



# SCAN

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## American Academy of Pediatrics Newsletter of the Section on Child Abuse and Neglect

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### Farewell from the Chairperson—Lori Frasier, MD, FAAP

This is a bittersweet note for me. As my last message to the section I have mixed feelings that my four year term as chair is ending. In all it has been a seven year opportunity to serve the section on the executive committee and as chair for the last four years. This has been one of my most rewarding positions and I plan to continue to be active in SOCAN in the future. I am pleased to be able to turn this position over to my dear friend and colleague Dr. Suzanne Starling, who I know will be the best chair of the executive committee yet! I also look forward to serving this community as a member of the new Child Abuse Pediatrics sub-board for the American Board of Pediatrics. New challenges await! Over the next two years, this sub-board will be writing the first examination in Child Abuse Pediatrics. The Section and Committee on Child Abuse and Neglect has been so involved in this process of sub-board certification, that it is a natural transition of responsibilities for me.

Other initiatives that the current executive committee have been involved with include: recruitment and retention of section members (Dr. Alex Levin as membership chair and Dr. Scott Benton as nominations chair), reviewing position statements from the Committee on Child Abuse and Neglect, continuing our highly successful proposal process for child abuse oriented programming at the NCE, working with PAS on introducing child abuse programming at the PAS

meetings, and working with the AAP on other CME offerings involving child abuse and neglect (Dr. Vince Palusci is a great program chair). Dr Emalee Flaherty has been a terrific awards chair and our section has given its highest honor to some of the most influential pediatricians in the country. I have served on the NACHRI task force in child abuse to assist NACHRI in developing a toolkit for children's hospitals to rate and further develop child abuse programs. Dr. Palusci and I have represented AAP on the planning committee for the Office of Child Abuse and Neglect's (OCAN) national conference. Two members of the executive committee Drs. Emalee Flaherty and John Stirling were our "Bright Futures" reviewers to ensure child abuse issues were addressed during well child visits. It has been elucidating to attend the AAP's Annual Leadership Forum (ALF) and be a voice for SOCAN in this great organization of pediatricians. SOCAN has been a strong supporter of child abuse prevention efforts and the development of the Health CARES network initiative which is now a primary focus of our AAP lobbyist Cindy Pelligrini in Washington DC.

In August 2006 we held our first joint meeting with the International Association of Forensic Nurses (IAFN) and the National Association of Pediatric Nurse Practitioners (NAPNAP)...

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## Preventing Child Abuse and Neglect with Home Visiting: Where Are We Today? - David Olds, PhD

In 1991 the US Advisory Board on Child Abuse and Neglect identified child maltreatment as a national emergency and recommended that a system of universal home visiting be established to prevent this devastating problem. The Advisory Board promoted national expansion of Hawaii Healthy Start (HHS), a program of paraprofessional home visiting that appeared to prevent maltreatment in a non-randomized study. In response to the Advisory Board's recommendation, the National Committee to Prevent Child Abuse (known now as Prevent Child Abuse America) created Healthy Families America, a national initiative designed to disseminate the Hawaii model throughout the United States. Today, HFA programs are located in 430 locations throughout the United States and Canada. For full details, go to [www.healthyfamiliesamerica.org](http://www.healthyfamiliesamerica.org).



**Dr. Olds is Professor of Pediatrics, Psychiatry, and Preventive Medicine at University of Colorado at Denver and Health Sciences Center**

This national effort was based upon thin evidentiary foundations, as there had been no randomized trial of the Hawaii program. For more rigorous evidence to support its recommendation, the Advisory Board relied upon results of the Elmira trial of the Nurse Family Partnership (NFP), a program of prenatal and infancy home visiting by nurses that differed in substantial ways from the Hawaii program. In the past decade, a series of randomized controlled trials has been conducted on the HHS program and its HFA spin-offs in Alaska, New York State, and San Diego.

There is no compelling evidence from these trials that HHS or HFA prevent maltreatment or other clinically important outcomes. While the trials found program effects on some aspects of self-reported parenting behavior and beliefs (including reports of some abusive behaviors), there are no effects on official reports of child abuse or neglect, childhood injuries, or other objectively measured outcomes consistent with the prevention of maltreatment. A short-term program effect on observed features of the environment, child development, and parent report of child behavior at age 2 were found in the Alaskan trial, but a corresponding effect on child development in San Diego did not endure.

Duggan and colleagues concluded that one of the reasons the Hawaiian and Alaskan programs did not work is that they were implemented poorly, but the San Diego program was an augmented version of HFA implemented extraordinarily well. This suggests that the disappointing results observed for HFA programs are not likely to be explained simply by poor implementation, but are more likely attributable to fundamental challenges with program design. Additional research should be conducted on improving the HFA model, but until there is strong evidence from replicated randomized trials that it can affect clinically important outcomes, policy makers have every right to question the claim that this program prevents maltreatment or improves child or family functioning. In 2004, the Washington State Institute for Public Policy estimated that HFA produces a \$4,500 loss on investment for every family served. The results of these studies emphasize the importance of not investing in large programmatic initiatives until there is strong evidence based on replicated randomized controlled trials to guide such efforts.

In 1996, our team, which had developed and tested the NFP in a series of randomized trials, accepted an invitation by the US Justice Department to set up the NFP in high-crime communities throughout the US. We had held off on offering it for public investment until we had enduring evidence of program effects on

clinically important outcomes from replicated randomized trials conducted in Elmira, NY, Memphis, TN, and Denver, CO. These trials indicate that it can affect the following outcomes:

- Prenatal health, including prenatal tobacco use and hypertensive disorders of pregnancy;
- Childhood injuries revealed in medical records;
- Subsequent pregnancies and intervals between subsequent births;
- Father and male partner involvement in the family;
- Women's employment and use of welfare;
- Children's school readiness, as reflected in intellectual functioning, language development, and behavioral regulation.

The Washington State Institute and the Rand Corporation estimate that the NFP saves \$17,000 for every family served.

One of the reasons the NFP has been given attention from policy makers is that it reduced substantiated reports of child abuse and neglect in Elmira. By child age 15, the nurse-visited group had 48% fewer verified reports of maltreatment than did the control group, and 77% fewer verified reports among mothers who were at higher risk compared to control-group counterparts. The impact of the NFP on substantiated cases of child abuse and neglect was limited to Elmira, however, as the rates of maltreatment found in official records in Memphis and Denver were too low in the first 2 years of children's lives (3-4%) to serve as valid outcomes. Overall, the rates in Elmira were about 3 times higher than in Memphis and Denver, and 6-7 times higher for families at greater risk. Given that CPS records typically only pick up a small fraction of actual maltreatment, the results in Elmira are even more important. Moreover, in trials of home visiting, maltreatment will be detected at a greater rate in visited families because visitors are mandated reporters, which leads to the relative under-detection of maltreatment in the control group.

***“By child age 15, the nurse-visited group had 48% fewer verified reports of maltreatment than did the control group.”***

Given low rates of substantiated reports of maltreatment in the population in Memphis, we did not hypothesize program effects on CPS records in the Memphis trial, but instead hypothesized that the program would affect childhood injuries revealed in the medical record. We observed program effects on injuries that conformed to the pattern observed in Elmira; program effects were especially large among children born to mothers with low psychological resources. In the Denver trial, the health-care delivery system was too complex to trace children's utilization patterns reliably, so we were unable to use their medical records to corroborate program impact on child maltreatment. Instead, we focused on examining infants' early emotional expressions, as emotional expressions are associated with child abuse and neglect. We found that nurse-visited 6-month-old infants born to mothers with low psychological resources had higher rates of observed emotional vitality and lower rates of emotional vulnerability than their control-group counterparts. As these children matured, program effects emerged on their language and executive functioning that were consistent with better prenatal and early care-giving environments.

When we accepted the invitation from the Justice Department invitation to replicate the NFP in community settings, we did so with apprehension because we were concerned that the program might be watered down...

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## Excerpt from *The Quarterly Update*—Spring 2006

The Quarterly contains reviews of recent peer-reviewed articles chosen from over 1,000 medical journals on the diagnosis, prevention and treatment of child abuse and neglect. Medical, legal, mental health and social work professionals summarize the articles and offer opinions about the validity and significance of the research findings. This timely information keeps child abuse professionals apprised of the most recent findings, informs their clinical practice, and improves their ability to make sound decisions, based on the latest data. The following is an excerpt from the Spring 2006 Issue.

Subscriptions and back issues are available by contacting: Robert M. Reece, MD, FAAP, Editor  
The Quarterly Update, 32 Quail Hollow Road, North Falmouth, MA 02556, Email: RMRreece1@aol.com

**Child Abuse Pediatrics: A new pediatric subspecialty.** Robert W. Block, Vincent J. Palusci. *J Pediatr* 2006;148:711-712. (from Tulsa Oklahoma and Detroit Michigan.)

In June 2005, the American Board of Pediatrics (ABP) accepted a petition to begin a new pediatric subspecialty, board certified by the ABP. It is anticipated that the American Board of Medical Specialties will approve this in 2006.

The authors of this paper - both long time child abuse pediatricians themselves- describe the evolution of the field now called Child Abuse Pediatrics from the early days when Kempe and Helfer pioneered this field to the present. They discuss the formation of the Helfer Society by “a group of pediatricians focusing on clinical, educational and research” in child abuse. They summarize the function of the child abuse pediatrician when they say that “these physicians serve as a resource to children, families, and communities by accurately diagnosing abuse, consulting with community agencies on child safety, providing expertise in courts of law, treating consequences of maltreatment, directing child abuse and neglect treatment and prevention programs and participating on multidisciplinary teams investigating and managing child abuse cases.”

There are two compelling reasons justifying this new subspecialty in pediatrics. The first is the need for more and better research. There are now over 31,000 citations in PubMed dealing with child abuse and neglect, more than 30 textbooks or monographs and several peer-reviewed journals devoted to child maltreatment. Through the Health CARES concept, a proposal for federal investment in a national health care infrastructure to reduce the health harms resulting from child abuse and neglect, it is hoped that significant funding will become available to support this new field as it seeks to answer numerous research questions.

The second reason –the need for enhanced education for current practitioners and for the next generation of physicians- has been emphasized by surveys indicating insufficient education for pediatric residents about child maltreatment. Increasing complexity in cases is being appreciated: diagnostic and treatment strategies are increasingly sophisticated. The role of the general pediatrician in child abuse cases will not be minimized, and the new specialist in child abuse pediatrics should serve the generalist in the same way as other subspecialists, such as the cardiologist or the endocrinologist. Full three-year Fellowships will yield the next academic leaders in the field as they define the core skills needed for medical students and residents. Opportunities for research will be greater within a Fellowship than is currently the case for those interested in pursuing research questions.

The numbers of child abuse pediatrics specialists is estimated to be 375 in the United States. This is calculated on estimates that 1 specialist is needed for each one million of population (based on 250 million population figure) and one specialist for each of the 125 medical schools. The reality of fiscal support will be a continuing problem and a large effort to obtain funding from local, state, federal and private foundations will need to be exerted.

**Reviewed by Robert M. Reece, MD**

**Reviewer's Note: This article needs to be read and understood by all Departmental Chairs within medical schools and hospitals, especially those in Pediatrics, Emergency Medicine, Obstetrics-Gynecology, orthopedics, neurosurgery, ophthalmology and Family Medicine. I am not sure the estimates for the numbers of needed child abuse pediatricians are based on reality, especially since the US population is reaching 300 million and we should probably base the need more on the population of children. But this is a small quibble and the rest of the article is very clear and succinct. I hope the funding issues can be solved in this time of national health care crisis.**

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## Preventing Child Abuse and Neglect with Home Visiting—Continued

(Continued from page three):

...in the process of being scaled up. We therefore built in procedures for ensuring faithful reproduction of the program's essential elements as it is replicated in new communities, which is managed today by the Nurse Family Partnership National Service office ([www.nursefamilypartnership.org](http://www.nursefamilypartnership.org)). In following this strategy, the NFP national office is supporting local programs that have greater likelihood of preventing child abuse and neglect and associated problems. Today, the NFP is operating in over 170 local operating sites, serving 20,000 families per year in 250 counties.

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