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The American Professional Society on the Abuse of Children in Partnership with the New York Foundling

About APSAC

Since being established in 1986, APSAC has served the field of child maltreatment as an interdisciplinary professional society. APSAC's Mission "is to improve society's response to the abuse and neglect of its children." APSAC's Vision is a world where all children and their families have access to the highest level of professional commitment and services to prevent and address child maltreatment. APSAC pursues its mission through expert training and educational activities, policy leadership, the production and dissemination of public education materials, collaboration, and consultation that emphasize theoretically sound research and evidence-based principles. APSAC's members are attorneys, social workers, law enforcement personnel, forensic interviewers, educators, researchers, and medical and behavioral health clinicians, and professionals from allied disciplines.

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The New York Foundling trusts in the power and potential of people and deliberately invests in proven practices. From bold beginnings in 1869, this New York-based nonprofit has supported hundreds of thousands of its neighbors on their own paths to stability, strength, and independence.

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The American Professional Society on the Abuse of Children™

ADVISOR

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Addressing Systemic Racism in the American Professional Society on the Abuse of Children Publications

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Abstract

The United States continues to grapple with longstanding policies and systems that have adversely impacted historically marginalized communities who identify (and are racialized) as non-White. These stem from a legacy of structural and systemic racism, and the long-term consequences of sanctioned colonization. This legacy rests upon a field of scholarly research that is similarly fraught with white supremacy. As a field, we must examine the process of producing and publishing the body of evidence that has codified harmful policies and practices. Although racial and ethnic disparities have been discussed for decades in the child welfare and health systems, systemic racism has received comparatively little attention in academic research and practice journals. In this commentary, the authors detail concrete steps over the coming years that will advance diversity, equity, inclusion and justice through American Professional Society on the Abuse of Children's (APSACs) practice journal, the *Advisor*. The journal is committed to anti-racist publication processes, such that the journal pledges to develop procedures, processes, structures, and culture for scholarly research that promotes diversity, equity, inclusion, and justice in all forms.

Keywords: *systemic racism, child maltreatment, diversity*

Addressing Systemic Racism

The United States has always suffered, and continues to endure, a plethora of traumatic harms directly related to white supremacy, a legacy of structural and systemic racism, and the long-term consequences of sanctioned colonization (for definitions of white supremacy, structural racism, systemic racism, colonialism, anti-racism, equity, and inclusion, see MP Associates, 2022). For decades, we have witnessed countless murders, disproportionate incarceration and involvement in child welfare, and other individual and systemic violence perpetrated on historically marginalized communities who identify (and are racialized) as non-White and have ultimately remained complicit in our tolerance of this structural trauma as status quo. There are innumerable examples of ways in which this complicity plays out in all our institutions, organizations, policies, and processes.

We, as members of the American Professional Society on the Abuse of Children (APSAC), seek to improve society's response to the abuse and neglect of its children. APSAC achieves its mission in several ways; most notably through expert training and educational activities, policy leadership and collaboration, and publication, both through peer reviewed and professional journals. Incorporated in 1987 by a multidisciplinary group of researchers, scholars, clinicians, and child advocates, APSAC has become a hub for training and education for the field. APSAC focuses on the entire continuum of services for children and families, including, but not limited to, prevention, investigation, clinical evaluation, intervention, and court involvement.

The APSAC *Advisor* is a peer reviewed quarterly news journal for professionals in the field of child abuse and neglect. The APSAC *Advisor* provides succinct, data-based, practice-oriented articles that keep interdisciplinary professionals informed of the latest developments in policy and practice in the field of child maltreatment. It is designed to highlight best practices in the field and publish original articles and current information about child maltreatment for professionals from a variety of backgrounds including medicine, law, law enforcement, social work, child protective services, psychology, public health and prevention in the U.S.

Recognizing that high-quality original research in the field of child abuse and neglect can and should have an immediate impact on the quality of children's lives, the editors and editorial board of the *Advisor* are committed to creating a journal that advances a rigorous scientific knowledge base, recognizing diversity across all realms, and remaining readily accessible to a diverse audience. The *Advisor* is committed to an anti-racist publication process, such that the journal pledges to develop procedures, processes, structure, and culture for scholarly research and practice recommendations that promote diversity, equity, inclusion, and justice in all forms.

The authors of this commentary represent various facets of the organization, such as members of the Board of Directors, the APSAC publications committee, the leadership and editorial board of Child Maltreatment and the *Advisor*, and the APSAC Commission for Racial Justice in Child Maltreatment.[1] In this commentary, the authors detail concrete steps to advance diversity, equity, inclusion and justice through our publication of the *Advisor*. While APSAC is in the process of developing policies, procedures, and practices to address these issues for its other publications, this commentary focuses specifically on the *Advisor*.

[1] In 2020, APSAC joined organizations around the world in responding to the murder of George Floyd by police officer Derek Chauvin. Specifically, APSAC committed to developing, monitoring, and providing regular updates on an organizational action plan to eliminate systemic racism and implicit bias in the child maltreatment field. APSAC's Commission for Racial Justice in Child Maltreatment was established and impaneled by APSAC board members and subject matter experts willing to develop recommendations for APSAC to confront systemic racism and biases that contribute to disproportionality and racial injustices experienced by historically marginalized communities who identify as non-white in the child protection and child welfare systems. The Commission's vision is that historically marginalized children and families who identify as non-white in the child protection and child welfare systems. The Commission's vision is that historically marginalized children and families who identify as non-white will be treated fairly and justly, without prejudice, and will enjoy the same opportunities as those who are White. To achieve this goal, APSAC's Commission for Racial Justice in Child Maltreatment released a call for nominations and a convening action plan, which included recommendations for anti-racism auditing, collaborations, training, credentialing, policy recommendations, a certificate program, and, as outlined in this commentary anti-racist publication.

System and Structural Racism

We believe it is important to acknowledge that systemic and structural racism persist within our child- and family-serving systems (e.g., child welfare, mental health, juvenile justice), impact our prevention and treatment efforts (Merritt, 2020, 2021), and are embedded within the research we rely on to substantiate our approaches to policy and practice. The field must acknowledge our collective inaction to fundamentally and intentionally challenge and alter the harmful policies and practices that create and maintain the inequities we see today in our child and family serving systems. For instance, mandated reporting can be biased as reflected by the fact that disproportionate numbers of Black and Native American children have contact with the child protection and child welfare systems (Palusci, & Botash, 2021). This does not occur by chance but instead is the direct consequence of a system designed to achieve these results. Image 1 provides an example of a timeline of child welfare policies and practices steeped in white supremacy that have directly targeted historically marginalized communities who identify as non-white. These child welfare policies are similarly tainted by white supremacy, which have led to continued disproportionalities in the child welfare system. This image is not meant to be exhaustive but is illustrative of the ways in which strategies and policies have disenfranchised historically marginalized communities who identify as non-White within one of the major child-serving systems within our field.

As a field, similarly fraught with a legacy of white supremacy, we must examine the process of producing and publishing the body of evidence that has codified harmful policies and practices. Although racial and ethnic disparities have been discussed for decades in the child welfare and health systems, systemic racism has received comparatively little attention in academic research and journals (Harris, 2021; Roberts et al., 2020). As we study the nature of our knowledge about child abuse and neglect, it becomes increasingly apparent that individual and systemic biases are also embedded across the research enterprise (Bonilla-Silva & Zuberi, 2008; Boyd, Lindo, Weeks & McLemore, 2020; Ogedegbe, 2020). Scientific communities and the platforms used to disseminate research and practice findings (i.e., academic journals and newsletters) have an ethical obligation to fundamentally re-think the research design and dissemination processes. This includes evaluation of the questions posed, the interpretation of findings, the pipelines created to bring scholars of color into the field, the standards for reviewing and publishing scientific articles, and the diversity of our reviewer pools and editorial boards. This process will challenge the field to examine deeply held epistemological and ontological standpoints that privilege certain types of knowledge and evidence over others (omitting evidence based on lived experiences).

There are a host of steps journals can implement, on an ongoing basis, to reassess internal processes to increase their ability for self-reflection regarding racial diversity, equity, inclusion, and justice. For instance, editorial and publication guidelines should be reviewed regularly, re- vised, if necessary, and disseminated to authors and reviewers. Scholars can be asked to unambiguously address and define race and ethnicity in their research, specify the importance related to the scope of work, and avoid samples that include people disproportionate in race, as well as analyses that inappropriately treat race and ethnicity as biological traits rather than as social constructs (Boyd, Lindo, Weeks & McLemore, 2020; Roberts et al., 2020). Moreover, researchers can be encouraged to push the boundaries toward solutions-oriented and strengths-based scholarship and explore methodologies that apply varying definitions of race and ethnicity in the context of disparities, race equity and racism, including its effect on maltreated children.

APSAC, our flagship, peer-reviewed journal, Child Maltreatment, and the *Advisor* do not have all the answers. With the help of the APSAC Board of Directors, the APSAC Anti-Racism Commission on Racial Justice in *Child Maltreatment*, and members of the editorial team of the *Advisor*, we are examining and reflecting on our editorial process,

inclusive of the practice-based relevance, intentional evaluation of the study questions, underlying theory and supporting literature, methodological and analytical choices, and the interpretation of results in terms of diversity, inclusion and equity. Following suit with others, we need to be clear about our research inquiries and aims, treatment and intervention designs, dissemination plans, the wording and language we choose, and how we use them (American Psychological Association, 2020; Flanagin, Frey, & Christiansen, 2021; Herrenkohl et al., 2020; Trent, 2019). As a platform for development and growth in the field, the *Advisor* can be an important source of information about the nature of and effective measures to highlight racism. Through our commitment to encouraging anti-racist science and promoting discourse concerning the structure and consequences of systemic racism, we endeavor to shape the field by promoting anti-racist policies, practices, and the very science base upon which they are predicated.

APSAC Advisor's Commitments to Promote Diversity, Equity, Inclusion, and Justice

This section outlines specific commitments from APSAC over the next years towards the goals of promoting diversity, equity, inclusion, and justice across all stages of the publishing process for the APSAC *Advisor.* APSAC's commitments to equitable and justice-oriented publishing fall into three major categories: representation, process, and content. To be clear, we are in no way suggesting that the required work will only take a year. Instead, we recognize that the work of promoting diversity, equity, inclusion, and justice through APSAC's publications is a lifelong endeavor and that our specified steps provide direction and accountability for our commitments.

We are also aware that none of these commitments will fully eliminate injustices and inequities within the field or even within the journal. Each of these commitments is designed to be achievable in the coming year and to lead to something more provocative in the years thereafter. To hold ourselves accountable, we commit to publishing an annual progress update on our website, evaluating the status of all our commitments, and planning next steps based on our progress.

Representation

- The *Advisor*'s Editor-in-Chief and Associate Editor will develop a plan to recruit historically marginalized scholars and practitioners who identify as non-White to write, review, and serve as Consulting Editors. The plan will include strategies to provide ongoing support to these scholars and practitioners. *Estimated completion: June 2025.*

Process

- The *Advisor* Editor-in-Chief and Associate Editor, in collaboration with APSAC staff, will revise author guidelines to require that each article addresses the issues of diversity, equity, inclusion, and justice. *Estimated completion: June 2025.*
- The *Advisor* Editor-in-Chief and Associate Editor will amend the reviewer guidelines to include an assessment of how well each article addresses the issues of diversity, equity, inclusion, and justice. The requirements will specifically state that articles should go beyond simply mentioning diversity, equity, inclusion, and justice, and instead, work to disrupt the status quo and advance the conversation around how these issues are discussed in scholarly work. *Estimated completion: December 2024.*
- The APSAC Publications Committee, in collaboration with APSAC staff, will amend the applications for *Advisor* Editor-in-Chief, Associate Editors, and Consulting Editors to include questions regarding commitments to diversity, equity, inclusion, and justice. *Estimated completion: June 2024.*

Content

- The APSAC Board of Directors, in collaboration with the *Advisor* Editor-in-Chief, will revise the current Aims and Scope of the *Advisor* to explicitly state our commitment to anti-racist research and publishing. *Estimated completion: December 2024.*

Conclusion

This commentary seeks to acknowledge the effects of systemic racism and harms done to historically marginalized communities who identify as non-White by those who create and disseminate research and practice findings in the field. In addition to our abovementioned commitments, we also seek to identify concrete ways that APSAC can support the *Advisor* in the process of rectifying some of these harms, beginning with our own leadership, publication processes, and resultant content. This undertaking is substantial in that it requires us to challenge everything we think we know about scholarship and publishing, whilst grappling with the acknowledgement of the harms of white supremacy and the impacts on all aspects of life. While we recognize that we cannot erase centuries of harm even with our most audacious goals and commitments, we do hope that, over time, the work we have embraced creates more equitable and just scholarship and publication, ultimately leading to better outcomes for all children and families.

Examples of systemic racism and child welfare in the U.S.

Systemic Racism and Child Welfare in the U.S.
A Timeline

1619-1865
SLAVERY

White people forcibly and often violently enslaved people of African descent, who were identified as chattel. Enslaved people of African descent were robbed of their human rights and parental authority to protect their children, make decisions regarding their children's well-being, and as a result, enslaved children and their families lived in constant fear of being separated.

1830/1838
INDIAN SCHOOLS

Indian Relocation Act and beginning of Federal Boarding (Residential) Schools and Missionary Schools

As part of Manifest Destiny and assimilationist principles, federal policy was introduced to exterminate non-White cultures. The federal government forcibly removed American Indian children from their families and sent them to residential boarding schools that systematically sought to extinguish native languages, religion, and culture.

1863-1877
RECONSTRUCTION

The 13th-15th Amendments are considered some of the greatest achievements of the Reconstruction Era. Despite this, white supremacy prevailed, and the due process clause of the 14th Amendment made room for racist policing and mass incarceration.

1865-NOW
WHITE TERROR

The Ku Klux Klan was erected as a Confederate terrorist revolt against Reconstruction that continued the legacy of killing and inflicting trauma against Black Americans. White mobs and people killed, attacked, and terrorized Black men, women, and children, justifying their actions with racist beliefs and often unsubstantiated or fabricated accusations. Those responsible for the violence and terror rarely, if ever, faced consequences.

1877-NOW
JIM CROW & SEGREGATION

Jim Crow laws legalized segregation and racist practices against Black people. Children's schools were underfunded and racially segregated, while schools for White children received more funding contributing to existing disparities in education and wealth.

1934-1939
NEW DEAL ERA

The New Deal Era policies created the modern social safety net. Black families were systematically and intentionally excluded from benefiting from services and supports (e.g., Federal Housing Administration redlining practices).

1940-1960
WELFARE POLICIES

Tensions churned as both white and black female reformers addressed financial programs (e.g., AFDC) and decisions related to means testing and moral testing (Black families scrutinized as underserving/unworthy).

1962
AFDC

ADC renamed to Aid to Families with Dependent Children (AFDC)

1960-1980
COLOR OF POVERTY

Increasingly, poverty is colorized/racialized in the media and associated with Black families burdening deserving families and in need of continued penalties masked as supports.

1971-NOW
WAR ON DRUGS

Although the explicit stated policy goal of War on Drugs was to reduce illicit drug use, politicians pursued the efforts to disrupt Black families and communities. The policies, which more harshly criminalized drugs that were more frequently used in Black than White communities, increased policing surveillance and started the modern era of mass incarceration of Black Americans.

1974
CAPTA

Original Child Abuse Prevention & Treatment Act (CAPTA) enacted

This landmark legislation established the modern child welfare system. While CAPTA created federal definitions of child abuse and neglect and established the grounds to fund research, it also started the criminalization of family's needs rather than creation of family supports. CAPTA focused on child abuse and neglect, without challenging the larger context of discriminatory policies and practices and the legacy of white supremacy nor seeking to build support for children and families regardless of race.

1978
INDIAN CHILD WELFARE ACT

Indian Child Welfare Act (ICWA) enacted

The federal government identified that state child welfare and private adoption agencies were removing American Indian and Alaska Native children from their homes and communities at a much higher rate than non-Native children. The policy sought to rectify the issue through policies that transferred authority to Native communities, but no additional resources were given to the communities to assist and support children and families.

1994
MULTIETHNIC PLACEMENT

Multiethnic Placement Act (MEPA)

While the stated purpose of the legislation was to expedite foster placements and adoption, when paired with disproportionality in child welfare and mass incarceration, some advocates argue that MEPA sets the stage for "white saviorism" and "cultural erasure" via transracial adoption. The Interethnic Placement Act (1996) amended MEPA and remains the principal federal legislation to direct considerations of race, color and national origin in foster care and adoptions decisions.

1997
ADOPTION AND SAFE FAMILIES ACT

The Adoption and Safe Families Act (ASFA) was designed to expedite adoptions and shorten the time that children remained in foster care by reducing the timeline for initiating Termination of Parental Rights (TPR). This policy did not explicitly address incarceration; parents incarcerated because of the War on Drugs, who were disproportionately Black, were more likely to have their rights terminated.

2018
FAMILY FIRST

Family First Prevention Services Act enacted

The legislation allows states to use Title IV-E foster care maintenance payments for children in foster care who are placed with a caregiver in a licensed residential family-based treatment facility for a Substance Use Disorder (SUD) and created a new funding stream to pay for SUD treatment, mental health services, or in-home parenting programs. Although the provisions in this act were framed as a solution to the number of children entering foster care due to the opioid crisis, it stands in stark contrast from the response to SUD seen in the War on Drugs, perhaps because heroin users are overwhelmingly White.

2017-NOW
CHILD SEPARATION AT THE U.S. BORDER

The federal government separated immigrant and refugee children from their families without due process at the U.S. border. The government kept children in detention centers and tent cities without plans for reunification. Allegations of staff and contractors abusing children in the detention facilities have been substantiated. While the policy officially ended in 2019, family separation continues under new policies.

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Practice in U.S. Children's Advocacy Centers: Results of a Survey of CAC Directors

Theodore P. Cross; Debra Whitcomb; Emi Maren

Abstract

Children's Advocacy Centers (CACs) coordinate the investigative and service response to child victimization through the use of multidisciplinary teams (MDTs). They offer children and families medical, therapeutic support, advocacy services, and other services. Presenting results from a U.S. survey completed by 222 CAC directors in 2015, the current study focuses on the composition of MDTs and the forms of assistance CACs provide. Large percentages of CACs had representation on the MDT from all the core group of disciplines specified by the standards of the National Children's Alliance (NCA), the membership group of CACs. Small but meaningful proportions of CACs had representation on their MDTs from disciplines that are not typically centrally involved in child maltreatment investigation and services, but they could play a critical role in some cases. A wide range of services specified in the article was provided to children and caregivers often or routinely. CACs varied on the provision of other services, such as support groups for children and for caregivers, domestic violence risk assessment and safety planning, and helping caregivers with protective orders, information about civil remedies, and legal assistance. This research suggests that CACs are meeting NCA standards while varying to some degree in the specific forms of assistance they provide. It also suggests that CACs may want to consider adding more types of professionals to their MDTs.

Children's Advocacy Centers (CACs) are central to the response to child abuse and neglect in the United States. CACs coordinate the investigative and service response to child victimization and support child survivors and their families to reduce the stress that follows a child maltreatment allegation. Multidisciplinary teams (MDTs) are the mechanism CACs use to coordinate investigation and service delivery in a centralized, child-friendly setting. CACs use forensic interviewers specially trained to work with children; additionally, they offer children and families medical, therapeutic, advocacy, and other services (Cross et al., 2008). CACs help non-offending adult family members as well as children because child victimization is traumatic for the entire family (van Toledo & Seymour, 2016). This also helps bolster the non-offending caregivers' support for the child, which research shows is important for reducing the impact of child victimization and improving outcomes (see Malloy & Lyon, 2006; National Children's Alliance, 2017).

The National Children's Alliance (NCA), the accrediting organization for CACs, reports 961 CACs in the United States as of this writing (NCA, 2024). Canada and Australia have developed similar networks of children's advocacy centers (Child & Youth Advocacy Centers, 2021; Hall, 2021), and a CAC was established in Israel 20 years ago (Taylor et al., 2021). A related approach, the Barnahus model, originated in the Nordic countries and is now spreading in Europe through the efforts of the PROMISE Barnahus network (Johansson & Stefansen, 2020).

The original CAC focused on child sexual abuse (Cramer, 1985), but CACs deal with physical abuse, child witnessing of violence, neglect, drug endangerment (NCA, 2021), and commercial and sexual exploitation of children (Brandt et al., 2018). CACs also deal with intimate partner violence (also known as domestic violence); it may not be the identified problem that led to a referral, but CACs may learn about it

in the course of the investigation because it often co-occurs with child abuse (Appel & Holden, 1998; Sijtsema et al., 2020). CACs are also devoting increased attention to sexual abuse perpetrated by children and youth (Sites & Widdiefield, 2020), including sibling abuse (Taylor et al., 2021).

Most research on CACs has examined individual CACs or small sets (see Elmquist et al., 2015; Herbert & Bromfield, 2016), and data are limited on practice across the range of CACs in the United States. Presenting results from a U.S. survey of CAC directors, the current study focuses on the composition of MDTs and the forms of assistance CACs provide. It is adapted from a previous research brief (Cross et al., 2022) and includes updated information on the 2023 standards that the NCA maintains for CACs to be accredited.

The MDT

One NCA standard states that the core MDT for CACs must include representatives from the disciplines of law enforcement, child protective services, prosecution, medicine, mental health, and victim advocacy as well as CAC staff. The leaders of organizations on the MDT sign a written agreement committing to the CAC mission, goals, principles, and policies. The MDT may expand to include other professionals as well, which may be indicated given that CACs are dealing with an increasingly wide range of victimization. The MDT concept is somewhat of an abstraction that refers primarily to the collaboration of organizations. The specific individuals acting in their role as MDT members will vary over time and from situation to situation.

Most every CAC case involves multiple disciplines from the start. CAC cases almost always originate from a referral from child protective services, law enforcement, or a hospital or other health care provider (see Simone et al., 2005). CACs differ in their referral sources and pathways. The specifics of the interagency agreement and the referral process in a given CAC may influence what types of cases are referred to the CAC and which disciplines are involved in the MDT. Members of the MDT with investigative responsibility observe forensic child interviews at the CAC to assist them with the investigation, and often meet before and after the interview to plan the investigation and service response. All MDT members participate in case review meetings designed to coordinate a holistic and effective interagency response to the child and family. In our experience, the work of an MDT extends well beyond any particular structure or function. It encompasses interdisciplinary collaboration on any aspect of CAC policy and practice, as well as a range of ad hoc actions taken to respond to thorny cases and practice obstacles and opportunities.

The CAC Service Response

The NCA also has standards about what services a CAC needs to offer children and caregivers. One standard states, "All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a health care provider with specialized training and expertise" (NCA, 2023 a, p. 38). Another standard states that "an MDT response must include screening for trauma exposure and/or symptoms by identified members of the MDT as part of the MDT response, who then use that information to link to mental health services for assessment and trauma-focused mental health treatment for child victims and caregivers" (NCA, 2023 a, p. 44). Some CACs provide mental health services themselves, and some CACs ensure that other organizations in the MDT provide mental health services (Cross et al., 2008).

The provision of victim support and advocacy is another NCA standard that encompasses several specific types of assistance. Among the specific supports, interventions, and services included within victim advocacy are the following:

- crisis assessment and intervention
- risk assessment
- safety planning and support for children and family
- assessment of individual needs and cultural considerations
- informing and supporting the family regarding the MDT response
- assessing the needs of children and nonoffending caregivers
- provision of education and access to victims' rights and crime victims' compensation
- help with getting concrete services (such as housing, protective orders, domestic violence intervention, food, transportation, and public assistance)
- providing referrals for mental health and specialized medical treatment
- providing access to transportation to interviews and services, treatment, and other case-related meetings
- engaging children and families to help them understand the investigation and/or prosecution
- updating the family on legal status and actions
- court education and courthouse/courtroom tours, support, and accompaniment

(see NCA, 2023 a, p. 33).

CACs provide support and advocacy services in different ways. A dedicated advocacy professional employed by the CAC, often termed a family advocate, may provide various support and advocacy services. Some of these services may be provided through linkages with community-based or system-based professionals, such as domestic violence advocates, rape crisis counselors, court appointment special advocates (CASAs), advocates at culturally specific programs, or victim advocates in a district attorney's office or associated law enforcement agency. CACs may also have dedicated programs or groups to provide some of these services. For example, some CACs offer structured programs to educate child victims about court procedures (e.g., LifeHouse Child Advocacy Center, n.d.). Other CACs provide support groups for caregivers (e.g., Children's Advocacy Center of the Bluegrass, 2021).

Previous Research

Two surveys of CACs have examined what disciplines were represented on MDTs and the services CACs provided. Jackson (2004) conducted semi-structured interviews with 117 CAC directors selected by stratified random sampling. Consistent with the NCA standard, all CACs in the sample had law enforcement, child protective services, and prosecution representation on their MDT. Large majorities also had representation from mental health professionals (87%), medical professionals (86%), and victim advocates (80%). Other professions were represented on a minority of multidisciplinary teams: schools (21%), juvenile courts (17%), assistant district attorneys (17%), probation and parole officers (10%), court-appointed special advocates (9%), and domestic violence providers (6%). The following components were each present in 92% to 100% of CACs in the sample: child-friendly facility, a multidisciplinary team, child investigative interviewing, medical examinations, mental health services, victim advocacy, case review, and case tracking.

Herbert et al. (2018) found that the following disciplines participated in multidisciplinary teams

routinely in 90% or more of CACs: child protective services, police, a forensic interviewer, prosecutors/district attorney, and mental health professionals—again, consistent with the NCA standard. It was also common for medical professionals to participate in MDTs (79%), although other disciplines participated in MDTs in fewer CACs: juvenile court (35%), rape crisis counselors/advocates (30%), domestic violence counselors/advocates (25%), and other agencies (26%). The relatively large percentage in the "other" category suggests that more can be learned about the specific agencies that may participate in the MDT in a meaningful proportion of CACs.

Herbert et al. (2018) also provided information from the survey on how frequently seven different categories of services were provided at the CAC off-site by other agencies. The CACs almost universally provided forensic interviewing (> 99%), victim advocacy (99%), mental health services (95%), and medical services or examinations (95%), or both. A majority provided rape crisis services (57%) and domestic violence services (52%), and 41% provided other services, which were not specified in the research.

Herbert et al. (2018) conducted a cluster analysis that sorted CACs into three groups. *Basic* CACs provided basic CAC functions with less agency participation in MDTs and fewer services. *Aggregator* CACs had more services but lower participation on the MDT. *Full-Service* CACs had extensive co-location, participation in the MDT, service delivery, and governance structures.

The NCA compiles statistics across CACs nationally. In 2023, 55% of CAC cases involved sexual abuse, 20% physical abuse, 7% witness to violence, 6% neglect, 3% drug endangerment, and 8% other types of abuse (NCA, 2023b). Note that we do not know what percentage of those children who witnessed violence were exposed to domestic violence at home. NCA statistics are also available on the frequency of the following services: onsite forensic interviewing (44% of children), referral to counseling (20%), counseling or therapy (20%), referral to counseling or therapy (20%), medical exams and treatment (16%), and offsite forensic interviews (1%).

Several questions about practice within Children's Advocacy Centers remain. The biggest gap is the limited information about the specific forms of assistance that Children's Advocacy Centers provide to child victims and their families. The NCA standards require CACs to provide victim advocacy, but it is not clear how frequently CACs provide the different specific supports, interventions, and services encompassed by the victim support and advocacy standard. In addition, Herbert and colleagues' (2018) cluster analysis suggests that CACs vary on which forms of assistance they will provide depending on whether they are a Basic, Aggregator, or Full-Service CAC. Information about this assistance could provide a more complete profile of what CACs offer. This could help identify strengths across the community of CACs nationally and gaps that could be addressed with further program development. One particular value of assessing strengths and gaps for CACs is to help us understand how prepared the community of CACs is to deal with the increasingly wide range of victimization for which MDTs and a coordinated approach are recommended. The survey conducted for the present article not only replicates some of the questions from previous surveys but also provides more detailed information on the kinds of help that CACs provide child victims and their families. In addition, it not only replicates Herbert and colleagues' (2018) assessment of representation on MDTs in CACs but also provides more options to specify which agencies are represented on the MDT, enabling us to learn more about the range of agencies that might participate.

Method

The first and second authors conducted a national online survey of CAC directors in the Spring of 2015. Questions for the survey were developed by consulting multiple published sources on Children's Advocacy Centers and by talking with numerous content experts. The authors also drew on their combined experience of over forty years of studying CACs.

At the authors' request, the NCA distributed an email invitation via its membership list to recruit participants. The email inviting participation included a link to a survey webpage in the Qualtrics online survey system. Two reminder emails were sent out at regular intervals. The survey was kept open for approximately three months, and 222 CAC directors responded. The vast majority of directors (84.0%) were from CACs accredited by NCA: others were from associate/developing CACs (11.4%), affiliated centers (4.1%), and one satellite site (0.5%). NCA (2014) reported a total of 777 CACs at the end of 2014. Thus, our sample represented approximately 28.6% of the CACs in the United States at that time. The research was approved by the Institutional Review Board of University of Illinois at Urbana-Champaign.

This article presents results from the survey regarding representation on the responding CACs' MDTs and from questions about the services provided to children and to caregivers. To assess representation on an MDT, respondents were asked "Which of the following disciplines are represented on your team? (check all that apply)" and were presented with a list of 16 different types of professionals (listed in Table 1), as well as an "other (specify)" category. To assess the provision of different forms of assistance to children and caregivers, respondents were asked "How often does your Center offer each of the following types of assistance for child victim/witnesses?" and "How often does your Center offer the following types of assistance for involved caregivers (sometimes referred to as non-offending parents)?" The options presented to respondents for each of these questions are listed in Table 1. Note that using the wording "does your Center offer" meant that most items could encompass assistance on-site or off-site that was provided by a CAC staff member or someone else, or provided by a partner agency based at the CAC. The wording of some items did distinguish between assistance offered at the Center versus externally.

Results

Table 2 shows the percentages of representation by different disciplines represented in the MDTs on the CACs in our sample. Large percentages (from 83.8% to 98.2%) of CACs had representation from all the core group of disciplines specified by the NCA standards (law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and CAC staff). Forensic interviewers were also represented on the vast majority of MDTs. Other professionals were represented in small percentages of MDTs.

The following services were provided often or routinely to children by a majority of CACs: individual counseling at the CAC, preparation for court appearances, medical examinations, case management, safety planning, referral to external mental health providers, referral to other services, information on crime victim and witnesses legal rights, and victim compensation applications. The following services were provided often or routinely to caregivers by a majority of CACs (see Figure 2): crisis intervention, case management, referrals for domestic violence services, referrals for counseling or support services, providing access to other services (e.g., transportation, housing, financial, food assistance), information about victim/witnesses' legal rights, and victim compensation applications. Interestingly, even though most CACs provided children individual counseling on-site, more than one-quarter never did this, presumably because they did not have this capacity on-site and relied instead on their partnership with off-site mental health providers.

The availability of other types of assistance varied considerably across CACs. Over one-quarter of CACs often or routinely offered support groups for children, but almost half never offered this. Over one-quarter often or routinely offered support groups for caregivers, but more than one-third never did. Over one-third offered domestic violence risk

assessment and safety planning, but more than one-third never offered this. Over one-quarter helped caregivers obtain protective orders, but almost one-half never did this. Over one-quarter provided caregivers information about civil remedies, but nearly half never provided this. Many respondents reported that they never offered children and caregivers legal assistance.

Discussion

The MDT core group of disciplines specified by the NCA standards are represented in the vast majority of CACs, with other disciplines represented in small proportions. These results are very similar to findings by Jackson (2004) and Herbert et al. (2018). These results suggest that CACs are generally successful at developing an MDT that meets standards in terms of representation.

The current study is unusual in that it provides statistics on the percentages of CACs offering a range of specific forms of assistance to children and their caregivers. It provides evidence of the wide range of actions CACs take to help, all consistent with the NCA standards.

The variability in the specific forms of assistance that CACs provide suggests that CACs develop in different ways. This variability is consistent with Herbert et al.'s (2018) distinction between Basic CACs and Aggregator and Full-Service CACs. It is unclear to what extent not providing a service stemmed from lack of capacity versus a CAC not including a service within its mission. The fact that a CAC did not provide a specific form of assistance does not necessarily mean that children and caregivers lacked that type of help in their community—a CAC could refrain from providing a service because another agency in the MDT is already providing it.

Small but meaningful proportions of CACs have representation on their MDTs from disciplines that are not typically centrally involved in child maltreatment investigation and services, but that could play a critical role in some cases. One can imagine the benefit. For example, if the offender in a child sexual abuse case is a minor, it can be useful to collaborate with juvenile court professionals. If the victim in a sexual abuse case is an adolescent, both rape crisis centers and CACs may respond at different points, and it may help the youth if they share information and coordinate service delivery. More research is needed on what it means functionally to participate in an MDT and specifically how it affects the quality of the response. Research should also examine whether lack of representation on an MDT diminishes coordination in a way that reduces the quality of the response to victims or is compensated by other linkages that CACs have with other disciplines. More research is needed in general on the coordination between the CAC response and that of other organizations.

One noteworthy finding is the variability in the CAC response to domestic violence. Over half of CACs often or routinely provided referral for domestic violence services, and just over one-third often or routinely provided domestic violence safety planning. Yet a number of CACs never provided services related to domestic violence. This variability is consistent with findings from Thackeray and colleagues' (2010) survey of CAC directors, which found that just over half of CACs conducted domestic violence assessments of female caregivers, but only 29.4% did so for more than 75% of female caregivers and only 28.8% of CACs required staff to have annual training on domestic violence. Despite the overlap between child abuse and domestic violence and the frequency with which CACs respond to domestic violence, only 10.1% of CACs in our sample had domestic violence advocates on their MDTs.

Research in several countries has identified a need for a coordinated response to child abuse and domestic violence and has assessed programmatic innovations to provide it (Cross et al., 2012; Nikolova et al., 2021; Wills et al., 2008). One factor limiting coordination may be what has been described as "troubled relationships" between CPS workers and domestic violent professionals (Postmus & Merritt,

2010, p. 310), who may clash because of their differing emphasis on the safety of the children and the safety of the caregiver. Given the profile of domestic violence among the problems that CACs deal with and the number of CACs that are not providing services related to domestic violence, it may be beneficial if domestic violence advocates were more frequently represented on multidisciplinary teams.

Limitations

We need to take study limitations into account in interpreting the results of this research. Only a minority of CAC directors participated in the research, and the CACs in the sample may not be representative of the entire population of CACs. Another limitation is that the data were collected 9 years prior to the writing of this article and may not be representative of current practice. NCA standards have changed twice since then. For example, the NCA 2017 revision made such changes as establishing clearer benchmarks for meeting standards and adding training requirements for the victim advocacy NCA standard (2023 a).

An additional limitation is some ambiguity in how we interpret results on types of assistance for children and caregivers. We do not know to what degree respondents' ratings of frequency of offering assistance is affected by the frequency with which a child or family needs that assistance. Yet another limitation of the survey is that it did not assess the strengths of CACs' partnerships with allied agencies, which may compensate for missing services at the CAC. The limitations of this research should make us tentative about the conclusions we can draw from it. They also suggest that we cannot fully assess what CACs offer children and families without more in-depth research about how cases are handled and what specific supports, interventions, and services are provided by every member of the MDT who responds once a CAC case is initiated.

Conclusion

The current research suggests that CACs are meeting NCA standards while varying to some degree in the specific forms of assistance they provide. They also suggest that CACs may want to consider adding more types of professionals to their MDTs, such as rape crisis counselors, juvenile court professionals, and domestic violence service providers. Yet much remains to be learned. One important topic is the linkage between CACs and domestic violence. Developing greater knowledge about how CACs can help children and families is likely to improve services for thousands of children and families across the country.

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Table 1

Types of Assistance Listed in the Survey

How often does your Center offer each of the following types of assistance for child victims/witnesses?
Individual counseling at the Center
Preparation for court appearances
Support groups at the Center
Medical exams
Legal assistance (e.g., related to dependency or juvenile court proceedings)
Case management
Safety planning
Referral to external sources for mental health services
Referrals to external sources for other support services (e.g., medical or substance abuse treatment).
Information about crime victim/witnesses' legal rights
Victim compensation application
Other (specify)

How often does your Center offer the following types of assistance for involved caregivers (sometimes referred to as "non-offending parents")?
Individual counseling for parents at the Center
Preparation of parents for child's court appearances
Crisis intervention
Case management
Legal assistance for parents
DV risk assessment and safety planning
Referrals for DV services
Obtaining protective orders
Referral of parents to external sources for counseling or support services
Access to services (e.g., transportation, housing, financial, food assistance)
Information about victim/witnesses' legal rights
Information about civil remedies
Victim compensation application
Other (specify)

Table 2

Disciplines Represented on Children's Advocacy Centers' Multidisciplinary Teams (N=222)

Variable	f	%
Law enforcement	218	98.2%
Child protection	217	97.7%
Prosecutor	214	96.4%
CAC staff	211	95.0%
Forensic interviewer	196	88.3%
Victim/witness advocate/assistant	192	86.5%
Health professional	186	83.8%
Mental health professional	202	91.0%
Juvenile court	85	38.3%
Rape crisis counselor/advocate	62	27.9%
DV counselor/advocate	50	22.5%
Schools	39	17.6%
Probation/parole	36	16.2%
GAL/CASA	35	15.8%
Other	22	9.9%
Sex offender treatment provider	14	6.3%
Child's attorney	8	3.6%

Figure 1

Assistance for child victim

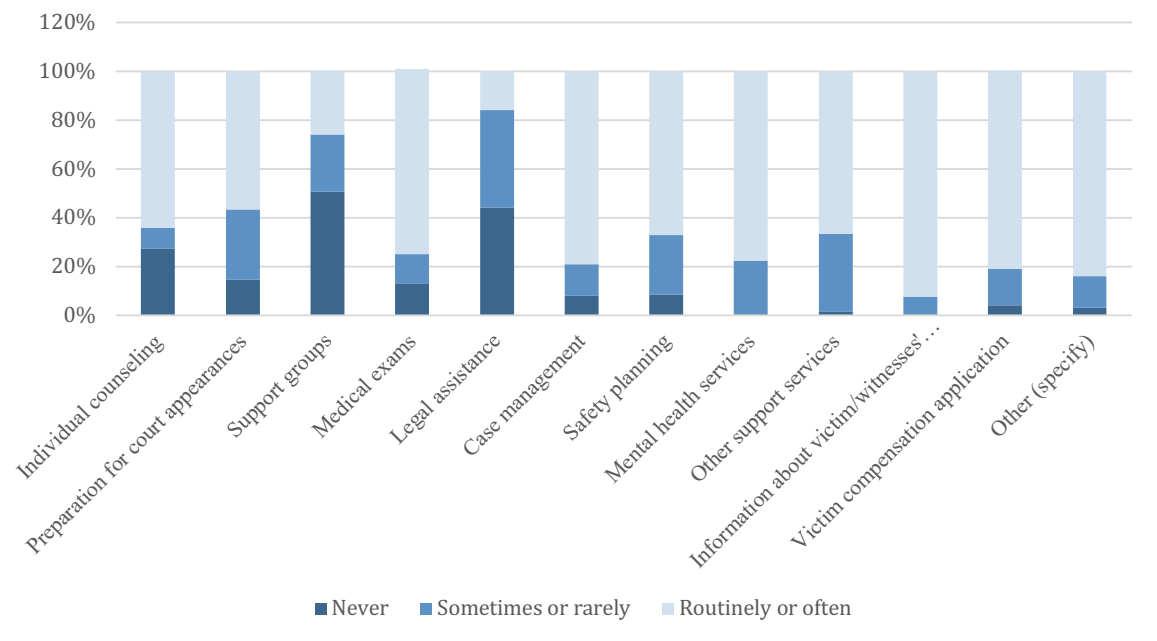
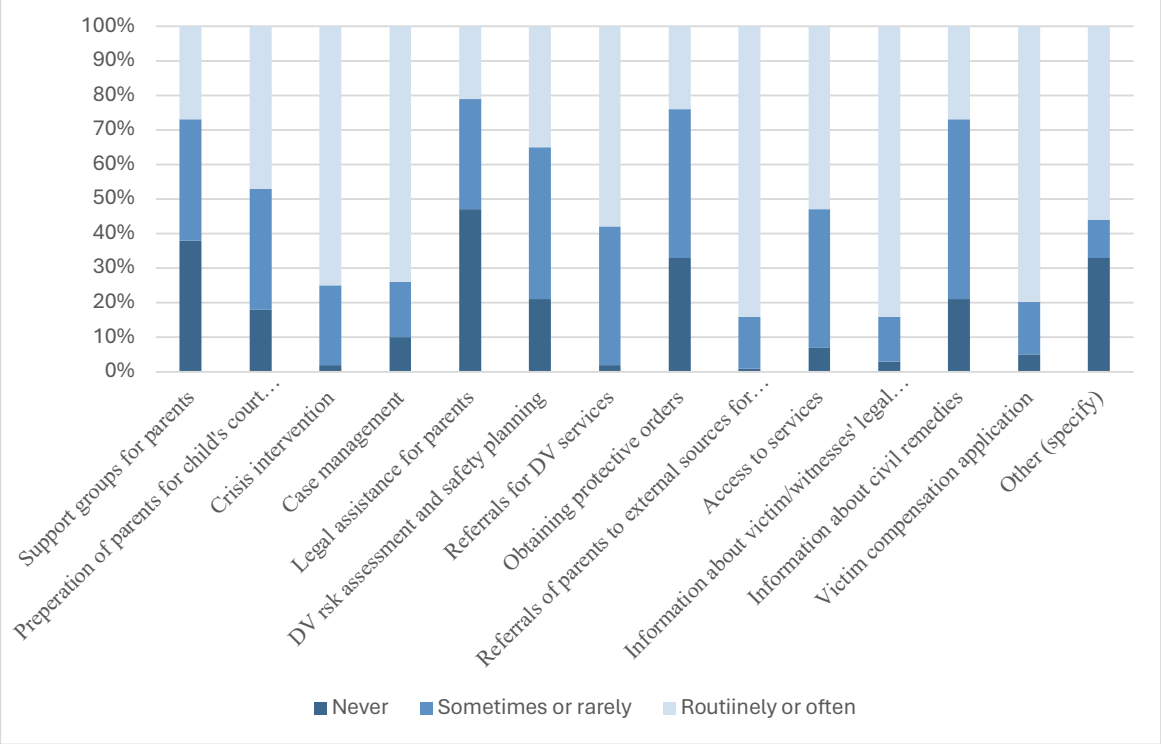


Figure 2

Assistance for caregivers



About the Authors

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An Investigative Odyssey: Considerations for Expanding the Evidentiary Scope in Child Maltreatment Investigations

Tyler I. Counsil, EdD

Abstract

Child maltreatment investigations have historically faced challenges with adequate evidence identification and collection woes. This can result in subpar outcomes for children impacted by abuse and neglect. This article serves as a primer for multidisciplinary team (MDT) professionals to better recognize the scope of evidence (both traditional and non-traditional) that can be considered for processing. It also explores key considerations on evidence handling and review of potential atypical MDT collaborators who can further empower investigators.

Keywords: *child maltreatment, DNA, evidence, forensics, investigation, multidisciplinary*

Evidence holds utmost importance in all facets of child maltreatment investigation. Two distinct types of investigations are commonly pursued: child protection inquiries and criminal investigations. Child protection investigations, overseen by child protective services (CPS) agencies, typically arise from reports alleging maltreatment by a caregiver. They prioritize the safety of the child. These investigations culminate in determining whether an allegation of maltreatment is substantiated, meaning there is adequate evidence to support it as a case of child maltreatment, alongside an assessment of the harm suffered by the children involved (DePanfilis, 2018; Drake, 2000). Cross and Casanueva's (2009) examination of 4,514 child protection cases revealed that caseworker evaluations of evidence sufficiency strongly influenced the substantiation decision.

In instances where alleged child abuse or neglect constitutes a criminal offense, law enforcement undertakes a criminal investigation, which is indispensable for prosecuting offenders of child maltreatment (Cross et al., 2021). Occasionally, both criminal and child protection investigations occur concurrently (Cross et al., 2015), and their effectiveness and efficiency are enhanced when conducted jointly or in coordination, often facilitated by multidisciplinary teams (Cross et al., 2005).

Numerous studies have demonstrated that the quality of evidence collected in criminal investigations is the primary determinant of child abuse prosecution (Block et al., 2023; Cross et al., 1994; Walsh et al., 2010). In a minority of cases, maltreatment results in a child's death, prompting post-mortem investigations. Here again, evidence collection is pivotal for case resolution, especially since the advent of forensic DNA profiling in 1984 (Royal Society, 2017).

Advances in forensic science have added new sources of evidence and increased the importance of thorough evidence collection. The increasing reliance on forensic science in criminal investigations generally is evident, with a 28% rise in evidence processing for forensic biology casework in the last five years (Burch et al., 2016). Studies highlight the significant impact of physical evidence on conviction rates across a range of crimes, emphasizing the importance of a scientific approach (Peterson, 1984; Peterson et al., 2010; Peterson et al., 2013).

Given the importance of evidence in child abuse cases, it is critical to educate frontline professionals in child-serving roles about evolving best practices in evidence collection and forensic processing. Although traditional forensic evidence

is crucial, overemphasis on limited types of evidence can also lead to neglect of other forms of corroborating proof, potentially resulting in missed opportunities for effective case resolution (Shelton, 2008). Lawyers and judges are often undereducated in forensic science and contextual evidence considerations (Sanger, 2019). Likewise, law enforcement is frequently outpaced as new techniques are launched to expand the breadth of potential evidence to process, collection methods evolve, and novel forensic testing processes are ushered to the frontlines (Wexler, 2018). Research on child protection investigators suggests that evidence collection is also not a part of their training (Chiu & Cross, 2020).

This article serves as a condensed resource for child protection professionals, offering insights into best practices related to traditional and novel evidence. It is an abridged version of the author's more comprehensive report available through Zero Abuse Project (Counsil, 2023). The current article aims to empower those investigating and prosecuting child abuse and neglect to enhance results for the children and non-offending caregivers seeking accurate dispensation of justice. The information herein may help expand the range of evidence collected and provide insights on interpretation of innovative evidence for multidisciplinary team (MDT) members responsible for investigating child abuse cases. MDT professionals who may benefit include law enforcement investigators, child protection investigators, prosecutors, death investigators, forensic interviewers, and clinical healthcare providers. These professionals are the core experts responsible for investigations into allegations related to child abuse and child-abuse fueled deaths. As a consortium of child-serving professionals, they can also advocate for the inclusion of new pathways for evidence processing and interpretation.

This document is not intended to provide an exhaustive list of every evidence type that may be present nor should it supersede specific jurisdictional and laboratory policies. It is merely a primer for highlighting general best practices for collecting various types of physical evidence and exploring non-traditional sources for evidence discovery and utilization within the scope of one's investigation. To that end, it should be made clear that any evidence processing techniques outlined here should be conducted by agency-designated and appropriately trained staff members. For instance, coroners and medical examiners may collect evidence related to their death scene investigation from the body proper. Law enforcement may designate scene investigators trained in the art of evidence processing and collection for inventorying evidence. As such, we hope these suggestions will spark possible enhancements or expansions to current evidentiary processes and procedures used by MDTs and to the skill sets of those MDT members with responsibility for processing evidence.

Important Aspects Regarding DNA in Casework

DNA stands out as a powerful tool for corroborating victim and eyewitness accounts in child abuse cases. It can be found directly deposited on the victim's person through contact or deposition of bodily fluids. DNA may also be found on items at the scene of the criminal act, deposited either through some direct contact with an object in the environment (e.g., the perpetrator touching victim's/suspect's clothes, an implement being used in the illegal act), body fluid release, or by way of transfer activity, where someone or something carrying the DNA indirectly deposits it on another person or thing (e.g., victim sheds suspect's DNA on a chair after garment brushes against it).

Specifically, DNA may be obtained through its presence in bodily cells trapped within a given serological fluid (e.g., blood, semen, saliva) or from cells present from some form of shedding or transfer event, where contact between an individual or item leads to DNA being deposited on an item of evidence. DNA processed and interpreted in this latter fashion, through contact or indirect transference, has been historically termed "touch DNA" because of its contact-based nature, though the

forensics world now favors alternative nomenclature (e.g., trace or transfer DNA) with respect to categorizing this type of evidence (Tozzo et al., 2022). DNA and its effectiveness in case resolution is enhanced by two key features: persistence and transferability.

DNA Persistence

Research shows that DNA, deposited through stains or contact, remains robust on items despite environmental exposure or time elapsed between crime and collection. Seminal stains, especially, exhibit resilience across fabric types and environments (Nabi et al., 2021). Studies reveal that even after extended storage or washing, viable DNA profiles can be retrieved from evidentiary items, such as clothing, highlighting the lasting presence of biological stains and touch DNA (Poetsch et al., 2017; Helmus et al., 2018).

DNA Transference

DNA transferability is demonstrated in studies where DNA from one source is inadvertently carried to another. Unstained items washed with stained clothing can pick up transferred DNA during laundering (Brayley-Morris et al., 2015). Similar findings apply to body fluid-soiled sheets, showing how fluids can transfer and yield full DNA profiles, even when no abuse occurred (Helmus et al., 2018). Another experiment has shown the potential transfer of DNA to confound case understanding, in particular where DNA from a non-case associated individual inadvertently passed across samples handled with or without gloves (Helmus et al., 2015).

Implications for Investigations

The studies suggest that great consideration be given to exploring all premises regarding how a source of DNA was deposited on a given item that may be of forensic value. Investigators must consider the persistence and transference of DNA in each case. Concerns about contamination of DNA from non-criminal actions due to transference have led justice agencies cautioning against using DNA results without appropriately vetting all hypotheses as to how that material arrived on a given item (National Institute of Justice & Office for Victims of Crime, 2001; Press, 2019). Global initiatives currently emphasize the need for a contextual understanding of DNA evidence, urging its consideration alongside other evidence sources for a more comprehensive investigation, rather than limiting a case to hinge upon the presence of DNA itself (Euroforgen-NoE, 2017). Despite the growing recognition of DNA challenges and interpretation of genetic material in correlation with concerns regarding deposition, persistence, and transference, forensic scientists remain underrepresented in MDTs (Greeson, 2010). Advocacy for their inclusion is supported by various agencies, given their training as it pertains to these subjects, thus emphasizing the importance of forensic expertise in ensuring accurate interpretation and communication of laboratory results in investigations (National Crime Justice Reference Service [NCJRS], 2011).

Given the complexities of forensic DNA analysis and the challenges posed by DNA persistence and transference, there is a pressing need for increased inclusion of forensic scientists in MDT investigations. The current lack of representation in MDTs risks compromising the accuracy and interpretation of forensic evidence, potentially leading to suboptimal outcomes for child victims seeking justice.

Evidence Considerations and New Collection Technologies

When considering traditional evidence for body fluid or DNA deposition (direct or indirect), one must consider the circumstances of the case and contextual information to make informed decisions as to what items should be collected for forensic analysis. The concern for false inclusions and exclusions has grown as sensitivity to detect lower amounts of DNA has increased in recent years. Specifically, false inclusions occur when an individual is implicated as directly contributing to a DNA source and is

implied as the offender in a case when there may be alternative reasons for their genetic material to be present. For instance, an individual's DNA may be present in a scene for innocuous reasons, such as attending a birthday party in the same room only for a criminal act to occur later in the day in this environment, where the DNA from that person persisted from shedding events related to the non-criminal activities committed prior. Likewise, false exclusions can occur when the actual perpetrator of a crime is not considered as a source with respect to profiles developed from items retrieved for forensic processing. An exclusion could occur because there was limited DNA present sufficient to generate a robust DNA profile for analysis, contamination leading to DNA obliteration, or excessive mixtures of genetic material, rendering separation of DNA profiles impossible.

Furthermore, contextual considerations—whether correctly or incorrectly applied to an investigation—can also skew interpretations as to how one's genetic material may or may not be present at a scene. As an example, a child who is not forensically interviewed may not have an opportunity to recall or disclose the use of a condom that might help explain potential lack of suspect DNA or bodily fluids in a sexual assault case. Failing to discuss or thoroughly investigate timelines and events that may have transpired in an environment prior to a criminal act could similarly lead investigators down an erroneous path where their bias leads. They may thus take the contributor of a DNA source found on-scene and improperly attempt to fit the donor to their hypotheses of what happened.

To that end, a thorough child maltreatment investigation must always focus on contextual clues and the totality of the circumstances and never rely solely on items that may result in forensically derived results. Just because DNA is present, in short, does not mean that an investigative team has a proverbial "smoking gun" situation given the challenges with persistence and transference. As such, investigators should focus on exploring all possible circumstances regarding why a contributor's DNA may be present or absent for a given case and thus work to substantiate the most logical hypothesis as to the nature of the crime and those involved while refuting or disproving alternative premises through the exploration of multiple types of evidence (e.g., testimonial, circumstantial, digital) when possible. Forensically interpreted evidence in isolation may not always be sufficient in today's world of increased scientific sensitivity; therefore, it is imperative that investigators consult with their MDT to explore all possibilities for evidence identification and interpretation, exhausting all avenues of inquiry.

Having noted the importance of context when considering physical or direct evidence, investigators may find several possible items that could be of probative value in a child maltreatment case. DNA can be discovered on various surfaces, including bedsheets, clothing, assorted surfaces, handles, and a multitude of contact-centric objects. Originating primarily from two sources—body fluids (serological evidence) and skin cells ("touch," "trace," or "contact" DNA)—these samples play a crucial role in child maltreatment investigations. Common body fluids linked to victimization in such cases include blood, semen, and saliva, each carrying probative value for assessing child abuse allegations. The collection of transfer DNA is equally significant in substantiating claims related to child abuse and neglect incidents. When gathered from prominent stains or conventional locations where deposition of cells laden with DNA are logical in the scope and nature of the case under investigation, these sources can provide robust, supporting clues in the grand scope of one's understanding of alleged criminal events. Potential sources of biological evidence are included in Table 1 for MDT consideration when exploring possible materials to collect and process in a forensic capacity to substantiate claims of maltreatment or to corroborate or refute claims and counterclaims about one's actions, presence, or other implications that would assist in successful criminal investigation.

Table 1. Possible Sources of Biological Evidence in Child Maltreatment Casework

Implements (e.g., items corroborated in injury/sexual assault events)
Contact surfaces (e.g., doorknobs, counters, sinks, toilets)
Bathroom or facial tissue (e.g., sources of clean-up, purging)
Garments, bedding (note: dirty, worn, in-laundry items could still be of forensic value)
Personal accessories, wearable items (e.g., hats, gloves, masks of contextual value)
Prophylactics (e.g., used condom)
Oral-centric implements (e.g., candy, toothpicks, food items)
Toys, play items (e.g., gifts or coercive elements from or used by alleged offender)
Bindings (e.g., tape, rope, cords, other traditional/non-traditional restraints)
Contusions (bruises), abrasions (scrapes); bite mark areas, licked/spit areas
Refuse or contextually applicable discarded items
Entomological (insect) evidence (e.g., maggots, flies, beetles)

Beyond traditional swabbing, scraping, and lifting, alternative methods for evidence collection are gaining traction in the field of scene investigation and merit consideration for child maltreatment cases. In this regard, investigators should consider exploring non-traditional, evidence-based conventions when atypical evidence might relay forensically relevant information that could support or refute the validity of one's investigative hypotheses. The M-Vac system, utilizing wet vacuum technology, exemplifies such innovation (M-Vac, n.d.). Functioning akin to household upholstery cleaners, it dispenses a sterile collection buffer and employs a pressurized vacuum nozzle to dislodge body fluids or skin cells.

Research has also shown that collection of DNA from non-traditional sources, including processing pets or other animals present at the scene of a crime for potential collection of transfer DNA, is of probative value in the context of a given case (Taylor, 2023). Detection of stains and bruises traditionally relies on visible light, but alternative light sources (ALS) at different wavelengths can enhance the identification of near-invisible stains and contusions. Guided by the National Institutes of Justice ALS landscape study, which offers insights into optimal wavelengths and filters for detecting body fluid and biological evidence, investigators can explore the ALS devices that show promise in child maltreatment evidence detection (Forensic Technology Center of Excellence, 2018).

Swab technology is also evolving with dissolvable swab materials, such as Luna Innovations' (2017) cellulose acetate swabs, offering improved DNA extraction compared with traditional cotton swabs. These swabs could be helpful for forensic laboratory analysts because dissolvable swabs yield more DNA than traditional ones, which could improve DNA profile development for one's case (Wise et al., 2021). Although traditional swabbing remains effective, case circumstances may warrant exploring other methods such as scraping or cutting of stains or thinking even more outside the box with respect to collection methods. Notably, a method involving soaking, or submersion, has also proven successful in collecting DNA from spent shell casings, presenting a viable alternative to traditional swabbing in firearm discharge cases related to child maltreatment (Montpetit & O'Donnell, 2015; Givens with The Trace, 2019).

In conclusion, there are many items that could be collected for substantiating or disproving claims of child maltreatment from a forensically relevant

perspective. So long as contextual considerations and exploring all avenues of evidence are addressed, the accuracy in interpretation of forensic results from such items will be objective and consistent. Although traditional evidence collection methods should still be considered for collecting forensic evidence, it is important to note that there are non-traditional avenues to consider that could improve the scope of understanding for a given case while also aligning with a commitment to rigorous science, reliable outcomes, and due process in optimizing evidence collection for child maltreatment cases.

Factors Affecting Evidence Collection and Forensic Interpretation

Evidence Quality

Several factors can impact the quality and quantity of evidence obtained through a sexual assault kit (SAK; National Institute of Justice [NIJ], 2017). Sexual assault kits are the tools forensic medical examiners use to gather and preserve evidence from a forensic medical examination of a child, adolescent, or adult sexual assault victim (Meunier-Sham et al., 2013). The characteristics of the case and the timing of events play crucial roles in determining the presence and viability of deposited DNA. Relevant case characteristics encompass, but are not confined to, the following (Lee & Ladd, 2001; Acosta, 2002; Magalhães et al., 2015):

- Age
- Activity level
- Activity type and frequency (e.g., toothbrushing, bathing, douching, exercise)
- Consumption habits (e.g., eating, drinking, smoking)
- Contamination or adulteration (e.g., evidence sullied by dirt or chemicals—accidentally, during the event or in an attempt to destroy evidence)
- Draining and sloughing
- Environmental exposure
- Location (e.g., skin surface versus penetration)
- Medical conditions (e.g., aspermia, oligospermia)
- Medically induced conditions (e.g., vasectomy)
- Nature of the crime (e.g., touch DNA versus body fluid deposition, ejaculation)
- Prophylactic use (e.g., condom or other barrier)
- Temperature

Collection Timeframes

Time represents a critical factor that significantly impacts the capacity to generate substantial forensic information. As time elapses, the likelihood of the intervening actions detailed above rises, diminishing the amount of evidence available for processing. Moreover, DNA can naturally degrade over time, resulting in the loss of partial or entire DNA sequences, thereby complicating profile generation and statistical interpretation (Hanssen et al., 2017). The NIJ (2017) best practices guide referenced previously offers recommended collection timelines based on historical precedent and assault research.

However, the authors emphasize that case circumstances should predominantly dictate the collection and processing timeline, as historical research data may be constrained by factors such as sample quality or quantity, as well as the chemistries and equipment used for analysis (NIJ, 2017). As mentioned earlier, studies indicate that both DNA and body fluids containing cells rich in DNA can persist for days, if not weeks, following the commission of a simulated or actual deviant act. Given these considerations, MDTs with inflexible timelines for evidence collection should reassess their practices (Alketbi, 2018; Ryan, 2018; Forger et al., 2021).

The discussion about timing and characteristics is applicable to victims who are still alive. However, time constraints cease to apply in cases where the child victim is deceased. Therefore, when investigating allegations of child maltreatment or homicide involving a deceased victim, all relevant evidence, such as dental flossing(s), pulled scalp hair, pulled pubic hair, and swabs of various body areas, should be processed. SAK items should be handled and submitted to a forensic laboratory in accordance with typical guidelines for submissions involving a living victim.

New Pieces to the Puzzle: Innovative Evidence Options and MDT Partners

In child maltreatment investigations, the inclusion of discussions and meetings with atypical practitioners, such as ophthalmologists, odontologists, anthropologists, entomologists, microbiologists, and veterinarians, is essential to ensure a comprehensive and multidisciplinary approach to casework. These specialized professionals bring unique expertise that can uncover critical insights and evidence. Collaborating with these atypical practitioners enhances the investigative toolkit, leading to a more thorough and accurate assessment of child maltreatment cases and ultimately supporting the pursuit of justice and child welfare.

Ophthalmological examinations can reveal physical abuse indicators, with 4%–6% of cases identified during eye exams (Levin, 2019). Retinal hemorrhaging is common in abusive head trauma cases, showcasing the role of optometrists in child abuse detection (Bhardwaj et al., 2010; Christian & Levin, 2018). Dental examinations can unveil evidence of physical and sexual abuse and neglect as well as aid bitemark analysis related to abuse event allegations (Fisher-Owens et al., 2017). Infections and damage to the mouth, throat, and corresponding tissues and teeth can also be indicative of maltreatment. Forensic odontologists can provide valuable insights and substantiate abuse and neglect claims (Jenny & Crawford-Jakubiak, 2013; Ramazani, 2014).

In child homicides, in which bodies may be concealed or damaged, traditional anthropological methods and remaining DNA-bearing sources (e.g., bones, teeth, tissue remnants) can aid identification (Federal Bureau of Investigation [FBI], 2019). Forensic entomology, examining insect morphology and growth stages, helps estimate time of death and provides insights beyond post-mortem intervals

(Wells & LaMotte, 2017). Insects can also carry viable human DNA from contacting the deceased or consuming their tissues, thus contributing to child homicide investigations (Li et al., 2011; Njau et al., 2016).

Forensic botany, including palynology and carpology, leverages ecological evidence for crime location, mode of abuse or death, and postmortem interval (PMI) determination (Coyle et al., 2005; Miller Coyle, 2005; Green, 2015). In child sexual abuse cases, carpology has successfully identified abuse through the presence of specific plant seeds, corroborating victim claims (Lee et al., 2019). Nontraditional sources such as Internet of Things (IoT) devices, video game consoles, and biometric monitors offer digital evidence (National Forensic Science Technology Center, n.d.). The Scientific Working Group on Digital Evidence (SWGDE; 2018) provides policies on handling digital evidence from diverse devices, emphasizing network isolation and storage considerations.

Forensic microbiology also holds significant importance in child maltreatment investigations, introducing innovative trace evidence and analysis methods. Advances in microbial genetics, comparable to DNA profiling, enable the identification of individuals through microbial communities left behind during contact transfers, such as pubic hair exchange (Williams & Gibson, 2017). Researchers are exploring the application of microbial genetics in child sexual assault cases, including the identification of sexually transmitted infection (STI) vectors. Molecular analysis of STI sources aids in rapidly identifying specific bacterial strains, correlating the source with the child victim, and facilitating prompt treatment (Hammerschlag & Gaydos, 2012). The intersection of animal and child abuse has also been strongly correlated in previous studies and suggests collaboration with veterinary practitioners (Becker & French, 2004; Newland et al., 2019; Robinson & Clausen, 2021). Veterinary forensics and organizations such as the American Society for the Prevention of Cruelty to Animals (ASPCA) offer expertise in cases involving animal maltreatment, aiding child maltreatment investigations (Parry & Stoll, 2020; ASPCA Veterinary Forensic Science Center, 2020).

From Insight to Action: How Multidisciplinary Teams Can Utilize Novel Evidence Information and Resources

When reviewing the material and information herein, the primary challenge MDT affiliates may face is how to turn this information into actionable insights for ready use in their investigative community. From the fields of forensic microbiology, botany, odontology, and beyond—including these disciplines' ability to create new avenues for evidence collection—to discussing the notion of transfer DNA and its ready ability to be deposited and persist on a given item, there exists a plethora of emerging techniques and insights that can significantly augment the capabilities of MDTs in uncovering crucial evidence and advancing justice for survivors of abuse. MDTs, however, may not realize the potential that such arenas of new evidence hold for their cases. Given that much of this atypical evidence may be of a fragile or living sort, persisting in fluctuating conditions that could result in its rapid destruction, it is imperative that professionals working investigations of a child abuse nature understand these new areas of inquiry so that they might explore them in a case-by-case fashion and can thus endeavor to keep this type of evidence safe from harm until a proper evidence collection professional can assist with preservation of such items.

This section will next outline how an MDT can best put this information to practical use within their community and better recognize when novel evidence types may be of use in their maltreatment investigations.

One key strategy for MDT members is to harness information on novel forensic avenues and best practices to pinpoint regional or state experts in relevant fields. These experts can provide invaluable training sessions on the latest collection

methods and evidence utilization considerations, tailored specifically to the nuances of child abuse investigations and local investigative resource availability. There are many avenues for beginning outreach to establish such connections for possible training and information sharing, ranging from curated online articles to professional organizations centered around a given forensic discipline, by which networking with state or regional professionals can be achieved. For example, the American Board of Forensic Entomology (n.d.) lists members and locations for convenient outreach. By connecting with these experts and staying updated on the latest practices and procedures, MDTs can expand their investigative standard operating procedures (SOPs) to incorporate cutting-edge techniques and methodologies that can expand the scope of evidence to strengthen their investigative capacity.

Specifically, MDT members can proactively engage with novel and non-traditional scientific experts in their communities to explore how they can enhance their investigative approaches. For example, connecting with a local odontologist and understanding their work and potential for investigative assistance can lead to new working relationships and collaboratives in which forensic dental evidence may become more routinized and thus a staple of child abuse investigations. By fostering collaboration with these experts and integrating their insights into the investigative process, MDTs can bolster their capabilities and become more adept at identifying and interpreting forensic evidence related to child abuse cases.

Furthermore, this information can serve as a catalyst for advocating for survivors of abuse and strategically driving improvements in investigative guidelines and protocols. By working collaboratively with experts in evidence collection and novel forensic fields, MDTs can advocate for research to support updates regarding enhanced timelines for evidence collection, trauma-informed collection techniques, and the implementation of new, standardized policies and procedures for processing various types of evidence (Wilson & Stone, 2010).

Additionally, MDTs can play a pivotal role in fueling innovation within crime labs by similarly advocating for the proper integration of these new practices and forensic evidence disciplines into routine investigative procedures. In short, by championing the adoption of innovative techniques and methodologies and working to standardize their incorporation into the scope of child abuse investigations, MDTs can contribute to the continuous evolution of forensic science and evidence collection and enhance the efficacy of child abuse investigations by expanding access to services and procedures that have historically been underutilized and adopted in a limited capacity. It should be noted that the novel disciplines outlined herein have been successfully used in court. For instance, forensic microbiology and results yielded from clinical laboratories have been used in court proceedings. The Scientific Working Group on Microbial Genetics and Forensics publishes best practice guidelines for forensic microbiological laboratories (Lehman, 2012). A subcommittee for forensic odontology exists, as established by the Organization of Scientific Area Committees (OSAC), which oversees standards and best practices for interpretation and presentation of such evidence at trial (2014). Groups such as the Vision Council, the Ophthalmology Foundation, the Accreditation Council for Graduate Medical Education, and more have established standards for processes and procedures for accreditation (Kuslitskiy, 2012; Ophthalmology Foundation, 2024). The International Forensic Veterinary Sciences Association (IFVSA, 2024) promotes standardized forensic veterinary practice and forensic entomology collection best practices; OSAC's Crime Scene Investigation and Reconstruction subcommittee (CSI&R, 2023) has established forensic entomology collection best practices; and the Entomological Society of America (n.d.) provides standards and credentialing for entomological professionals who endeavor to work in this field and that may be responsible for the interpretation and admissibility of insect-laden evidence in court. In summation, several accrediting and standardizing bodies exist to ensure the optimal quality, consistency, and integrity in the collection and interpretation of such novel items of evidence by vetted professionals within the field, and historic

precedence exists whereby these items have been admitted into a court of law.

In essence, by embracing information on novel forensic avenues and best practices and by seeking out those experts in the fields of emerging forensic techniques and evidence processing, MDTs can empower themselves to navigate complex investigative challenges, advocate for survivors, and drive positive change within the investigative community. Through collaboration, innovation, and a commitment to excellence, MDTs can elevate the standards of child abuse investigations and ensure that justice is served for those most vulnerable in our society.

Conclusion

This article has explored critical aspects of evidence considerations in child abuse investigations, emphasizing the exploration of both traditional and atypical sources of information. By delving into the realms of forensic biology, entomology, botany, digital forensics, and more, alongside exploring novel options for detecting and obtaining evidence for a given case, a given investigative agency can expand its understanding of evidence of the breadth of potential sources for forensic processing in each case. Additionally, recognizing the pivotal roles of non-traditional collaborators such as forensic optometrists, dentists, and veterinary professionals highlights the interdisciplinary and fluid nature of child abuse investigations. Strengthening one's commitment to comprehensive training and collaborative approaches regarding child maltreatment evidence identification, collection, and interpretation will enhance an investigative agency's ability to uncover vital evidence, ultimately fostering justice and safeguarding the well-being of vulnerable children.

About the Author

Tyler I. Counsil, EdD, *has over a decade of experience in forensic science and medicolegal death investigation. He has worked as a microbiologist, DNA specialist, quality assurance and quality control manager, and forensic scientist. His extensive training includes DNA and body fluid testing, drug analysis, firearms examination, fingerprinting, and crime scene investigation. Currently, he serves as Chief Deputy Coroner for Daviess County, Indiana, where he excels in scene processing and evidence collection.*

In addition to his forensic work, Dr. Counsil has over 10 years of experience in higher education as Associate Professor and Departmental Chair for Child Advocacy Studies (CAST), Criminal Justice, and Forensic Science programs. He is dedicated to enhancing child advocacy through experiential training and supports faculty in implementing CAST programs as Director of CAST for the Zero Abuse Project. He holds a B.A. in Biology from Hanover College, a B.S. in Criminal Justice from Oakland City University, and both an M.S. and Ed.D. in Biology from Ball State University. He is a member of several professional organizations, including the American Academy of Forensic Sciences and the International Association of Coroners and Medical Examiners.

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Navigating Oral Health Disparities in Community Dental Care Settings: Reconceptualizing Dental Neglect

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Abstract

Poverty and neglect can often be inappropriately conflated, particularly in dental practice settings where access to community supports for families is limited and variable. Although poverty and neglect are interrelated, poverty is not synonymous with neglect. Dental professionals, whose practices are frequently private or external to care networks, find themselves particularly vulnerable, isolated, and ill supported to address pertinent social issues faced by families seeking care and unable to effectively mitigate barriers to obtaining regular, preventive oral health care. Dental health care settings may thus, by necessity, lean frequently on child welfare and social service agencies to help manage cases of adverse oral health involving impoverished children, particularly when in-office social work support and access to community-based resources are limited. This article aims to provide alternative sources of interventions in a dental practice setting across three trajectories—practical, office-based efforts, and development of broader, external resource networks and policy change.

Key Words: *Socio-Economic Determinants of Health, Child Neglect, Health Disparity Population, Health, Oral*

In 2021, approximately 18% of all U.S. children under 5 years old lived in poverty (Annie E. Casey Foundation, 2020). Children living below the federal poverty level, compared with children above it, have statistically significant poorer overall health (29.8% vs. 18.0%, $P = .03$) (Truschel et al., 2023).

The socioeconomic conditions within which one lives represent a key social determinant of health (SDOH), or non-medical factor influencing, either positively or negatively, long-term health outcomes (Centers for Disease Control and Prevention [CDCP], 2022). Research suggests SDOH have a profound impact on health, beyond that of either genetic factors or access to health care services; therefore, poverty has been highly correlated with adverse health outcomes, disproportionately impacting communities of color and driving health inequities at critical stages of child development (CDCP, 2022; Matthews, 2020; U.S. Census Bureau, 2020). Poverty is unlikely to be an isolated phenomenon but rather predisposes individuals to other social and health-related adversity; as a result, these factors are particularly prevalent in vulnerable

populations lacking stable access to health and social services, including migrant populations and those affected by systemic racism (Matthews, 2020).

Poverty is considered one of the strongest predictors of child neglect, rendering a child nearly 7 times more likely to experience neglect than peers in more affluent households (Sattler, 2023; Sedlak et al., 2010). *Neglect* is generally defined as failure by a caregiver to provide for a child's basic survival, physical, and emotional needs, namely nutrition, clothing, shelter, hygiene, and health care (Child Welfare Information Gateway, 2023), factors that poverty may directly impact.

Although poverty and neglect are interrelated, poverty is not synonymous with neglect. However, a recent comparison of state-level *neglect* definitions indicated less than half distinguish between involuntary neglect (when a child's needs are not being met because of caregiver physical or financial limitations) and maltreatment, with wide latitude (Rebbe, 2018).While many families experience material hardship, child neglect occurs when hardship reaches a level of deprivation, a metric difficult to measure but with resultant harm or potential harm to the child (Kobulsky & Dubowitz, 2022). Poverty is hypothesized to constrain caregivers' time and resources, whose focus is on prioritization of basic needs (including food and shelter) (Annie E. Casey Foundation, 2020). Through a complex interplay of risk, many factors associated with both poverty and neglect (unemployment, housing instability, parenting stress, limited health care access) impact a caregiver's ability to meet a child's basic needs (Berger et al., 2009).

Oral Health Disparities and Social Determinants of Health

Dental neglect specifically refers to a caregiver's failure to provide basic oral care (oral hygiene, proper diet, and establishment of a dental home) for a child, failure to seek treatment for oral pain, and untreated infection (American Academy of Pediatric Dentistry, 2020; Noble et al., 2014). Identification of dental caries and infection in a child in conjunction with history of missed appointments and lack of continuity of care traditionally has signaled dental neglect for many youth-serving dental professionals (Raphael, 1999). Although neglect may in fact have occurred, the multitude of psychosocial factors that may contribute to oral health disparities including a family's experience of SDOH and socioeconomic stressors should be thoroughly assessed. It is known that oral health disparities persist among vulnerable populations, including those adults and children experiencing poverty; children living in poverty, with less access to early, liberal dental care and more frequent cariogenic diets, are more likely to experience dental caries than affluent peers (Dye et al., 2017). Inextricable linkage between poor dental health outcomes, SDOH, and other structural barriers such as school and work absence policies, discriminatory treatment, structural racism, difficulty finding a dental professional who accepts public insurance, financial constraints, frequency of cariogenic diets, and caregiver expectations of poor oral health (Kelly et al., 2005) lends complexity to neglect evaluations. Data suggest some racial/ethnic and socioeconomic groups experience worse oral health, attributed to SDOH; according to 2011–2016 data from the Centers for Disease Control, among children aged from 2 to 5 years, approximately 33% of Mexican American and 28% of non-Hispanic Black children have experienced cavities in their primary teeth compared with 18% of non-Hispanic White children (CDCP, 2019). Among children aged from 2 to 5 years, 17% of children from low-income households have untreated cavities in their primary teeth, a rate that is 3 times higher than that for children from higher-income households (CDCP, 2019).

Dental professionals may differ from families in their perceptions and beliefs about oral health; for example, presence of caries may reflect lack of caregiver knowledge, understanding, or resources rather than neglectful parenting, an area prudent to assess (Souster & Innes, 2014). Moreover, the racial-ethnic distribution of the current dental workforce does not reflect that of the U.S. population, which may impact communication, trust, and cultural sensitivity (Wright et al., 2021).

Shifting the Approach to Upstream Family Support

Dental professionals, whose practices are frequently private or external to care networks, can find themselves particularly vulnerable, isolated, and ill supported to address pertinent social issues faced by families seeking care and unable to effectively mitigate barriers to obtaining regular, preventive oral health care. Dental health care settings may thus, by necessity, lean frequently on child welfare and social service agencies to help manage cases of adverse oral health involving impoverished children, particularly when in-office social work support and access to community-based resources are limited. Response to dental neglect concerns by child welfare, and level of intervention, varies broadly; many jurisdictions lack specific definitional criteria for dental neglect, which contributes potentially to disparities and variability in interventions, including punitive measures (Silva et al., 2023).

Flaws in the current approach to childhood oral health disparities including need for frequent child welfare involvement are simple to point out; conceptualizing and devising effective solutions, such as policies, processes, and actions to address the interplay of SDOH, dental neglect, and broader societal inequities, pose significantly greater challenge. A paradigm shift toward addressing both the child's dental needs acutely and the broader societal and community context within which those needs developed is urgently needed. When considering care for the whole child, oral health is an oft-overlooked factor in ensuring a child's holistic wellbeing. Identifying which co-occurring risk factors impact families' capacities to meet children's basic needs while experiencing poverty may be a critical step toward neglect prevention and better inform upstream intervention, with the potential to reduce misappropriated referrals for child neglect (Sattler, 2023).

School-based oral health screening programs, whereby a dental professional can screen children for oral health needs during school hours, can help to mitigate barriers for families such as transportation, parental leave from work, and childcare for siblings. School-based programs also provide an opportunity to disseminate oral health supplies such as toothbrushes and fluoridated toothpaste to families who may not be able to afford purchasing these items. However, school-based programs frequently refer children to external dental offices for restorative care, settings that are less equipped to navigate a family's psychosocial needs.

In a dental practice setting, interventions can be envisioned across three trajectories—practical, office-based efforts; development of broader, external resource networks; and policy changes (Table 1). Consistent with recommendations from the CDC (CDCP, 2022), standardized data collection on SDOH and oral health disparities may identify cases traditionally (perhaps prematurely) categorized as dental neglect in need of upstream support services (Table 1). Information should be utilized to provide the family with practical resources and accessible support networks. Kim and Drake (2023) suggest poverty amelioration efforts and provision of material and family support potentially reduce child maltreatment incidents and child welfare reports; thus, provision of food or clothing through in-office food pantries or clothing closets may represent one practical strategy dental offices can employ to provide material resources to families. Transportation issues are highly documented as a barrier to health care access, particularly for those with lower incomes or the under-/uninsured (Syed et al., 2013). In settings with a disproportionate SDOH burden among families seeking care, including disproportionate transportation issues, it may be helpful to adapt office infrastructure through hiring or engagement of volunteer staff as a community liaison. Community liaisons are responsible for connecting families with community resources, programming, and/or transportation services (Garg et al., 2012). Dental practices serving families impacted by poverty should be encouraged to offer supportive services. Unfortunately, providing these services can be both time consuming and costly with no direct financial return to support these practices. Creation of a billable code for such services, reimbursed by public insurance, may be appropriate. Payment reform efforts, including transition to a value-based payment (VBP) model, may importantly allocate funding and prioritize addressing

SDOH through case coordination mechanisms with social service providers (Tobin-Tyler & Ahmad, 2020).

Dental professionals should develop culturally competent anticipatory guidance to enhance oral health literacy among families seeking care and be aware of culturally variable perceptions and beliefs about oral health that may impact dental care-seeking behaviors. For example, families with low socioeconomic status have lower health literacy and lower dental IQ, which in turn compromises the message given by their provider during a dental visit (National Institute of Dental and Craniofacial Research, 2005). What ultimately is labeled dental neglect by a treating professional may in fact be due to lack of caregiver understanding that caries is a bacterial infection and chronic disease that will compromise overall child health. Communities at higher risk of caries may benefit from oral health messaging tailored within their cultural context. Messaging should not just be limited to oral hygiene practices but should also include dietary education encouraging proper nutrition, low-sugar diets, and reduction of alcohol and tobacco use. This message can be introduced through educational interventions for children at dental clinics incorporating linguistically and culturally adapted prevention activities; as a result, interventions/best practices have been developed that can improve the health of vulnerable population groups including refugees and migrants (Riza et al., 2020). Many cultures view dental caries as a rite of childhood, and there may be no expectation of healthy primary teeth; subsequently, the presence of untreated, rampant caries may cause a dental professional to consider the possibility of dental neglect in these scenarios, without consideration or comprehension of related cultural context. Given varied cultural beliefs about oral health, hosting educational events in community spaces where families feel comfortable, such as religious organizations, community centers, and schools, can be one way to direct oral health information in an environment where families may be more receptive.

Developing robust, external resource networks—community engagement—can importantly connect families with partnering organizations where families can access services to positively impact the child's overall health. Dental referral networks/information pools can be created in collaboration with child welfare and community agencies to ensure community stakeholders have updated and relevant information to refer families to dental care. In urban settings that are resource dense, this pathway is more feasible than in rural settings where resource supports may be limited. Both urban and rural setting primary care offices can also be utilized as a source of screening, education, and preventative services; identifying at-risk children early will address acuity of dental needs and create better habits that will follow the child into adulthood. Finally, on a macro level, advocating for policies that bolster economic security for impoverished families is another way to support families and promote better oral and general health outcomes. For example, advocating for social policies such as the Earned Income Tax Credit (EITC) is important to strengthen the economic security of low-income families and may reduce child maltreatment, including reports of neglect across multiple age groups (Kovski et al., 2022).

Conclusion

Poverty and neglect can often be inappropriately conflated, particularly in dental practice settings where access to community supports for families is limited and variable. While reporting of safety concerns and engagement of child welfare may be appropriate and necessary in some cases, consideration of SDOH and their complex interplay with both poverty and oral health disparities is necessary when evaluating dental neglect concerns. Assessment of social contributors and intervention through upstream family supports may aid dental neglect prevention efforts and ultimately reduce need for child welfare involvement. Dental practice settings can take practical steps to address SDOH within the office and community to improve oral health in childhood.

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Table 1. Interventions to address SDOH in pediatric dental populations.

Office-Based Interventions	Accessing Networks	Policy-Based Interventions
Collection of information related to SDOH in the medical record	Creating a printed referral list for families to utilize with specific contacts at community-based organizations characterized by needs, i.e., housing, transportation, food	Creating a billable code in the dental office for providing social supportive services
In-office donated food pantry	Partnering with community-based networks, i.e., food banks, community centers	Advocating for social policies such as the Earned Income Tax Credit (EITC), which is important to strengthen the economic security of low-income families
In-office donated clothing closet	Partnering with organizations who help families access benefits such as local social service networks	
Creating a program that recycles gently used car-seats/strollers and baby carriers		
Installing a community-based liaison in the office who assists families in accessing and addressing resources		

Using Public Policy to Support Children in Families With Substance Abuse Disorders

Frank E. Vandervort, JD; Vincent J. Palusci, MD, MS

Abstract

Amid the COVID-19 global pandemic, substance abuse has increased. Consistent with this increase has been an increase in the incidence of infants with prenatal substance exposure (IPSE). Prenatal exposure to illicit drugs, licit drugs used illicitly, and alcohol have a range of negative health effects on newborns. This article reviews these effects and federal and state policies in this area, using child maltreatment report data to characterize associations with state statutes. We then review courts' rationales for prohibiting agency action to protect IPSEs and re-frame and re-conceptualize these cases within the existing "aggravated circumstances" framework in federal law.

Introduction

The authors will introduce the topic of this article by way of two brief case examples from one of the author's (FEV) recent professional experiences.

Case 1: *Shortly after his birth, DC began to exhibit withdrawal symptoms and had to be treated in the neonatal intensive care unit. His mother, who was 26 years old, told her medical providers that she used heroin during her pregnancy. Consistent with state law, a report was made to children's protective services (CPS). Urine and meconium drug tests revealed that DC had been prenatally exposed to amphetamines, opioids, and THC, the active ingredient in marijuana. He spent 29 days in the hospital as he was weaned from the various drugs he'd been exposed to and was treated for medical complications attendant to that exposure. DC's father died of a heroin overdose shortly after DC's mother became pregnant. Although the mother had had four previous referrals for child maltreatment related to drug abuse, including a previous case involving an IPSE, CPS conducted only a superficial investigation and determined that the mother was unable to care for DC. Further investigation by the child's lawyer disclosed that the mother began using and abusing substances at age 14 and that she had been arrested four times for offenses related to her substance use; she also had a history of mental health difficulties and had been diagnosed with anxiety disorder, attention deficit disorder, and posttraumatic stress disorder.*

Case 2: *SH was born exposed to illicit drugs—cocaine and heroin—as well as methadone (which was not prescribed) and alcohol. Shortly after his birth, SH was transferred to the NICU as a result of drug withdrawal and seizures. A CPS referral was made. During the investigation the mother was hostile and aggressive and at times refused to answer the investigator's question. The mother, who was 34 at the time of SH's birth, had previously had a child removed from her custody after she was arrested for assaulting the toddler on a public bus while intoxicated (alcohol). That child was subsequently returned to her custody after she "successfully" completed substance abuse treatment for her alcohol abuse and individual therapy. By the time of SH's birth, the mother had a 20-year history of polysubstance abuse, had never maintained employment for longer than a few weeks at a time, and had seven criminal convictions, primarily theft-related crimes and prostitution that she stated was how she supported her drug habit. SH's father, too, was addicted to drugs, in particular heroin and cocaine. Throughout the mother's pregnancy, he facilitated her drug use by obtaining drugs for her and using them with her. He had an extensive history of mental illness and within the year before SH's birth had been involuntarily hospitalized on*

three occasions, twice after suicide attempts. The couple lived in public housing provided by their city of residence. The couple had an extensive history of domestic violence, with numerous police contacts as a result.

These case summaries illustrate the multiple challenges presented by instances of drug exposed newborns that result in CPS filing child maltreatment actions in the nation's family and juvenile courts. In each, the courts refused to consider moving toward early permanency in favor of offering "reasonable efforts" to reunify the families. In each, it took more than two years and an enormous commitment of public resources before the courts would consider an alternative permanency plan (which was ultimately implemented in each case). In each, the passage of time revealed the child had significant impairments to their health, including intellectual functioning impairment, visual impairments, and developmental and educational deficits as a result of their prenatal drug exposure.

This article suggests the need to reconsider how we approach families in such cases and argues that the needs of the community cry out for a more balanced application of the law to ensure children such as DC and SH achieve permanency more quickly. Their needs, we argue, rather than the needs of their parents must be the focus of the community's efforts.

Nature and Scope of the Problem

Incidence and Harm

Prenatal exposure to illicit drugs, licit drugs used illicitly, and alcohol have a range of negative health effects on newborns. These include physical harms, intellectual impairments, attention-deficit disorder, damaging the child's ability to develop essential psychological attachments to a primary caregiver during infancy, educational handicaps, and increased juvenile delinquency. However, our knowledge about the harms caused by prenatal drug and alcohol exposure is still evolving. Many early studies were confounded by the presence of multiple substances. From a research perspective, the presence of more than one substance makes it difficult, if not impossible, to say drug X caused Y harm. From a functional point of view, it does not matter whether a child's, say, intellectual deficit was caused by prenatal exposure to cocaine rather than heroin or both. That said, a number of findings have emerged as more research has allowed us to understand the immediate and long-term effects of specific substances on children:

Alcohol. The harms of alcohol to the developing fetus are difficult to overstate. For instance, prenatal exposure to alcohol is a leading cause of intellectual disability in the United States (Williams & Smith, 2015). The American Academy of Pediatrics takes the position that no amount of alcohol use during pregnancy is safe (Williams & Smith, 2015). The impacts of prenatal exposure to alcohol imposes tremendous consequences on both the individual child and on the communities in which such a child lives. Research suggests that prenatal alcohol exposure often goes unrecognized or is misdiagnosed (Chasnoff et al., 2015).

Tobacco. Smoking tobacco has numerous harmful impacts on the developing fetus. Among these are increased risk of miscarriage, low birth weight, and increased risk of perinatal death. Prenatal exposure to tobacco smoke negatively impacts cognitive and behavioral functioning, as well as motor and sensory functions.

Marijuana. Children born exposed to marijuana experience sleep disturbances through the first 3 years of life, increased impulsivity, decreased attention, and lowered IQ. By age 10, these children exhibit increased levels of juvenile delinquency, which continues into adolescence. Prenatal exposure seems particularly to impact the brain's executive functioning (Ross et al., 2015; Day et al., 2011; Irner, 2012).

Cocaine. Research finds a correlation between prenatal exposure to cocaine and premature birth, low birth weight, smaller than average head circumference, and generalized growth retardation. As they grow, these children may experience poor

self-regulation, increased excitability, and poorer language skills than their non-exposed peers. They may also have difficulty attaching to a primary caregiver. Later in childhood, these children exhibit increased aggression and elevated levels of delinquent behavior. Imaging studies have shown structural abnormalities in their brains (Ross et al., 2015; Shankaran et al., 2007).

Methamphetamine. Prenatal methamphetamine exposure is associated with premature birth, low birth weight, growth restrictions during gestation, cardiac and cranial anomalies, brain development deficits (e.g., visual-motor integration, verbal-spatial memory, and attention), and small brain size (Ross et al., 2015).

Opioids. Opioid use has increased dramatically in recent years. Use during pregnancy is associated with lower birth weight, small head circumference, smaller brain volume, increased cognitive and motor skills impairment, hyperactivity, and increased difficulties with attention. These children may experience structural brain deficits that are "debilitating and long-lasting" (Ross et al., 2015, p. 68). Infants with opioid exposure can be born opioid dependent and may go through a withdrawal syndrome, which, if untreated, can be life threatening. Today, when healthcare professionals treat opioid addiction, they typically do so with medications that themselves can have harmful side effects, but which have benefits that outweigh these risks. For example, heroin addiction may be treated with methadone, but methadone use during pregnancy may result in a newborn who experiences withdrawal symptoms with a number of the same or similar impacts. The rationale for this form of treatment is that both withdrawal and relapse present even greater risks to the developing child.

In addition to the prenatal environment, the postnatal environment plays a critical role in mitigating or exacerbating the impacts of prenatal exposure. Infants continue to be exposed to illegal drugs used by their parents after birth (Clara et al., 2024). Like individual children, communities suffer great harm. First, the obstetrical and neonatal care provided to approximately one-half of these newborns is paid for by Medicaid. When not paid for by public resources, the cost of providing medical care to these babies drives up the cost of private health insurance. Second, communities must provide additional mental health and special educational services that these children later require. These IPSEs and their families require a tremendous amount of public and private resources. IPSEs disproportionately utilize health care, mental health, and special educational services throughout childhood and adolescence and into adulthood. Newborns may spend days, weeks, even months in expensive neonatal intensive care units as they experience physical withdrawal. As the cases summarized in the introduction illustrate, this is, in part, due to the use of multiple substances, the interactive effects of which can exacerbate the child's medical condition and complicate treatment. Society must absorb increased rates of juvenile delinquency and criminal justice involvement with their attendant costs. Some of these children, particularly those exposed to alcohol, experience lifelong disabilities that leave them dependent on public systems of care for decades (Patrick et al., 2012). Ongoing intervention and education expenses dwarf medical costs, and lifetime costs of lost productivity are even higher.

Laws and Policies

The Comprehensive Addiction and Recovery Act (CARA) of 2016 amended the Child Abuse Prevention and Treatment Act (CAPTA) by adding a requirement to report the number of IPSE, the number of IPSE with a plan of safe care, and the number of ISPE with a referral to appropriate services. CARA's requirements include the following:

(1) Policies and procedures (such as appropriate referrals to CPS and for other appropriate services) to address the needs of infants born with and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, including a requirement that health-care providers involved in the delivery or care of such infants notify

the CPS system of the occurrence of such condition in such infants.

(2) The development of a plan of safe care (POSC) for the infant born and identified as being affected by substance use or withdrawal symptoms or fetal alcohol spectrum disorder to ensure the safety and wellbeing of such infant following their release from the care of healthcare providers, including addressing the health and substance use disorder treatment needs of the infant and affected family members or caregivers.

The requirement to respond to the needs of IPSE appears in the laws and policies of many U.S. states. The child abuse and neglect reporting laws in approximately 26 states and the District of Columbia specifically require health-care providers to report when they treat infants who show evidence at birth of having been exposed to drugs, alcohol, or other controlled substances. In 23 states and the District of Columbia, prenatal exposure to controlled substances is included in definitions of child abuse or neglect in civil statutes, regulations, or agency policies. Illinois, Minnesota, North Dakota, Oregon, and Wisconsin require mandated reporters to report when they suspect that pregnant women are abusing substances so that the women can be referred for treatment. In Rhode Island, a report of substance use by a pregnant woman may be made, but an investigation will be conducted only for the newborn or other children in the home if there is an allegation of abuse and/or neglect beyond the substance use.

In many states, the actions that child welfare agencies must take in response to reports of substance-exposed infants are focused on providing treatment and support so that the infants are able to stay with their mothers. For example, 13 states and the District of Columbia require the agency to complete an assessment of needs for the infant and for the infant's family and to make a referral to appropriate services. For fiscal year 2020, of the 27 states that reported 21,964 screened-in cases of IPSE, 71.4% had a plan of safe care. In the twenty-eight states that reported 20,648 screened-in cases of IPSE, 65.0% had a referral to appropriate services (U.S. Department of Health & Human Services [USDHHS], 2022b).

Despite CAPTA requirements, one independent review of U.S. state laws found that fewer than half of all U.S. states (N = 20) address the issue of an infant being born addicted to or showing effects of illegal substances as meeting the definition of abuse or neglect. In a cross-sectional analysis of eight states (AR, AZ, CO, KY, MA, MD, NV, and UT), criminal prosecution policies were associated with greater odds of NAS immediately and in the longer term, but there was no association between NAS and states with CPS reporting policies (Faherty et al., 2019). Although the laws often vary in wording, they have some common elements. In general, laws outline the action taken by the mother (use of substances) and the resultant effect on the newborn (some type of serious harm/injury or risk). Laws are clear that the substances must not have been part of supervised medical treatment for the mother. Arizona, for example, defines neglect as a child born with an illegal substance present in the child's bodily fluids or the mother's as result of the mother's use. Some states (e.g., DC, GA, LA) make reference to the child being born addicted to a drug or showing withdrawal symptoms at birth. Some states define neglect as when the child may be in need of services and care that the parents seem unable to provide (e.g., OH) (Kenny et al., 2023).

NCANDS Report Data

While limited in its ability as administrative data to identify IPSE, the National Child Abuse and Neglect Data System (USDHHS, 2022a) collects information about child maltreatment reports made to the states, which are available in aggregate as well as at the individual level, de-identified data. When cases are substantiated or founded or if the child is identified as an alternate level victim, there are a number of child and family data fields from state record systems available. Records can be selected by child, state, and age in years, although newborns *per se* are not identified. Although not infant-specific, *alcohol exposure* is defined as "compulsive use of alcohol that is not of a temporary nature. Includes Fetal

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Alcohol Syndrome or exposure to alcohol during pregnancy. This field indicates if alcohol abuse or prenatal exposure to alcohol is a problem of the child" (USDHHS, 2022a, p. 52). For drug exposure, it defines "compulsive use of or need for drugs that is not of a temporary nature. Includes infants exposed to drugs during pregnancy" (USDHHS, 2022a, p. 53). These fields indicate if drug abuse or prenatal exposure to drugs is a problem in the child.

There were 3,605,201 births recorded in the U.S. in 2020 (Martin et al., 2021). For NCANDS 2020, 27 states included infants reported by medical providers with alcohol of drug exposure (USDHHS, 2022b, Table 3-10, p. 48). A number of states did not include data for both drugs and alcohol. To achieve a better estimate, we replaced unavailable data using the NCANDS Child File dataset. This resulted in combined data from 47 U.S. states and the District of Columbia. Using this combined dataset, we calculated that there were 36,793 confirmed reports available in the dataset with infant drug exposure; of these, there were 7,043 confirmed cases of infant alcohol exposure and 37,627 with either drug or alcohol exposure from among 3,145,000 total reports and 618,000 confirmed victims (USDHHS, 2022b). Overall, there were 11.949 confirmed reports per 1,000 births for drug exposure, 1.917 for alcohol, and 11.584 for either drug or alcohol exposure. Although not statistically significant, differences in rates were noted based on state laws regarding infant reporting, prenatal reporting, and referrals for services (Child Welfare Information Gateway, 2020). States with required infant CPS reporting had 2.1 times the rate of confirmed cases identified for drug or alcohol exposure, states with prenatal CPS reporting had 0.82 times the rate, and those with referral procedures in place had 1.5 times the rate compared with those states without a similar procedure (see Table 1). This suggests that while states with reporting requirements and services actually have more confirmed reports, prenatal reporting actually identifies *fewer* children. Given what we know about reporting in general (Palusci & Vandervort, 2014), it is unclear if having broader mandated reporting laws actually results in more cases or just more reports.

Table 1. Confirmed reports with infant alcohol or drug exposure in NCANDS, 2020: Average rates per 1,000 births of drug or alcohol use, by state statute.

State Laws	Drug Exposure*	Alcohol exposure*	Either alcohol or drug exposure*
State law requiring infant CPS reporting (27 states)	15.606	3.477	15.351
No state law	7.124	0.214	7.302
State law requiring prenatal CPS reporting (6 states)	9.488	2.750	9.563
No state law	11.745	1.837	11.722
State law requiring referral (13 states)	16.345	1.579	15.329
No state law	10.217	2.010	10.439
Overall	**11.949**	**1.917**	**11.584**

**rate per 1,000 births (Martin et al., 2021) Source: Child Welfare Information Gateway, 2020; USDHHS, 2022b, Table 3-10.*

We Know This Is a (Substantial) Undercount of Children Prenatally Exposed

It can be difficult to identify infants with prenatal drug or alcohol exposure. The first challenge is identifying mothers with substance use. The American College of Obstetrics and Gynecology has a policy against testing for drug use during pregnancy (ACOG, n.d.). In practice, screening for drugs and alcohol is based on history obtained from the mother, which may be inaccurate (Oni et al., 2022). When mothers are tested, some challenges for determining whether an infant was exposed to alcohol and/or drugs during pregnancy are that testing, if done on specimens from the mother, is affected by the rate of drug and alcohol excretion. This is affected by many factors, including the amount of alcohol or other drug taken; the frequency of use; the mother's daily liquid intake, health status, exercise, age, sex, body weight, and metabolic rate; and the concurrent use of other drugs, including alcohol and/or nicotine. Babies have other factors that influence whether a test will be accurate, such as the timing of the last maternal use of the drug or alcohol, how the test was done, and whether they exhibit physical signs. A fetal alcohol spectrum disorder diagnosis, for example, requires a medical evaluation and neurodevelopmental assessment conducted by a multidisciplinary team. Neurobehavioral outcomes will depend on the dose and pattern of alcohol consumption and the developmental stage when the fetus was exposed; those harms are usually not apparent at birth.

Most pediatric providers do not *test* all babies, relying instead on *selective testing* based on risk factors or other indicators. Where everyone is tested, numbers can increase substantially. In an anonymous study of meconium (newborn stool) obtained from 461 mother-infant pairs in a community hospital in a Midwestern city over 3 months, 6.94% of all tests were positive, doubling the rate of identification compared with prior clinical screening and selective testing (Pippenger et al., 1999). The substances identified among births in this reportedly low-risk community were marijuana (3.25%), opiates of abuse (1.08%), and cocaine (0.87%). This study and others have raised concerns about fairness of selective testing regimens, which may be biased based on poverty, race, and ethnicity rather than actual risk for drug or

alcohol use. Ellsworth and colleagues (2010) assessed 2,121 mother-infant pairs and found that infants born to Black mothers were more likely than those born to White mothers to have testing performed whether they did (35.1% vs 12.9%) or did not meet screening criteria (5.3% vs 1.2%), and Black race remained independently associated with drug testing even when controlling for income, insurance status, and maternal education. They concluded that providers seemed to have used race in addition to recognized risk criteria as a factor in deciding whether to test an infant for maternal illicit drug use. When compared with background rates obtained anonymously, this suggests that White infants are inappropriately less likely to be tested even with recommended screening protocols in place.

IPSE Live With Parents With Comorbid Problems

By definition, IPSE live with at least one parent and very often two who misuse substances. These adults frequently have comorbid disorders and social determinants of health that increase the risk of harm, that render parenting more difficult, if not impossible, and that make treatment intervention less likely to be successful (Knight, 2015).

Domestic Violence

Women who abuse substances are at an elevated risk of domestic violence victimization at the hands of their partners (Rivera et al., 2015). Nearly two decades of research has repeatedly found an interactive effect of substance abuse and interpersonal violence (IPV) between partners, suggesting that the presence of IPV between partners and substance abuse occur hand-in-glove. That is, IPV tends to lead to increased substance use while increased substance use leads to increases in IPV (Rivera et al., 2015).

Mental Illness

The linkage between mental health problems and substance abuse is well-researched and well-documented (Deutsch et al., 2021; Knight, 2015; Brooner et al., 1997). In 2019, the National Survey on Drug Use and Health found that 9.5 million Americans experience comorbid substance use and mental health disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Among the most prevalent mental health disorders experienced by these parents is depression**.** In their study of 1436 prenatally exposed infants and their mothers, Deutsch and her colleagues (2021) found that 55% had co-occurring mental health challenges.

Personality Disorder

Personality disorders, too, are prevalent among those with substance use disorders (Verheul, 2020; Brooner et al., 1997). Brooner and his colleagues' study of more than 700 opioid addicted patients who sought treatment found that a quarter of those patients also had a personality disorder. Particularly concerning is the presence of narcissistic or anti-social personality disorders. One who is narcissistic cannot recognize the wants and needs of another, a condition that presents obvious concern about one's ability to provide a minimally adequate level of parenting to a child, particularly an infant who, because of difficulties associated with their prenatal exposure, may need an elevated level of care. Anti-social personality disorder is defined, in large part, by a lack of empathy for others and a willingness to violate the rights of others, even to the point of inflicting physical harm to get one's way or meet one's needs. Studies have found that a quarter or more of individuals with substance use disorders suffer specifically from anti-social personality disorder (Brooner et al., 1997). Treatment of personality disorders is a difficult, long-term process in the best of circumstances. It has little hope of succeeding in anything like the timeframe necessary to meet the needs of newborn children (Rodrigo et al., 2010).

Joblessness

As the introductory cases illustrate, parents of IPSE who are petitioned to court frequently experience an inability to obtain and maintain gainful, legitimate employment (Knight, 2015). The National Survey on Drug Use and Health conducted in 2019 concluded

that "[i]llicit drug use accounted for $49 billion in reduced participation in the workforce" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021, p. 3). As a result, many addicted pregnant persons turn to sex-work, and, in so doing, expose their children to more and greater threats (Knight, 2015).

Housing Instability

Individuals who experience substance abuse disorders, and particularly those with attendant comorbidities, struggle to maintain housing. Nationwide, there is a shortage of affordable housing for families. Even when subsidized housing is available, through Section 8 or other programs at the federal, state, and local levels, these individuals have difficulty maintaining their physical homes (Chassman et al., 2023; Knight, 2015; Paplepu et al., 2010).

Incarceration

Substance-abusing parents are susceptible to incarcerations. The 2016 Survey of Prison Inmates found that 38% reported at the time of their arrest that they were using drugs; 30% reported drinking alcohol at the time of the offense for which they were sentenced; 64% reported using at least one drug in the 30 days before their incarceration; and a large percentage of prisoners met *DSM IV* criteria for substance use disorder (U.S. Department of Justice, 2021). This may be primarily because of the need to procure and use illegal drugs or licit drugs illicitly, because of the ways in which these adults obtain money to procure drugs to support their habits, or because of their actions while under the influence (e.g., driving under the influence, assaultive behavior). Regardless of the specifics, parents who face frequent incarceration may be unavailable to provide care and support for their children. In some circumstances, incarceration precipitates withdrawal, which, as noted, can be harmful to the fetus. Incarceration and attendant criminal convictions may make it more difficult for parents to obtain and maintain treatment, employment, and housing.

Polysubstance Exposure

Cases in which CPS seeks a court's protection of an IPSE typically present a truly daunting set of difficulties to overcome. It is not unusual that the child who is the subject of the state's concern to be born having been exposed to numerous substances—2, 3, even 4 is quite typical. These children often experience withdrawal and may have a range of physical injuries to their bodies and brains—some obvious and some entirely hidden until they develop over time. On average, the polysubstance abusing parent faces a much more difficult treatment trajectory than the parent who abuses a single substance (Crummy et al., 2020). That is, the parents whose children are the subject of child protective court actions present complex cases that strain our known capacity to treat. When that difficulty is the foundation for the comorbid existence of mental illness, personality disorder, domestic violence, and job and housing instability, it becomes virtually impossible to realistically expect anything like a true recovery and rehabilitation within a timeframe that will serve the needs of the child, which are by law the paramount consideration in a child protection proceeding.

Treatment Efficacy

When an individual is addicted to substances, particularly with polysubstance use or where there are comorbid factors such as mental illness, treatment may take years to be effective. Similarly, relapse is part of the ordinary course of recovery from substance use, with comorbidities generally increasing the number of relapses. In complex cases of the sort that CPS is likely to seek court intervention, the rate of relapse is likely to be elevated. The time to achieve sufficient sobriety to be able to provide reasonably safe care for a young child may directly conflict with the developmental needs of the child, which the law makes clear must be the paramount concern in child protection cases (Beaulieu et al. 2021). As a result, even if a parent may be able to achieve a level of sobriety to provide care for a child, the timeline necessary to achieve

that goal may be inconsistent with the needs of the developing child, particularly where that developing child has special needs that result from the prenatal exposure to substances.

The Role of Fathers

Although mothers are often the focus, fathers too often are disregarded. Some women may become pregnant through sex work and the father's identity may be either unknown or unknowable (Knight, 2015). Yet, research from around the world makes clear the importance of fathers in their children's lives (McMahon & Rounsaville, 2002). Two decades ago, McMahon and Rounsaville (2002) observed that "the status of substance abusing men as fathers is rarely acknowledged in the conceptualization of public policy, service delivery, or research focusing on the adverse consequences of drug and alcohol abuse" (p. 1109). It appears that things have not changed much in the past two decades. It remains the situation that these men, their contribution to the problems child protection involved pregnant women experience, the harms done as a result of prenatal drug exposure, and their responsibilities are regularly overlooked. Indeed, they are virtually absent from the discussions of prenatal exposure. In Deutsch and her colleagues' study of over 1,400 drug exposed newborns, they found that "data regarding fathers . . . was profoundly limited, resulting from either lack of family involvement or identification" (Deutsch et al., 2021, p. 241). As the illustrative cases make clear, the presence of these men in the lives of substance abusing pregnant women is often problematic as they may contribute to the litany of problems outlined earlier in this article.

Research suggests that substance abusing fathers have more children with more partners and expend less effort actually parenting those children than non-substance abusing fathers (McMahon & Rounsaville, 2002). As in SH's case, substance abusing fathers of children who enter the child protection system may be the perpetrators of domestic violence, both during and after the pregnancy. They may coerce their partners and the mothers of their children into substance use while at the same time discouraging them from seeking treatment (Rivera et al., 2015). They are sometimes the pregnant woman's drug supplier. Even if not the primary supplier, they may conspire in the effort to obtain and use drugs.

The Legal Framework of Child Protection

While parents have a constitutionally protected interest in the care, custody, and control of their children (*Meyer v. Nebraska*, 1923), the United States Supreme Court recognized that the State has an important interest in the welfare of children that must be balanced against that parental interest. Thus, the court declared in *Prince v. Massachusetts* (1944) "that the state has a wide range of power for limiting parental freedom and authority affecting the child's welfare" (p. 167). Specifically, as it relates to child abuse or neglect, the Court has described the State as possessing an "urgent interest in the welfare of the child" (*Lassiter v. Department of Social Services*, 1981, p. 27). The child's safety, however, is subject to the exercise of discretion by State child protective authorities (*DeShaney v. Winnebego County Department of Social Services*, 1989). Regardless of how that discretion is exercised, "the State . . . has a compelling interest in protecting children from abuse, both after and before the abuse occurs" (*In re O.R.*, 2002, 876).

To protect the states' interests, Congress passed, and various Presidents have signed into law, a series of federal funding statutes aimed at incentivizing the individual states to establish child protection systems that meet certain minimum standards. Most relevant to the present discussion are the CAPTA and the Adoption Assistance and Child Welfare Act of 1980, which established Titles IV-B and VI-E of the Social Security Act (SSA). These provisions of the SSA provide funding, respectively, for state efforts respond to child maltreatment, to provide tertiary services aimed at preventing additional maltreatment and to fund the foster care placement of children, when necessary.

In order to protect parents' interests in caring for their children, the law typically requires that the state make "reasonable efforts" to maintain familial integrity before it seeks to remove a child and to reunify the parent and child when removal is necessary. Research has suggested that laws that recognize prenatal substance exposure constitutes child maltreatment may discourage pregnant women from seeking prenatal care, which may have negative consequences for the child (Atkins & Durrance, 2020); Austin et al., 2022). The law, however, provides that child protection agencies and courts may make any decision that will serve a child's best interests in an individual case. These findings should be considered by policymakers and practitioners as they formulate responses. The federal statutes have been amended a number of times over the years, most recently, as they relate to the present discussion, CARA. CARA amended CAPTA to require that states receiving federal grants include in their regimes for mandated reporting a requirement that children born "affected by withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder" be reported to CPS; federal law, however, leaves to the individual states the authority whether to define such prenatal exposure as child abuse or child neglect (42 U.S.C. 5106a(b)(2)(B)(ii)). Additionally, federal law since 2016 has required that states adopt procedures to ensure that a POSC is implemented for each newborn who has experienced prenatal exposure to drugs or alcohol (42 U.S.C. § 5106a(b)(2)(B)(iii)). As noted above, not all states are in compliance with these requirements.

In addition to addressing the needs of the newborn and their family, POSC is an effective way for state authorities to meet the law's "reasonable efforts" requirement. Although the research in this area is limited, there are empirical suggestions that POSC can be effective in protecting children while preserving families (Deutsch et al., 2021). To be effective, however, these plans must address a wide range of needs. Deutsch and her colleagues wrote that parents of drug-exposed newborns "have diverse needs, including co-occurring need for parenting or job skills support, intimate partner violence counseling, [and] home visiting nursing" (Deutsch et al., 2021, p. 241). These other services are routinely provided to families as part of the state's implementation of family preservation services. POSC may not always be in the best interest of the child since recovery may require many attempts (Kelly et al., 2019). When reasonable efforts are made, it is important to assess the situation on an ongoing basis.

Prenatal Exposure as a Basis for Court Action

Despite these numerous efforts to maintain children with their families, many drug-exposed newborns must be petitioned to court in order to remove them from parental custody and protect them from additional harm.

> *"[Her] substance abuse has been a serious and chronic problem, and that prior efforts to rehabilitate [her] have been unsuccessful. [The mother], who was 39 years old at the time of the termination [of parental rights] hearing, admitted that she began using alcohol and marijuana on a daily basis at the age of 12, was using cocaine regularly by the age of 19, began using heroin at the age of 23, and had completed at least 11 residential substance abuse treatment programs. She further admitted that she used cocaine both while she was pregnant with the instant child and again shortly after the child's birth, when CPS was involved. (In re Helge, 2015, p. 5)"*

The mother in that case had previously lost her rights to another child as a result of ongoing substance abuse. This one and the two described in the introduction to this article are typical of the cases in which CPS

petitions a family or juvenile court, which involve the most challenging cases of drug exposed newborns. Substance abuse is chronic and difficult to treat. Many women give birth to multiple drug-exposed newborns. In a study of all IPSE born in Delaware between November 1, 2018, and October 31, 2020 (1,436 children), researchers found that 23.7% of the mothers had previously given birth to at least one drug-exposed infant (Deutsch et al., 2021). A parent's failure to comply with or inability to benefit from family preservation services provided though a POSC that results in court action portends a poor prognosis.

Over the past several decades, state courts across the country have concluded that giving birth to a child prenatally exposed to illicit drugs or alcohol is in itself grounds for the state to intervene into family life to protect the newborn child (e.g., *In re O.R.*, 2002; *In re Dustin T.*, 1992; *In the Matter of Stefanel Tyesha C.*, 1990; *In re Baby X*, 1980). At least one state court has recognized that chronic substance abuse by *either* parent during pregnancy may be grounds to remove a child upon the child's birth (*Matter of Pima County Juvenile Severance Act No. S-120171*, 1995). But as we have discussed, most of the parents involved in these cases experience an array of problems that make successful reunification a long-term proposition, at best, and very often unlikely.

The federal law allows each state to define "aggravated circumstances" that would obviate the need to engage in efforts to reunify the family (42 U.S.C. § 671(a)(15)(D)). These circumstances often include serious injuries. As discussed earlier in this article, many children who are prenatally exposed to drugs and alcohol suffer just this type of permanent, debilitating injury. In addition, although the Children's Bureau of the Department of Health and Human Services has undermined its operation by a singular focus on family reunification, since 1997, federal law has explicitly provided the following:

Nothing [in federal law] shall be construed as precluding State courts or State agencies from initiating the termination of parental rights for reasons other than, or for timelines earlier than, those specified in [Title IV-E] when such actions are determined to be in the best interests of the child. (42 U.S.C. § 675 note construction)

Another section of federal law makes clear that a state family or juvenile court may make any decision in an individual child protection case that will serve the interests of the child (42 U.S.C. § 678).

The specific form the authority granted by federal law will take largely depends on the law of the individual states. Illinois has a model statute. In relevant part, it provides that

it may be appropriate to expedite termination of parental rights: . . . (c) in those extreme cases in which a parent's incapacity to care for the child, combined with an extremely poor prognosis for treatment or rehabilitation, justifies expedited termination of parental rights. (705 ILCS §405/1(1)(c))

In states with laws similar to Illinois's, the child protection agency should consider whether cases involving drug exposed newborns should be petitioned under these laws that allow for immediate termination of parental rights, which would make the child available for alternative permanent planning immediately.

Where state "aggravated circumstances" law does not encompass drug-exposed newborns, either explicitly or implicitly, or where the state lacks a statute similar to Illinois, the state legislature should consider amending the law to explicitly provide the following: (1) newborns who have been exposed to drugs or alcohol should be covered by the state's abuse and neglect laws, and (2) giving birth to a drug-exposed newborn triggers a review to determine whether immediate termination of parental rights would serve the child's best interests and would protect the state's "urgent" interest in the child's welfare. Where immediate termination of parental rights is not appropriate and "reasonable efforts" must be made, child protection agencies and courts should assess on an ongoing basis whether early termination of parental rights would serve the child's needs for safety, permanency, and wellbeing and whether such action would serve the State's interests.

Conclusion

Each year in the United States, tens of thousands of children are born having been exposed to drugs or alcohol prenatally. Variations in state laws, medical practice, and types of exposure allow a substantial proportion to go unrecognized, unreported, and untreated. A relatively small number of those children are petitioned to family or juvenile courts. These children's parents often present with an array of difficult life circumstances that make reunification unlikely or impossible in a timeframe that will meet the needs of that child and the serve the state's "urgent" interest in the child's welfare. In such cases, state actors should consider whether immediate or early termination of parental rights would best serve the interests of the child and the state.

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Institutional (Chain of Command) Child Abuse Reporting: An Exploratory Overview

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Abstract

This study aims to address a gap in the literature in the United States regarding institutional reporting and its impact on children. Institutional or chain of command child abuse reporting requires the mandatory reporter (MR) to report suspected child maltreatment to their supervisor or designee rather than directly to child protective services (CPS), or law enforcement, or both. After reviewing limited available research, anecdotal evidence, expert opinions, and court cases and after comparing statutory reforms, the authors identify serious child safety concerns regarding institutional reporting: It is the common denominator of ongoing child sexual abuse in institutions and organizations, it places the MR at greater risk of retaliation, it decreases child maltreatment reporting, it dilutes the report's validity and makes it more difficult to assess danger in the home, it increases the liability risk for the institution/organization, it attracts predators, it prioritizes lawsuit fears over children's safety, and it allows reporting law violations. The study concludes with limitations and recommendations for needed legislative changes to better safeguard vulnerable children and the MRs tasked with protecting them.

Key Words: *Institutional reporting, chain of command reporting, child maltreatment prevention, retaliation against mandatory reporters, mandatory reporting of child abuse*

Introduction

Abuse Reporting of Children in Educational Institutions

Failure to report sexual abuse by educational institutions nationwide demonstrates a systemic problem associated with institutional reporting, as evidenced by the following examples. In 2011, the nation learned that Pennsylvania State University's top administrators did not report Jerry Sandusky's rape of a child. Their failure to report allowed Sandusky to continue preying upon young boys for more than a decade (Freeh Sporkin & Sullivan, 2012). The Penn State scandal compelled Pennsylvania legislators to examine their child abuse reporting laws. They discovered Pennsylvania was one of only seven states (including Georgia, Idaho, Massachusetts, Missouri, South Dakota, and Virginia) that allowed hospital, school, and organizational employees to report to a supervisor or designee rather than directly to child protective services (CPS) or the police (National Center for the Prosecution of Child Abuse [NCPCA], 2016).

Recognizing how institutional reporting jeopardized children's safety, Pennsylvania eliminated institutional reporting in 2014 and made all school employees and volunteers mandatory reporters (MRs; Rittmeyer, 2014). Pennsylvania's S21 legislation required MRs to make an immediate direct report of suspected abuse to ChildLine and immediately notify the person in charge of the institution, school, facility, or agency (Suspected Child Abuse—Mandated Reporting Requirements Act, 2022).

Although there are several significant changes to the way child abuse is reported and investigated in Pennsylvania, the most significant change affecting

educators is that chain of command reporting procedure for child abuse is no longer acceptable. This is something that went from an accepted practice to a third-degree felony if the underlying abuse rises to the level of a felony (Persick, 2015).

Further, Pennsylvania's Domestic Relations Code SB 33 (2014) safeguards reporting MRs, providing whistleblower protection from employment discrimination for MRs who make good faith reports. If the MR is fired or discriminated against regarding any employment practice and a ruling is found in favor of the MR, the MR may be reinstated with back pay.

The Penn State scandal highlighted how direct reporting could have prevented decades of further harm to child victims, and the nation took note (Guardia, n.d.). Consequently, between 2012 and 2019, state legislators enacted 140 bills to amend, strengthen, and expand existing child abuse reporting laws (Guardia, n.d.; National Conference of State Legislators [NCSL], 2021).

Many other educational institutions have experienced scandals related to unreported sexual abuse. The University of Maryland–Baltimore County (UMBC) settled a $4.14 million lawsuit with students affected by the sexual misconduct of a swimming coach who sexually abused and harassed male swimmers (U.S. Department of Justice [USDOJ], 2024). The USDOJ (2024) claimed UMBC's administrators warned the coach of impending locker searches in 2015 after students complained he was using a camera to film them, thereby thwarting the investigation. Further, when a male student reported sexual touching by the coach in 2019, the administration again failed to report any misconduct.

In 2023, an Ithaca College student reported that the associate dean of the Roy H. Park School of Communications and three other employees had sexually harassed and abused him (Pierre & Panwar, 2024). According to Pierre and Panwar (2024), the student filed a lawsuit against Ithaca College, stating the administration knew about the professor's Grindr page, which targeted students. Though administrators and faculty knew about the abuse, the school failed to report it, causing further harm to the student.

In addition to not reporting sexual assaults or harassment by faculty and staff, many educational institutions fail to report sexual assaults by other students. Hilldale College, Occidental College, Liberty University, and the University of Connecticut are several colleges that have been investigated in the last decade for failure to report sexual assault or rape on campus (Booth-Singleton, 2023; Burchill, 2022; Testa, 2014; Umansky, 2024), continuing to foster a culture of silence.

Institutional reporting in high school has also contributed to the ongoing abuse of minors. In the Los Angeles Unified School District (LAUSD), a teacher sexually assaulted multiple students, according to Kim (2014). In 1983, a parent reported that a teacher exposed himself to students. For three decades, numerous other complaints have been made about this teacher's sexual behavior with students, including masturbating during classes in the 1990s. Only when photos were turned over to the police by an unknown source in 2011 was an investigation initiated. The teacher eventually pleaded no contest and was sentenced to 25 years in prison.

New Hampshire, in 2020, closed its legal loophole, which allowed high school faculty and staff to have sexual contact with students ages 16–18, making it illegal for those in charge of students to have sexual contact with students ages 13–18 and for 10 months post-graduation. O'Grady (2020) reported that this new law was a direct result of a particular teacher who had engaged in sexual behavior with students for years before the school finally acted, despite complaints from coworkers and students alike. The school claimed no evidence of wrongdoing as the students were within the legal age of consent in New Hampshire, ignoring the power differential between teachers and students.

Zimmerman (2023) clarified in his report, *Catching the Trash*, that teacher unions, educational agencies, principals, and other school personnel would instead cover up sexual abuse by teachers rather than report abuse. He stated that teachers are routinely allowed to resign and move to other schools, labeling this as "passing the trash" (p. 3).

In 2011, seven states (GA, ID, PA, MA, MO, SD, VA) permitted institutional reporting; by 2020, five of those states enacted legal reform with four getting rid of institutional reporting altogether (NCPCA, 2016). Most states enacted criminal penalties for officials who interfere with or prevent mandated reporting (Guardia, n.d.). Massachusetts, South Dakota, and Idaho are the only three remaining states whose laws allow MRs who work in youth-serving institutions and organizations to report suspected abuse to their superiors without any accountability for officials who fail to report (NCPCA, 2016). These legislative changes demonstrate the recognition by most states that direct reporting without interference is the superior reporting procedure.

Specifically, in 2013, Missouri updated its law to state, "The reporting requirements under this section are individual, and no supervisor or administrator may impede or inhibit any reporting under this section" (Reports of Abuse, Neglect, and Under Age Eighteen Deaths). Before enacting this law, MRs in various institutions (e.g., schools, hospitals, etc.) had to report to their supervisor or a designated person, who would then report to CPS. Although not eliminating institutional reporting, Georgia and Virginia added strong protections from administrator inaction or coverup. Georgia's codified law (Guidelines for Mandatory Reporting of Suspected Child Abuse by Public Health Personnel [Guidelines], 2022) prohibits "the person in charge … from exercising any control, restraint or modification, or making any other change to the information provided by the reporter." Georgia also mandated that:

> [w]ithin 24 hours of receiving such report, such entity shall acknowledge, in writing, the receipt of such report to the reporting individual. Within five days of completing the investigation of the suspected child abuse, such entity shall disclose, in writing, to the school counselor for the school such child was attending at the time of the reported child abuse whether the suspected child abuse was confirmed or unconfirmed. If a school does not have a school counselor, such disclosure shall be made to the principal.
> (Guidelines …, 2022)

This legislation helps ensure that the proper government authorities will be notified (Guardia, n.d.).

In 2015, Virginia passed the Complaints and Reports of Suspected Child Abuse or Neglect Act, which states,

> If the initial report of suspected abuse is made to a person in charge or designee … that superior shall notify the initial reporter when the report is made … [and] shall forward to the initial reporter any communication resulting from the report, including any actions taken regarding the report. (para. 2)

Virginia's new law ensures that the MR will disclose all pertinent information regarding the report to CPS (Guardia, n.d.).

South Dakota enacted the Oral Report of Abuse or Neglect—To Whom Made— Response Report (2015), which requires the MR who witnessed the disclosure or evidence to be present and available when the initial report is made to authorities by the MR's supervisor. However, South Dakota still allows an MR to report up the chain of command in a hospital or school setting. Further, South Dakota law does not address employer retaliation for an MR's direct communication with CPS, law enforcement, or accountability if the superior fails to act (Guardia, n.d.).

In Massachusetts, top administrators make the final decision on what (and if) child abuse allegations are reported to CPS (Guardia, n.d.). The Office of Child Advocate's (2021) Massachusetts Mandated Reporter Commission (MRC) interim report noted that "it is not uncommon" for MRs to make a report to their supervisor and believe a 51-A (the required report of suspected abuse) was filed with CPS "only to discover months later that a report was never made" (p. 58). On June 30, 2021, despite knowing that many MA supervisors failed to follow through and report suspected abuse directly to CPS/police, MRC recommended keeping institutional reporting in their state law. MRC rationalized that damage to the institution or alleged abuser via an investigation needs to be weighed against the need to protect children. This continues to send the message that the institution or the abuser is more important than the abused child.

Other Areas of Institutional Reporting of Sexual Abuse

In the following examples, the sexual abuse of vulnerable children continued unchecked for decades because MRs were employed in settings where direct reporting was prohibited. Though fallout from chain of command reporting may be found across many religious institutions, universities, and organizations, the authors chose these *specific examples* because they were well documented, demonstrate the far-reaching impact on children across varied settings, and highlight the importance of direct reporting.

Reporting Religious Abuse

Examples of systemic institutional problems are ample across many varied religious institutions. Although the Catholic church is the most well-known example, many religious institutions have covered up sexual abuse. The Church of Jesus Christ of Latter-day Saints (LDS) has had its share of scandals (Rezendes & Dearen, 2023). In April 2023 (Associated Press [AP], 2023), according to an AP staff writer, the LDS church was required to pay $2.28 billion to a woman who reported the church covered up repeated sexual abuse by her stepfather. The woman had told many church members and officials about the abuse, but church leaders failed to act. Rezendes and Dearen (2023) reported there were recordings of church leaders derailing investigations by prohibiting bishops from testifying about known abuse, written confidentiality agreements, and pledges to destroy critical information about abuse.

In 2019, the Southern Baptist Convention (SBC) faced a similar scandal when hundreds of cases of sexual abuse by clergy surfaced (Gross, 2022). Gross (2022) interviewed the journalist Robert Downen from the Houston Chronicle, who broke the story in 2019. As a result of Downen's story, the SBC commissioned an independent study regarding sexual abuse within the church. The commission discovered a secret list of abusers maintained by the SBC since 2007, detailing more than 700 victims of sexual abuse by clergy, church volunteers, and others within the church. The SBC had transferred many clergy members to other congregations, giving them access to numerous children in multiple states. Rather than report the abuse, the SBC "passed the trash."

Accusations and systemic coverups of child sexual abuse within the international Catholic Church hierarchy began receiving public attention in the 1980s and 1990s. In 2002, the *Boston Globe*'s Spotlight team revealed that for decades, U.S. bishops and archbishops had accepted priests with histories of sexually abusing children, reassigning them to other parishes and schools to abuse new victims. Thousands of abuse allegations made by victims, parents, and church staff were covered up within the Church hierarchical reporting system. Problems with accountability are rooted in the Church structure, with dioceses governed "like fiefdoms … with little centralized oversight above the level of bishops or archbishops assigned to that region" (Green, 2019, para 26).

A 2018 Pennsylvania grand jury report of child sexual abuse in six of Pennsylvania's eight dioceses found that in 54 of the state's 67 counties, priests abused over 1000 children. These abuse allegations were covered up by Church officials: "Priests were raping little boys and girls, and the men of God who were responsible for them not only did nothing, they hid it all for decades" (Pennsylvania State Supreme Court, 2018, p. 7).

There has been a growing international movement to hold Church leaders accountable for systemic abuse and coverups. In February 2019, Pope Francis abolished the practice of "pontifical secret" regarding clergy sexual abuse cases in response to increasing criticism that such confidentiality shields pedophiles, prevents direct reporting to the police, and silences victims (CBS News, 2019). Pope Francis decreed that "pontifical secret" no longer applies to abuse allegations. However, the Vatican fails to mandate direct reporting of suspected abuse to law enforcement (Winfield, 2019).

The U.S. Conference of Catholic Bishops voted to establish an independent third-party system for reporting suspected child sexual abuse by current and retired bishops (Sadowski, 2019). The system would allow individuals to report online or through a toll-free number. All reports must be reported to the appropriate bishop or archbishop, who must report to law enforcement. This lack of outside oversight is a prime example of an inherent conflict of interest.

Dallam et al.'s (2021) and CHILD USA's (2021) research further confirms that the U.S. archdioceses failed to enact sufficient policies to prevent child sexual abuse. After examining 32 written policies on child protection and comparing policies across archdioceses, the researchers found the current policies to be inconsistent and inadequate. They identified the need for the Catholic Church to adopt evidence-based best practices for reporting and addressing child sexual abuse within the organization. While each of the archdioceses has policies for direct reporting to civil authorities, these policies fail to consistently adhere to the states' reporting laws, do not identify who is an MR, rarely specify what information should be included in reports to authorities, and do not consistently address ramifications for failing to report.

Reporting USA Olympic Sports and USA Gymnastics Abuse

Since 1982, over 290 coaches and officials associated with the USA Olympic sports organizations have been accused of sexual misconduct, according to Hobson and Rich (2017b, para. 3) in their *Washington Post* review of sports governing bodies' banned lists, newspaper articles, and court documents in several states. Interviews with dozens of Olympic sports officials and a review of thousands of pages of lawsuit records filed by victims reveal a culture that prioritizes winning and reducing liability risk over children's safety.

In 2010, attorney and Olympic gold medalist Nancy Hogshead-Makar began receiving calls regarding the sexual abuse of athletes participating in Olympic and club sports, according to Moran (2018). She learned that sports' governing bodies under the USA Olympic Committee (USOC) stated that they did not have a legal duty to protect athletes from abuse or enough insurance to address abuse claims. In 2012, she helped convince the USOC's board to adopt a rule preventing coaches from having relationships (sexual or romantic) with athletes they were coaching, regardless of age or consent. They were given a year to implement the rule. However, over time, she recognized the USOC's lack of commitment to protect athletes.

The Larry Nassar scandal, which revealed how a former USA Gymnastics and Michigan State University doctor had sexually abused hundreds of women for decades, prompted changes. With bipartisan support, Congress gave final approval to the Protecting Young Victims From Sexual Abuse and Safe Sport Authorization Act, also known as the Safe Sport Act (Protecting Young Victims From Sexual Abuse and Safe Sport Authorization Act, P.L. 115-126, 2018; Moran, 2018). This law tasks the USOC and its national governing bodies with a legal duty to prevent sexual, physical, and emotional abuse

of amateur athletes. Those involved in USA Olympic and amateur sports must report any sexual abuse allegations *directly* to law enforcement within 24 hours.

On January 3, 2018, the Safe Sport Act (Protecting Young Victims From Sexual Abuse and Safe Sport Authorization Act) was passed by Congress, requiring members of youth-serving sports organizations to report suspected child abuse immediately to police and then to the U.S. Center for SafeSport (the USOC portal for reporting abuse and training coaches on abuse), designating everyone in the Olympic movement as an MR. The USOC (2012) specifically addresses MR retaliation in a "no retaliation regardless of the outcome" policy:

> *...[The] USOC will not encourage, allow, or tolerate attempts from any individual to retaliate, punish, allow, or in any way harm any individual(s) who report a concern in good faith. Such actions against a complainant will be considered a violation of this policy and grounds for disciplinary action. Any allegations of retaliation should be reported using the same process as for reporting an initial concern. (p. 14)*

Failure to report may result in being charged with a federal crime. The complainant's name is required on the reporting form but may be withheld if requested or as law permits. Anonymous reports are allowed. The Act also created an independent body, U.S. Center for SafeSport, responsible for investigating complaints and ensuring compliance (Gibbs, 2018; Lahitou, 2018).

The Empowering Olympic, Paralympic, and Amateur Athletes Act of 2020 (Bill Track, P.L. 116-189) further protects amateur athletes from abuse by coaches and other U.S. Olympic and Paralympic employees, requiring suspected abuse of a minor be immediately and directly reported to law enforcement (§ 36.1.D). MRs are further protected as whistleblowers. The Center for SafeSport shall report to Congress within 72 hours of an attempt to interfere in or influence the outcome of an investigation (Bill Track 50, n.d., para. 1).

Reporting Abuse by the Boy Scouts of America (BSA)

According to Hamilton and Timon (2020), 35% of BSA victims reported that someone else knew about the abuse at the time it occurred. One in five told Scout leaders or someone else told Scout leaders for them at the time of the abuse. One victim's (S. D.) lawsuit alleged that the BSA's organization conspired to keep the sexual abuse of victims a secret (Epstein, 2019). Epstein (2019) reported that the BSA allegedly made 120 reports to the police but acknowledged a history where cases were ignored or handled in a manner inconsistent with protecting scouts. Currently, BSA requires members to report directly to authorities, even if there is a conflict with state law. Additionally, the member who suspects abuse must be the one to make the report. (BSA, 2023). As of May 2020, 82,000 BSA sexual abuse victims have come forward (Baker, 2020).

Impact of Abuse on Native American Children

A 2019, a Frontline and *Wall Street Journal* story documented multiple sexual abuse incidents at an Indian Health Service (IHS) substance abuse treatment facility for teens in North Carolina (Weaver, 2019). Weaver stated that several employees reported that an IHS manager instructed them not to report, and one employee stated that she believed she could be fired for insubordination for reporting. However, a few employees did report to the police and the Cherokee Family Safety Program. Those employees later resigned or were fired.

South Dakota has experienced several child sexual abuse (CSA) scandals spanning decades (Weaver et al., 2019), all involving Native American children. According to Weaver et al. (2019), in the Pine Ridge sex scandal, a fellow doctor and MR reported Dr. Weber for suspected child sexual abuse. The colleague experienced retaliation by being transferred to a job in North Dakota, reducing his annual salary by a third. Another professional said he did not report outside the institution because he feared firing. The investigation by the

Wall Street Journal and *Frontline* found that IHS "missed or ignored warning signs, tried to silence whistleblowers, and allowed Mr. Weber to continue treating children despite suspicions of colleagues up and down the chain of command" (para. 6).

In early 2019, IHS updated its child maltreatment reporting policies to address sexual abuse by healthcare professionals. The new policies require employees to report abuse suspicions directly to CPS or law enforcement and their supervisor within 24 hours (Indian Health Service, 2019). However, challenges persisted, such as fear of retaliation, difficulty protecting the MR's identity, fear that supervisors will not respond appropriately, and confusion over who is supposed to oversee abuse allegations (Chiedi, 2019; Frosch & Weaver, 2019b).

In 2019, a Presidential Task Force on protecting Native American Children in IHS was established (USDOJ, 2020). The purpose of the task force, according to the USDOJ (2020), was to examine systematic problems contributing to serial sexual abuse and address prevention. Recommendations included standardized sexual abuse reporting policies across all clinics and hospitals, centralizing efforts to screen new providers' backgrounds, and yearly training on sexual abuse by federal law enforcement personnel for employees. The report recommended that Congress pass laws requiring all federal employees to report suspected sexual abuse directly to law enforcement and to strip child sex offenders of federal pensions (Weaver, 2020).

Other South Dakota cases, where state law allows youth-serving institutions and organizations' MRs to report suspected abuse to their superiors, demonstrate the devastating impact of institutional reporting on Native American children. In March 2019, the Catholic Diocese of Sioux Falls, South Dakota, named 11 priests accused of committing child sex abuse between 1950 and 1992 (Anderson & Fugleberg, 2019). More than 100 former students of South Dakota's Catholic-run boarding schools filed lawsuits against the federal government, the Sioux Falls diocese, and various religious orders that ran the schools (Anderson, 2019). Anderson (2019) reported that the lawsuits maintain that abuse was perpetrated on children by priests, nuns, and school employees. The allegations in the lawsuits against the Sioux Falls diocese span from the 1940s through the 1970s.

Between 2004 and 2010, victims filed several lawsuits, according to Anderson (2019). In response, the Diocese maintained that they were not responsible for any alleged abuse that took place at Catholic-run schools. South Dakota lawmakers passed last-minute legislation changing the state's statute of limitations, making it impossible for victims older than 40 to pursue legal action against any institution. The Rapid City Diocese, according to Zionts (2019), published a list of 21 priests credibly accused of sexual abuse while serving in schools, churches, hospitals, and on the Pine Ridge and Rosebud reservations from 1951 to 2018. All priests are deceased except for one, who was suspended from ministry in 2018 after his abuse was reported to the police. In 2019, he was sentenced to 6 years in prison.

Abuse Reporting by Governments and the U.S. Military

Between 2010 and 2014, Lardner et al. (2016) reported there were approximately 1,584 substantiated cases of military dependents being sexually abused. In 840 cases, the perpetrator was an enlisted service member; in 332 cases, the perpetrator was a family member. Consequently, three Democratic senators urged the Defense Secretary to lift the military's "cloak of secrecy" and make records more transparent from their sex crimes trials (para. 9).

In 2016, Talia's Law (National Defense Authorization Act for the Fiscal Year 2017, 2016) was enacted, requiring any childcare provider on a U.S. Department of Defense installation to report suspected abuse directly to CPS and the provider's supervisor. This law was incorporated into the more significant 2016 National Defense Authorization Act in 2017 after Talia, the child for whom the law is named, was beaten to death by her enlisted father (military.com, 2017). Talia's mother sued the U.S. Department of Defense for failing to report the suspected abuse.

Warner's research (2019) noted that clergy CSA and military sexual assaults present serious unaddressed issues by Congress, the media, and grand jury investigations. Religious and military institutions "claim and may be accorded separate and privileged status, beyond the reach of democratic laws and procedures" (p. 20). As of April 28, 2023, institutional reporting regarding child abuse remains within the military:

> (a) The Secretary of Defense shall request each State to provide for the reporting to the Secretary of any report the State receives of known or suspected instances of child abuse and neglect in which the person taking care of the child is a member of the armed forces (or the spouse of the member).
>
> (b) In this section, the term "child abuse and neglect" has the meaning provided in section 3 of the Child Abuse Prevention and Treatment Act. (PL 93–247; 42 U.S.C. 5101 note; Reporting of Child Abuse. 10 U.S. Code § 1787, 2013)

In 2022, according to military.com, the military finally gave the option of direct reporting to CPS or to 911 while still providing for institutional reporting to military police or the Family Advocacy Program (FAP). If people report abuse to FAP, FAP will then notify CPS. Although not totally doing away with institutional reporting in the military, this new directive at least gives the option to report outside military institutions.

Professionals Who Support Direct Reporting of Abuse

Child abuse experts have also weighed in on institutional reporting and its impact on children. Victor Vieth, former director of the National Center for the Prosecution of Child Abuse and founder of the Zero Abuse Project, said institutional reporting policies "defy common sense and should be changed" (abc7NY, 2011, para. 7). Further, "allegations of physical or sexual child abuse must be promptly and thoroughly investigated…[T]he response should be coordinated, sensitive and swift" (Vieth, 2001, para. 4).

Further, Mathews et al. (2008) conducted a comparative study of policy-based reporting duties in government and non-government schools in Western Australia, Queensland, and New South Wales. They found that non-government teachers in Queensland and both non-government and government teachers in Western Australia must report suspected abuse to a director of the school's governing body or the principal. They concluded that reporting directly to the relevant government department would not add to a principal's busy workload and would prevent lost, delayed, or unforwarded reports. He determined that the principal should be informed that the teacher intends to report and concluded that direct reporting by the teacher was the superior reporting method. They also recommended that policies inform reporting teachers that their identities will be protected to the greatest possible degree.

International child maltreatment law expert Ben Mathew's research and recommendations led to all eight Australian states and territories and New Zealand adopting direct reporting statutes in the mid-2000s (Mathews et al., 2006). Mathews and Walsh (2011) recommended that teachers report directly to a child safety department or law enforcement while keeping school principals informed. This would avoid any failure by the principal to forward the report.

Mathews et al. (2016) conducted a 7-year study exploring the impact of the new direct reporting legislation in the State of Western Australia. Results demonstrated that MR reports of suspected child sexual abuse increased from a mean of 662 pre-law to 2448 post-law. The number of investigated reports increased 3 times from a mean of 451 to 1363 and the number of substantiated investigations increased from an annual mean of 160 to 327, indicating that the number of identified sexually abused children doubled. *These numbers indicate that enacting direct reporting increases the number of reports made and investigated and increases the number of identified sexually abused children, raising their chances of receiving much-needed services.*

Best practices in child abuse reporting are also addressed by other professionals. Jetta Bernier, Executive Director of Massachusetts Citizens for Children (MassKids), and Marci Hamilton, Founder of CHILD USA, have identified institutional reporting as a safety hazard to children in their support of the the Child Sexual Abuse Prevention Bill (Massachusetts Citizens for Children, 2017). Bernier calls for ending institutional reporting, and Hamilton calls out child sexual abuse embedded in institutions (Child Sexual Abuse Prevention Bill, 2017; Hamilton, 2021).

CHILD USA (2021) developed the gold standard evidence-based and expert-vetted policies for youth-serving organizations to prevent child sexual abuse and to report appropriately:

> Staff and administrators must report abuse directly to civil authorities. This mode of reporting must take priority over reporting to internal administrative bodies.... Policies mandating proper reporting to civil authorities contributes to prevention by making sure that child sexual offenders are not transferred, absolved by internal investigations, or otherwise inappropriately protected. (p. 14)

Further, the American Bar Association (Davidson, 2012) recommended eliminating chain- of-command reporting, providing whistleblower protections for those who report outside their institution and significantly increasing penalties for anyone who tries to prevent a mandated report.

The authors found very little support for institutional reporting. Deborah A. Ausburn, a proponent of Georgia's institutional reporting law, explained, "Institutions want to know what is going on before they get a visit from child protection authorities" (2019, para. 3). She argued that individual MR reports may miss a pattern of repeated behavior suggesting abuse that a supervisor with institutional knowledge may be more aware of. She suggested that supervisors require staff to write their concerns so they can make the report together.

Another proponent stated that institutional reporting "results in both a cleaner and safer approach for children by having a well-identified and more thoroughly trained professional make the report, so long as the superior does not delay the report or conduct their investigation" (Committee on Health, Education, Labor, and Pensions, 2011, p. 23). The designated person must then make an immediate verbal report followed by a written report to the authorities. Other suggestions included providing written assurance to the MR that the report was filed and ensuring institutions do not punish or prevent the MR from reporting directly to the designee or authorities.

Authors' Conclusions

After reviewing the limited available research, anecdotal evidence, expert opinions, and court cases and comparing statutory reforms, we have identified the following ongoing child safety concerns regarding institutional reporting:

Promoting a culture of silence, *institutional reporting* places the brand and reputation of the institution above all and is the common denominator in the following examples of child sexual abuse scandals: the Catholic Church, USA Olympic Sports, the Boy Scouts, the Bureau of Indian Affairs, and U.S. Military (Daniels, 2017; Formicola, 2016; Frosch & Weaver, 2019a; Gerber, 2016; Grimm, 2020; Persick, 2015). Institutions wary of lawsuits or bad press are apt to look the other way in the hope of protecting the institution and not the child. We have seen this fact repeated numerous times in sexual abuse scandals within institutions (MRC, 2021; Vieth, n.d., personal communication).

Nesbitt (2016) says adverse employment actions such as firing, demotions, job transfers, and being delisted may result from mandated reporting (Nesbitt, 2016). The MR is perceived as a troublemaker or disloyal to the institution and punished. MR employees who report outside the institution directly to CPS or the police may be fired or disciplined for violating their employer's protocol (*Conley v. Roman Catholic*

Archbishop, 2000). Further, state laws protecting MRs from adverse employment actions are not present in every state and may be unenforced. In just over half of the states, employer retaliation, such as firing, is prohibited following reporting. However, only 11 states include an enforcement statute for retaliation (Hughes, 2018). Additionally, research has found that retaliation against reporting MRs is more prevalent in hospital and agency settings, where institutional reporting is more common. Even witnessing another MR's retaliation after reporting suspected child maltreatment results in other MRs being less likely to report (Sippel et al., 2023).

On May 23, 2017, the Pennsylvania Superior Court in *Krolczyk v. Goddard Systems, Inc.* (2017) issued a landmark employment ruling, allowing fired MR employees to sue for wrongful discharge after they planned to report suspected child abuse as legally required to the U.S. Department of Public Welfare. Superior Court Judge Mary Bowes, at line 551, explained in her ruling that "[i]f an MR could be fired for articulating an intent to report suspected abuse, it would have a chilling effect on the very purpose for the statute in question." This decision means that MR employees who report suspected child abuse can initiate wrongful termination claims if no contract exists (i.e., "at-will employees"), which limits the employer's ability to fire them. Moreover, they can demonstrate that the firing resulted from their performance of a legal duty or reporting a crime (Rees, 2017). This research implies that reporting MRs are at greater risk of retaliation.

There is an inherent conflict of interest when institutions and schools can weigh the damage to their organization's reputation and liability costs against their reporting duty. If top administrators delay or fail to report, abuse may continue for years, causing vulnerable children further preventable harm (Big Island Now, 2016; Gerber, 2016). Maltreatment suspicions may be discouraged to preserve a school district's reputation (Dombrowski & Gischlar, 2006). Further, school administrators can create obstacles, making it difficult for educators to report. The MR employee must bypass the administrator or face legal sanction (Crosson-Tower, 2003). Kenny (2001) reported that a teacher survey (N=197) revealed that 73% had never reported. Eleven percent indicated there were instances where they suspected abuse but failed to report it. One reason for this was that they felt unsupported by their administrators.

Educators lacking support from their educational institution for reporting are less likely to report (Bell & Singh, 2016). Though school professionals recognize child maltreatment more than any other group of MRs, according to the Fourth National Incidence Study of Child Abuse and Neglect (Sedlak et al., 2010), 20% reported their schools prevented direct reporting to CPS. They surmised this may be one reason for the low-investigation rate (20% or less) for maltreated children in schools (p. 22).

Bryant (2009) surveyed 740 members of the American School Counselor Association. Factors influencing their decision *not* to report suspected abuse included feeling the administration would not support reporting (n=20), the principal directed them not to report (n = 17), and they were not the schools' authorized MR (n=13). Therefore, research demonstrates that institutional reporting decreases the chance that a report will be made.

A direct maltreatment report is already secondhand when the MR relays the information to CPS or the police. However, with institutional reporting, the MR may have to report to a designee, who then relays it to a top administrator, who then contacts law enforcement, diluting the report's validity. If the institution reports, critical details may be omitted, resulting in the report being screened out. The person directly receiving information regarding suspected abuse would be best positioned to provide critical details and answer follow-up questions (Vieth, personal communication). For instance, mental health professionals are trained to observe a client's nonverbal behavior, which is essential when a child reports abuse. Research indicates that children's nonverbal emotions tend to occur more often and precede their verbal disclosure (Karni-Visel et al., 2023).

According to forensic computer analyst Hollie Strand and Special Agent Cam Corey, institutional reporting means child victims are more likely to be interviewed multiple times, diluting the report's validity (Nord, 2015). This makes the process more traumatic and forces children to defend their stories. It also makes it more difficult for police and/or CPS to assess safety concerns accurately. This may result in children remaining in dangerous homes (Mandatory Child Abuse Reports, 2015). Therefore, direct reporting increases a report's validity, making assessing danger in the home easier.

Additionally, predators are drawn to places where they have easy access to children. When an institution fails to report and moves the alleged predator to another location, this may send an unintended invitation to other predators. It also allows predators to perpetrate on large numbers of children and the same child for many years (Epstein, 2019; Formicola, 2016).

In *Landstrom v Barrington* (1990), a teacher reported abuse to her principal, who reported to CPS. When the report proved unfounded, the parents sued the school district. It took 3 years for the court to conclude that the district was not liable. In October 2013, Penn State was sued after top administrators failed to report, resulting in $59.7 million paid to 26 victims (CNN Editorial Research, n.d.). In *Doe v. Gavins* (2023), the plaintiffs won $650,000 against the city of Boston due to a school creating an unsafe environment where sexual assault "flourished" (1.A.2), where abuse reporting was discouraged, and where the reporting MR teacher was fired. Further, Michigan State University (MSU) was fined $4.5 million for improperly handling the Larry Nassar case after MSU was required to pay over $500 million to Nassar's victims (Bauer-Wolf, 2019). Recently, the U.S. Department of Education fined Liberty University $14 million for failing to report sexual assaults. Instead, Liberty University punished the victims for failing to follow the campus code of conduct and did not punish the alleged perpetrators (Umansky, 2024).

According to Guardia (n.d.), a review of 16 appellate civil court cases brought by parents and child victims who experienced sexual abuse in Massachusetts schools highlights the tragedies that occur when state law allows school MRs to report to their superiors, who then fail to make a report. While school officials spend time on internal investigations and cover-ups, children experience ongoing abuse. In *Thomas v. Town of Chelmsford* (2017), the court ruled that schools do not have a special relationship with students and an obligation to protect them from outside harm, stating that schools and municipalities were immune from prosecution for failing to report abuse. The First Circuit Court of Appeals upheld the decision, despite eight other Circuit Court of Appeals ruling otherwise in similar cases (Guardia, n.d.). Guardia (n.d.) explained that many of Massachusetts's courts have granted qualified immunity in civil courts to schools and their respective administrators, boards, and committee members for failing to report abuse. Students were irreparably harmed in these cases, demonstrating poorer grades, academic progress, and school attendance.

These civil cases represent a fraction of Massachusetts's school child sexual abuse cases in which administrators delayed or failed to report. Further, the resulting confidential lawsuit settlement agreements between victims and school districts cost taxpayers millions, making it impossible to assess the full impact of institutional reporting accurately. Such examples demonstrate that chain-of-command reporting may increase the institution's liability risks.

Hobson and Rich (2017a) reported that when a taekwondo coach was accused of sexually abusing three aspiring female Olympic athletes, one victim attempted to get the Olympic national governing body, USA Taekwondo, to ban him from coaching. Court records indicate that though the governing body believed the victim, they did not ban the coach because they "feared a lawsuit." The *Washington Post* (Hobson & Rich, 2017a, 2017) reported that this is a familiar story for those who work with sports victims: fear of getting sued surpasses children's safety. Consequently, the United States Olympic and

Paralympic committees opened a web-based portal in 2017 called the U.S. Center for SafeSport to train coaches on sexual abuse issues/protocol and for players to report abuse by coaches (Hobson & Rich, 2017a).

Sinanan (2011) reported that some schools create their reporting procedures and fail to comply with reporting laws by conducting internal investigations. Bartucci (2012) found that 26% of 59 midwestern principals reported not strictly adhering to established reporting laws. Other principals reported that there were no written policies or procedures addressing child maltreatment reporting (Bell & Singh, 2017). Prioritizing lawsuit fears over child safety and allowing reporting violations also appear to be associated with institutional reporting.

Recommendations

Mandating direct reporting in all states and settings (public and private) and requiring reporting within 24 hours to CPS or law enforcement and the reporter's superior will make child abuse laws consistent across jurisdictions. This greatly clarifies an MR's reporting role. Failure to report must result in steep fines and criminal charges to ensure those responsible for reporting are following the law.

Classifying all those who have contact with children in any capacity as MRs and expanding the definition of *school* to include all public and private state colleges and universities will enhance child protection. This is important when power differentials exist between coaches, professors, and children under their care at extracurricular camps held on university and college campuses. In addition, all religious leaders and volunteers (pastors, nuns, bishops, Sunday school teachers, etc.) should be classified as MRs. Child abuse is a crime and should supersede religious freedom.

Creating whistleblower protections for reporting MR employees who may experience retaliation for direct reporting is crucial to protecting MRs when performing their legal duty. Whistleblower protections should apply if an employer tries to prevent, discourage, or intentionally release the MR's identity or discipline reporting MRs. Creating a special cause of action for MRs who face retaliation in the form of harassment, defamation of character, or frivolous licensure board complaints is also essential. Sippel et al. (2023) stated that statutes should include monetary damages for a prevailing MR, including attorneys' fees and court costs. Statutes should also include a method to enforce the statute once enacted.

Additionally, since many MRs reported being unsure of existing laws, MRs need required training on how to recognize child maltreatment and the who, when, where, and how to report it. Training on proactively responding to multiple types of retaliation following reporting is critical. MRs should be educated on state and federal immunity laws offering protection against retaliation (e.g., filing suit against wrongful termination) (Sippel et al., 2023). All states should be required to adopt and implement child sexual abuse prevention education in all K-12 schools, providing training for identifying and reporting suspected abuse. The Enough Abuse Campaign and Erin's Law are examples. Senator Joan Lovely (2019) introduced a petition to a bill (Massachusetts Bill S.313, 2019) as an example of comprehensive legislation to prevent. Annual training should be required for employees, independent contractors, and volunteers in schools and youth-serving organizations to help individuals identify and report suspected abuse.

Establishing a national data system within and between states for child abuse offenders who have a history of sexual misconduct and abuse would be prudent to ensure that perpetrators are unable to change from school to school, state to state, or church to church. This would create greater oversight when an abuser crosses state lines. No more "passing the trash" from one state, institution, church, or school to the next.

States should also mandate that insurance carriers cover negligent failure to prevent child sexual abuse in youth-serving organizations. States should require insurance carriers to conduct an annual state-of-the-art "child protection audit." If the organization fails the audit, insurance carriers should deny coverage

until the organization has remedied it (Hamilton, 2019, para. 7).

The Safe Sport Act should be further evaluated for efficacy. This will help determine whether the Safe Sport Act could be expanded and modified to protect children in the public domain.

Limitations

An exploratory study was conducted due to a gap in the research regarding institutional reporting in the United States. Because exploratory research only provides qualitative data, the interpretation may be biased. Therefore, additional research is needed to validate the identified concerns regarding institutional reporting.

Further, there is a lack of data comparing the effectiveness of direct versus institutional reporting in the United States. This limits our information to available means, including anecdotal information, court documents, statutory reforms, expert opinions, and newspaper reports. Mathews et al.'s (2016) research is the only known research examining the differences in reporting behavior, number of investigations, and number of substantiated reports before and after implementing direct reporting. More research is needed in the United States and other countries where institutional reporting exists.

Summary

This study identified ongoing child safety concerns regarding institutional reporting. Chain-of-command reporting is the common denominator of ongoing child sexual abuse in institutions and organizations, placing the MR at greater risk of retaliation while decreasing child maltreatment reporting. It dilutes the report's validity, making assessing danger in the home more difficult. It increases the liability risk for the institution or organization, may attract predators, prioritizes lawsuit fears over children's safety, and enables reporting law violations. Enacting direct reporting in all states and settings, public and private, may prevent ongoing child abuse and provide greater protection for reporting MRs and the children they serve.

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