide guidelines for medical evaluations
- Provide cross-training to improve understanding of medical evaluations among MDT members
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2017
Survey of CACs reaffirmed barriers identified in 2013

2018
Recognition of need to identify the gap and the target more specifically
2014: “When to Refer” Guidelines & Additional Resources

- “When to Refer Guidelines” developed; endorsed by Texas Pediatric Society (TPS) and Children’s Hospital Association of Texas (CHAT)
- Training videos for MDT members developed and disseminated
- Medical Evaluation Toolkit developed and disseminated
- Regional trainings for MDT members launched
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2015–2016
Efforts continue to expand access to medical evaluations

2017
Survey of CACs reaffirmed barriers identified in 2013

2018
Recognition of need to identify the gap and the target more specifically
2015-2016: Efforts continue, but CACs/MDTs still face barriers to expanding their medical services.
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2017
Survey of CACs reaffirmed barriers identified in 2013

2018
Recognition of need to identify the gap and the target more specifically
2017: Survey of CACs Reaffirms Barriers

Hospital support appears to have improved somewhat.

CACs still report reluctance to refer among law enforcement as significant barrier.

CACs report that overall, most MDTs are not using the “When to Refer” guidelines because of a lack of buy-in among partner agencies.
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2018
Recognition of need to identify the gap and the target more specifically
2018: Recognition of the Need to Identify the Gap and the Target

- We knew that in Texas, only 16% of children who came to the attention of a CAC/MDT were receiving medical evaluations, and we knew that nationally, that number was 34%.
- We knew that a gap existed for children in Texas, but what we did not know was how big that gap was.
- In other words, we did not know what the percentage of kids referred for medical evaluations should be.
Identifying the Gap and the Target

- CACTX aimed to get a better understanding of the percentage of kids that should receive a medical evaluation based on best-practice guidelines.

- Four CACs across Texas collected data for three months for this project. They looked at intakes and compared each child’s information to the “When to Refer” guidelines for medical evaluations.

- The centers then recorded each intake and whether the child met the “When to Refer” guidelines.

- Some of the CACs also reported additional data, such as how many children actually received medical evaluations, and the barriers that prevented children from receiving evaluations.
Identifying the Gap and the Target

TARGET: This is the percentage we need to determine.

Intake
(Intake reviewer compares intake to guidelines)

Does the child meet criteria for a medical evaluation?

- Yes

Was the child referred for a medical evaluation?

- Yes

Did the child receive a medical evaluation?

- Yes

- No

Why not?

- No

Why not?

- Unsure

Reassess Post-Forensic Interview / Further Investigation
“When to Refer”
Guidelines Review

When to Refer Children for Medical Evaluations:
Guidelines for Texas Children’s Advocacy Centers

March 2014

Endorsed by the Texas Pediatric Society and the Children’s Hospital Association of Texas
Guidelines for Referral for Medical Evaluations

**Criteria A**

When a child is first encountered by a non-medical MDT member and has not yet had a medical evaluation after an injury or an outcry of abuse.

**Criteria B**

When a child has been treated for suspected abusive injuries by a medical provider, including a first responder (EMS), who is not part of the MDT. Review of the case by the MDT’s medical consultant is recommended.

**Criteria C**

Other specific situations that should be reviewed with the MDT medical consultant to determine the need for medical evaluation.
Criteria A

**SEXUAL ABUSE**

- Contact of abuser’s mouth with child’s genital or anus at any time
- Contact of abuser’s genitals with child’s genitals or anus at any time
- Contact of abuser’s hands or fingers with child’s genital or anus
- Risk for partial or incomplete disclosure or recantation, regardless of type of contact reported by child
- Preteen sibling of a preteen child confirmed to have STD

**PHYSICAL ABUSE**

- Child is 0-6 months of age with any injury
- Patterned bruises, lacerations, or burns
- Child states he/she has been hit in the face, hit with an object, whipped, punched, slapped, kicked, or beaten
- Child appears malnourished or starved and/or demonstrates deprivational behaviors
- Siblings or housemates of children with injuries or conditions that are being evaluated for serious abuse or neglect
- Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures, chest or abdominal injuries
- Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive
Criteria B

SEXUAL ABUSE

Child examined and report initiated by non-MDT provider for genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child

Child or adolescent diagnosed by a non-MDT medical provider with an abnormal examination or an STD

PHYSICAL ABUSE

Severe injury or condition that required medical attention or hospitalization and that initiated a report to CPS or law enforcement
• Child displays abnormal sexualized behaviors
• Child has been exposed to pornography
• Child was in the care of intoxicated caregivers.
• Domestic or other violence has occurred in the home.
• Child expresses fear or appears fearful of the parent or caregiver
• Child was left unsupervised in environments that are potentially dangerous or lethal
• Child was not protected and/or basic needs were not being met.
• Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment
• Caregiver of investigator expressed a request for examination or a serious concern not included in other criteria
• Drug-endangered children
• Child exposed to an alleged or reported perpetrator of other children
Findings

32%–72% of intakes involve a child who meets criteria for referral for a medical evaluation.

20%–57% of intakes involve a child who meets criteria for referral for a physical abuse medical evaluation.

21%–46% of intakes involve a child who meets criteria for a referral for a sexual abuse medical evaluation.
Findings

Met Criteria A

32% - 72%

of intakes involve a child who meets criteria for referral for a medical evaluation.

20% - 57%

of intakes involve a child who meets criteria for referral for a physical abuse medical evaluation.

21% - 46%

of intakes involve a child who meets criteria for a referral for a sexual abuse medical evaluation.
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Limitations

Centers who participated in this project were not asked to track data regarding consultations that took place with a medical provider under Criteria B and C, so it is unknown how many of these cases would be determined to need a medical evaluation.

Determinations about which cases met the criteria for referral for a medical evaluation were made based on information contained in statewide intakes, which could lead to overreporting of cases requiring a medical evaluations for jurisdictions who receive a high number of suspected false reports.
Medical Evaluations Provided

Four jurisdictions; September 2018- November 2018 (Q1)

- Children Who Received a Medical Evaluation
- Children Who Qualified for a Medical Evaluation under Criteria A
- Children Who Qualified for a Medical Evaluation under Any Criteria
Medical Evaluations Provided

Sexual Abuse Cases

- Children Who Received a Sexual Abuse Medical Evaluation
- Children Who Qualified for a Sexual Abuse Criteria A Medical Evaluation
- Children Who Qualified for Any Sexual Abuse Medical Evaluation

Physical Abuse Cases

- Children Who Received a Physical Abuse Medical Evaluation
- Children Who Qualified for a Physical Abuse Criteria A Medical Evaluation
- Children Who Qualified for Any Physical Abuse Medical Evaluation
We know now that somewhere between 32% and 72% of children who come to our attention should be referred for a medical evaluation.

We know that 32% of children meet criteria A for referral for a medical evaluation. These children likely have the highest need for services.

**Our goal:**
Move the needle closer to 32%.
Now What?

Discuss data and findings with membership.

Encourage and equip centers to collect their own data to inform program expansion.

Focus on children with highest need (criteria A); focus on moving the needle closer to 32%.

Work with Texas Pediatric Society (TPS) Committee on Child Abuse and Neglect to update and reformat guidelines.

Disseminate updated guidelines to membership.

Incorporate updated guidelines into the working protocol review process.
Thank you!