

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

December 13, 2011

Testimony of
Robert W. Block, MD, FAAP

On behalf of the
American Academy of Pediatrics

Before the
Senate Health, Education, Labor and Pensions Committee hearing
"Breaking the Silence on Child Abuse: Protection, Prevention,
Intervention, and Deterrence"

Chairperson Mikulski and Ranking member Burr, and members of the Subcommittee on Children and Families, thank you for inviting me to speak today and for your leadership on this important issue. My name is Dr. Robert W. Block and I am honored to provide testimony on behalf of myself and the over 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics (AAP).

American Academy of Pediatrics' Work in Child Welfare

Recognizing pediatricians' unique role in child welfare, the issue of abuse and neglect was first addressed by the AAP in 1962, when the AAP's executive board advised the Committee on Infant and Preschool Child to address the issue of the battered child syndrome. An official Committee on Child Abuse and Neglect (COCAN) was officially established in 1990. That same year, the Academy established an education and training arm, the Section on Child Abuse and Neglect (SOCAN), which has approximately 550 members comprised of child abuse pediatricians, general pediatricians and affiliate members (physicians and allied health professionals).

These two entities have supported AAP's ongoing efforts in this field, and have since developed 24 policy statements and clinical reports; created a residency curriculum and fellowship programs in child abuse and neglect; and contributed to the education and training of pediatricians and others working in the field of child maltreatment through its annual conference, numerous educational manuals, publications, and electronic and web-based resources.

Currently, AAP collaborates with organizations and agencies such as the American Academy of Child and Adolescent Psychiatry; the Academy on Violence and Abuse; American Medical Association, Futures Without Violence, National Association of Children's Hospital and Related

Institutions (NACHRI), and National Health Collaborative on Violence and Abuse. The Academy also works with various federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Department of Health and Human Services Office of Child Abuse and Neglect, and the Department of Justice (DOJ). Currently the organization is partnered with the Department of Justice to assist pediatricians in identifying children who are exposed to sexual violence and connecting them with the resources and treatment they need.

I became interested in child maltreatment during my residency training in Philadelphia between 1969 and 1972. I continued to work as a general academic pediatrician at the University of Oklahoma, Tulsa campus from 1975 onward, specializing in child abuse since 1985. I was the founding Chair of the American Board of Pediatrics sub-board on child abuse pediatrics, and hold certificate #1, culminating a 37 year career in Tulsa. I have personally evaluated over 2,000 individual cases, and reviewed and testified in many cases as well. Throughout my many years in this field, the question I am most frequently asked is, "How can you do this work?" My answer is, "how can you not?"

Child Maltreatment in America

In 2008, U.S. state and local child protective services (CPS) received 3.3 million reports of children being abused or neglected. Seventy-one percent of the children were classified as victims of child neglect; 16% as victims of physical abuse; 9 percent as victims of sexual abuse; and 7 percent as victims of emotional abuse.ⁱ A non CPS study indicated that one in five children has been the victim of maltreatment.ⁱⁱ

Sadly, these numbers are almost certainly only the tip of the iceberg. The majority of cases of abuse and neglect go unreported. In one major study sponsored by the CDC, 25% of adults reported having been victims of physical and/or emotional abuse as a child, 28% said they had been physically abused, 21% said they had been sexually abused, and 11% had been psychologically abused.ⁱⁱⁱ

Long-term Health Effects of Abuse

Not all children will have the opportunity to become adults, but every adult was once a child. The experiences and opportunities afforded to each of us in our early years, both positive and negative, have a long-term impact on our health and development and create a substantial imprint on the adults that we one day become. Pediatricians today are caring for and protecting the beginning of health for a child's entire life span, especially for vulnerable children who are victims of abuse or neglect. In order to optimize the health and well-being of our entire society, we must not view children and their welfare as isolated individuals or events, but instead recognize that children's physical and mental health must be addressed as the beginning of health across the entire life course.

Children who have suffered abuse or neglect may develop a variety of short- or long-term behavioral and functional problems including conduct disorders, poor academic performance, decreased cognitive functioning, emotional instability, depression, a tendency to be aggressive or violent with others, post-traumatic stress disorder (PTSD), sleep disturbances, anxiety, oppositional behavior, and others.^{iv, v} These conditions can linger long after the abuse or neglect has ceased, even with consistent and attentive parenting by foster or adoptive parents or birth parents who have successfully changed their own behaviors. In addition, abused or neglected

children often suffer impairments in their language abilities and cognitive skills and one recent study found 36 percent of preschoolers in foster care to be developmentally delayed.^{vi} These deficiencies almost certainly correlate with inadequate parental care during sensitive periods of development, providing children with less exposure to language and fewer opportunities for cognitive development.

Until recently, the medical field did not have a complete understanding that child abuse and neglect not only damage an individual's short-term health, but also alters a child's neural physiology. Pediatricians now understand that the dysfunctional behaviors that manifest themselves in children who experience abuse or neglect are the result of the brain's physiological adaptations to the abnormal world in which the developing child exists.

Early maltreatment alters the child's neural physiology to adapt the brain structurally to its environment, while also significantly changing the expected responses to stress and affecting the child's ability to learn from experience. When a child suffers an adverse experience, the part of the brain that acts in emotional regulation (the amygdala) initially becomes more sensitive to stress.^{vii} However, when a child suffers repeated stressful experiences, the amygdala will shrink as a result of chronic exposure to high concentrations of stress hormones, thereby becoming less sensitive to stressful experiences over time.^{viii} The more chronic stress the child experiences, the more physiological changes in the brain are likely to take place.

By allowing experiences to alter its structure, the brain can grow to become the best brain for a child's given surroundings. For example, a more visually complex environment may favor a larger visual cortex, whereas a child born blind might devote more cortical area to hearing. Similarly, a

brain grown in a more threatening world may benefit from a more highly developed fight-or-flight response than would be necessary in a healthier environment.^{ix, x} These adaptations in the brain, although initially useful for managing and surviving in the child's stressful environment, do not prepare the child for success in school or for lifelong health and productivity. The brain's adaptations will also affect the individual's response to stimuli, resulting in an altered response to stressful situations across the child's life span.^{xi, xii}

Adverse Childhood Experiences Study

Child abuse not only alters a child's brain chemistry and neurophysiology, but an increasing body of evidence also documents the robust relationship between adverse experiences in early childhood and a host of other medical complications that manifest throughout an individual's life. It was not until the 1980s and 1990s that researchers recognized that risk factors for diseases, such as smoking, alcohol abuse, and risky sexual behaviors, were not randomly distributed in the population. In fact, risk factors for many chronic diseases tended to cluster; if an individual had one risk factor, he or she was likely to have one or more other risk factors as well. The landmark Adverse Childhood Experiences (ACE) study,^{xiii} sponsored by the CDC and Kaiser Permanente and conducted by co-principal investigators Vincent J. Felitti, MD and Robert F. Anda, MD MS, was one of the first long-term studies to examine the direct connection between risk factors for disease and poor health status in adulthood and their antecedents in adverse experiences during childhood.

The ACE study surveyed almost 18,000 middle-class adults insured through Kaiser Permanente's Health Maintenance Organization (HMO), regarding their childhood experiences involving abuse, neglect, or family dysfunction. Specifically, individuals were asked about their experiences of psychological, physical or sexual abuse; violence against their mother; living in a household with

individuals who were substance abusers, mentally ill, suicidal, or ever imprisoned; and the death of a biological parent, regardless of the cause of death. The adverse childhood experiences were then compared to adult risk behaviors, disease, and health status. A prospective arm of the study continues to follow the cohort to compare childhood experiences against current emergency department use, doctor office visits, medication costs, hospitalizations, illnesses, and death.

Of the thousands of responders, more than half reported at least one adverse childhood experience and more than ten percent experienced five or more adverse experiences. Among those adults who had experienced the highest levels of childhood trauma, those individuals were:

- Five times more likely to have been alcoholic;
- Nine times more likely to have abused illegal drugs;
- Three times more likely to be clinically depressed;
- Four times more likely to smoke;
- 17 times more likely to have attempted suicide;
- Three times more likely to have an unintended pregnancy;
- Three times more likely to report more than 50 sexual partners;
- Two times more likely to develop heart disease; and
- Two times more likely to be obese.

The ACE study demonstrated a graded relationship of adverse childhood experiences to the presence of adult diseases, including heart disease, cancer, chronic lung disease, and liver disease, as well as unintended pregnancy,^{xiv} sexually transmitted diseases,^{xv} and alcoholism. Individuals who experienced multiple categories of adverse experiences during childhood were likely to have

multiple health risk factors as adults. Child abuse, neglect, and other circumstances that disrupt the parent-child relationship are significantly associated with many leading causes of adult death and poor quality of life. Based on this study, childhood trauma, including abuse and neglect, may be the leading cause of poor health among adults in the United States.

Pediatricians' Role in Child Maltreatment Detection

Pediatricians are in an excellent position to detect and prevent child abuse because of their unique relationships with families^{xvi} and expertise in child development, and because the youngest children represent the highest proportion of victims. Because pediatricians have contact with families during challenging and stressful times (e.g., when a child is ill), they can become familiar with a family's stressors and strengths. Certain elements of normal child development are often the triggers for child maltreatment and cause difficulty for some parents, specifically excessive crying, awakening at night, separation anxiety, normal exploratory behavior, normal negativism, normal poor appetite, and toilet-training resistance. Experts suggest that pediatricians anticipate these normal developmental stages and provide guidance to families about how to best manage potentially difficult situations that may trigger physical abuse. For example, pediatricians already discuss with parents how much their infant cries and can offer strategies for coping. The literature shows that parents view pediatricians as respected advisors and counselors.^{xvii} A majority of pediatricians (70%) that participated in the study agreed that they can help prevent physical abuse by providing this anticipatory guidance. In addition to providing guidance during key developmental periods, physicians are often connected to community resources that have the welfare of the child and family as a priority.

Detecting sexual abuse, however, is very different. Because of the existing relationship with children and their families, physicians must be able to detect emotional and behavioral changes that indicate abuse may have occurred. Pediatricians will almost certainly encounter sexually abused children in their practices and may be asked by parents and other professionals for consultation.

The diagnosis of sexual abuse and the protection of the child from additional harm depend, in part, on the pediatrician's willingness to consider abuse as a possibility. Sexually abused children who have not disclosed abuse may present to medical settings with a variety of symptoms and signs. Because children who are sexually abused are generally coerced into secrecy, the clinician may need a high level of suspicion and may need to carefully and appropriately question the child to detect sexual abuse in these situations. Many pediatricians do not feel prepared to conduct such comprehensive medical assessments. In such circumstances, pediatricians may refer children to other physicians or health care professionals with expertise in the evaluation and treatment of sexually abused children.^{xviii}

Sexually abused children are seen by pediatricians in a variety of circumstances such as: (1) the child or adolescent is taken to the pediatrician because he or she has made a statement of abuse or abuse has been witnessed; (2) the child is brought to the pediatrician by social service or law enforcement professionals for a non-acute medical evaluation for possible sexual abuse as part of an investigation; (3) the child is brought to an emergency department after a suspected episode of acute sexual abuse for a medical evaluation, evidence collection, and crisis management; (4) the child is brought to the pediatrician or emergency department because a caregiver or other individual suspects abuse because of behavioral or physical symptoms; or (5) the child is brought to the pediatrician for a routine physical examination, and during the course of the examination,

behavioral or physical signs of sexual abuse are detected. Whether it is physical or sexual abuse, pediatricians must be trained to identify injuries and behavioral changes, and to understand their role in confronting or reporting abuse.

Pediatricians' Role in Reporting Child Maltreatment

Pediatricians, other physicians, teachers, law enforcement officials, and others are required by law in every state to report suspected as well as known cases of child abuse to the proper authorities. In many states, the suspicion of child sexual abuse as a possible diagnosis requires a report to both the appropriate law enforcement and child protective service agencies. With funding from the Agency for Healthcare Research and Quality (AHRQ), the AAP Pediatric Research in the Office Setting (PROS) network conducted a study on child abuse recognition and reporting behaviors of pediatricians and sponsored a multidisciplinary conference in an effort to identify strategies to reduce or eliminate barriers to reporting and improve the health and well-being of abused children. The study found that clinicians reported 6% of the 1683 patients to child protective services. Clinicians did not report 27% of injuries considered likely or very likely caused by child abuse and 76% of injuries considered possibly caused by child abuse. The data indicate that clinicians vary in how they judge the level of suspicion at which they should invoke the "reasonable suspicion" criterion that mandates a report to CPS. These prospective results confirm published results of clinician surveys.^{xix} A recent study conducted by the Academy found that many pediatricians are not reporting all suspected cases of child abuse and neglect. The reasons for this included:

- A belief that one had to be certain that abuse or neglect had occurred;
- Lack of confidence in CPS intervention;
- Lack of feedback from CPS in prior cases reported;
- Reliance on others to report (e.g. emergency room personnel); and

- Fear of legal retribution from families.^{xx}

Even within the medical community there are inconsistencies with what is suspicious and varying degrees of knowledge and understanding of what reporting means in terms of a child's safety and well-being. What many fail to realize is that a report is NOT an accusation; but rather is a request for further investigation. This underscores the importance of specialized education and training for pediatricians, as well as for all mandated reporters. The Academy is fully committed to educating our members and giving them the tools to report all cases of abuse and neglect and serve these children appropriately. As president of the AAP, I can assure you that this endeavor is embraced at the very highest levels of leadership within the organization.

As mentioned above, one common reason mandatory reporters do not to report suspected child abuse relates to the fear of legal retribution. The Child Abuse Prevention and Treatment Act (CAPTA) requires each state to provide immunity from civil or criminal liability for individuals who make good faith reports of suspected or known child abuse or neglect. "Good faith" reports refer to the assumption that the reporter, to the best of his or her knowledge, had reason to believe the child in question was subjected to abuse or neglect. These good faith protections from liability are incredibly important, but unfortunately do not go far enough to protect pediatricians and other mandatory reporters from frivolous law suits. For instance, these laws do not protect physicians or other mandatory reporters who consult, cooperate or assist with the filing of a mandatory report. There is much anecdotal evidence of a primary care pediatrician who suspects a child is victim of abuse, and requests a child abuse specialist to review the case. If the primary care pediatrician then makes a report to child services, he or she is protected from suit; the child abuse specialist, however, is not protected and often targeted for civil liability. Further, I have colleagues in child

abuse pediatrics who have been sued for violating families' 4th and 14th Amendment rights after filing good faith reports of suspected child abuse.

It is incredibly unfortunate that pediatricians, medical specialists, and other mandatory reporters who are striving to protect children to the best of their abilities are targeted in this way. In addition, it takes incredible amounts of time and financial resources to make repeated visits to court, retain legal counsel, and cover other legal expenses involved in each individual suit, as well as an intense emotional toll. Our time and resources would be much better spent caring for the children who need us.

Inter-State Issues

CAPTA established the federal definition of child abuse and neglect: "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm." Most states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, U.S. Virgin Islands and Puerto Rico, have civil and criminal statutes that expand on the CAPTA child abuse definition and further specify different types of abuse. Unfortunately, these state laws vary widely, providing children with only a patchwork of protection against a variety of forms of abuse and neglect. For instance, depending on the state in which a child resides, civil and/or criminal statutes may protect that child against any combination of the following types of abuse: physical abuse, neglect, sexual abuse or sexual exploitation, emotional abuse, parental substance abuse and/or abandonment.

In addition to wide variations in child abuse definitions, state laws vary widely and are incredibly inconsistent with regard to who may be charged with child maltreatment and when a report of suspected child abuse or neglect must be made. Generally, states require a report of suspected child abuse to be made when an individual knows or has reasonable cause to believe that a child has been subjected to abuse or neglect. These standards provide guidance only for mandatory reporters of child abuse in deciding whether to make a report to child protective services and do not apply to the general public. Further, several state statutes define the persons who can be reported to child protective services as perpetrators of abuse or neglect, mandating that only individuals who have some relationship or regular responsibility for the child may be reported to child services. State laws generally define this person as parents, guardians, foster parents, relatives, or other caregivers responsible for a child. Individuals who may only have occasional or rare contact with a child would not be included under many states' child abuse reporting laws.

Many states also provide exceptions in their child abuse laws that exempt certain acts from their statutory definitions of child abuse or neglect. A number of states specify that financial inability to provide for a child is exempted from the definition of neglect. Physical discipline is exempted from the definition of abuse in some states, as long as the discipline is "reasonable" and "causes no bodily injury" to the child. One of the most common exemptions from child abuse and neglect statutes (included in the laws of 31 states, the District of Columbia, Guam and Puerto Rico) exempts parents who choose not to seek medical care for their children due to religious beliefs. Of the 34 states/jurisdictions with such laws, only 16 states and Puerto Rico authorize the court to order medical treatment for a child when the child's condition requires medical intervention. The American Academy of Pediatrics considers refusing medically-necessary treatment to any child to

be medical neglect. Unfortunately, there are far too many stories of children who have died as a result of medical neglect when readily available medical interventions could have been accessed.

Child abuse and neglect cases are further complicated when a child crosses state boundaries. Every state and county, and most large cities in the United States administer their own child welfare systems. Each child welfare department may have different statutory requirements with regard to child abuse and neglect; the agencies may also collect different data, work with law enforcement, and track children and their families in different ways. Although every state participates in inter-state compacts, state agencies differ in response time and in the quantity of information shared with other states. Because of these inter-state and inter-jurisdictional issues, a report of suspected child abuse or a case of substantiated abuse in one state would not carry with a child if he or she moves to another state. If an investigation of suspected abuse or neglect is underway, a parent or caregiver may move across state lines for the intent purpose of avoiding child protective services. In these cases, it may be months or years before another report is made or substantiated, resulting in continued abuse or neglect. Unfortunately, abused or neglected children slip through the cracks far too frequently.

Child Abuse Pediatrics

All pediatricians do receive some training in child abuse and virtually every physician will encounter and report cases of child abuse and neglect during their careers. However, in recognition of the strong scientific basis for child abuse pediatrics and the need to address the comprehensive medical assessment and diagnosis of child maltreatment, the American Board of Pediatrics recently approved a new subspecialty of Child Abuse Pediatrics and the first board exam was offered in November 2009. Since that time, more than 200 pediatricians have become certified in the new

field of child abuse pediatrics. This small cadre of doctors not only perform exams, but they also serve as expert witnesses, see and treat patients, perform research, and teach residents and medical students. These pediatricians often work in academic settings or with Child Advocacy Centers, and serve as a resource to their fellow health care providers, social workers, child protective services, law enforcement, the judiciary, and many others. As one of these subspecialists, I can attest personally that we are spread extremely thin, isolated from one another, and often find it difficult access appropriate funding for the work we do.

Moving Forward: Recommendations for Child Abuse Protection, Prevention, Intervention and Deterrence

The AAP has a long-standing commitment to the health and well-being of children and is contributing to this field in a number of ways. Above all, the American Academy of Pediatrics is committed to the health and well-being of all infants, children, adolescents, young adults, and their families across the country and with that in mind, respectfully submits the following recommendations:

Support for the Medical Home: Every child should have a medical home that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally-effective. The medical home can help provide the primary prevention to ensure child abuse does not occur. The pediatrician can work with new or struggling parents to develop productive parenting and discipline techniques as well as identify families that may need further assistance to prevent abuse or neglect from taking place.

If a child is a victim of abuse, a medical home can provide a crucial source of stability, continuity of care, and information. Although many patients with a significant history of trauma will need to be followed by mental health professionals, the pediatrician still plays an important role in management and coordination of care among specialists. In the US there is a disturbing shortage of appropriately trained child and adolescent psychiatrists and other mental health professionals who are trained to work with children. By providing a medical home, the pediatrician could work longitudinally with caregivers and continue to treat symptoms that are obstructing therapy. Pediatricians can also facilitate access to community resources, work closely with the child's school to address behavioral challenges to learning, and help coordinate care among specialists in other disciplines. However, this work is extraordinarily time consuming, and many pediatricians are precluded from doing this important work due to lack of payment for their time.

Health Care Financing: Children who have been victims of abuse present incredibly complicated cases that require multidisciplinary, intensive health care treatments. For instance, one child may require immediate care for his or her injuries sustained as a result of abuse, followed by psychological therapy by mental health professionals, as well as coordination among the child abuse pediatrician, primary care physician, law enforcement, child welfare services, and others.

Each victim of child abuse needs and deserves thorough and sustained medical care, but unfortunately, the health care financing system does not recognize or acknowledge the time and costs associated with each individual child abuse case. Health care financing for these vulnerable children should support child welfare goals of health, safety, and permanency for all children and adolescents. Health care financing should provide payment to health care professionals for the more complex and lengthy visits that are typical of and necessary for children who have been

victims of maltreatment. Financing must also cover the cost of the health care management to ensure that this medically complex population receives appropriate and timely health care services. If a child is found to be a victim of abuse or neglect and therefore moved into foster care, it is essential that these children receive the benefits of state and federal entitlement programs for which they are eligible without delay.

Education and Resources for Child Abuse Pediatricians: The new Child Abuse Pediatrics subspecialty has the potential to greatly expand the knowledge base and number of physicians with expertise in this very important area. Unfortunately, unlike other medical subspecialties, there is limited funding for pediatricians to enter child abuse pediatric training programs and not many fellowships for child abuse pediatrics exist. Further, because of limited resources and strained budgets at many hospitals, it is difficult for the medical centers to create new fellowship programs to support the intensive, interdisciplinary and coordinated approach of child abuse pediatrics. In addition, the child abuse fellowships and training programs that currently exist are generally located as part of large academic medical institutions in major metropolitan areas, which results in a poor geographic distribution of physicians with the experience, knowledge, and education to diagnose and treat serious and complicated child abuse or neglect cases. More financial support is necessary to ensure every physician with the interest and passion to pursue child abuse pediatrics is able to do so.

Because almost any physician that cares for children is likely to encounter a victim of abuse or neglect in his or her career, it is absolutely necessary that physicians, especially pediatricians, have the resources and training necessary to identify victims of abuse and intervene properly. For this reason, the AAP has proposed the Health Child Abuse Research, Education, and Services (Health

CARES) network. The Health CARES network would serve as regional consortia to help bring the medical profession into full partnership in the prevention, diagnosis, and treatment of child abuse and neglect. Health CARES would also provide the infrastructure to collect and coordinate resources for services, education, and research on child maltreatment. The network would also serve as Centers of Excellence to disseminate best practices in abuse diagnosis and prevention, provide further education and curricula for all health care providers, and provide resources for multidisciplinary research.

Mental Health and Child Welfare Workforce: In addition to increasing opportunities for physicians and pediatricians to expand their own knowledge of child abuse pediatrics, it is necessary to also provide greater support for the expansion of the mental health profession workforce and the child welfare workforce. Today, child welfare workers have overwhelming caseloads, work long hours, and are generally underpaid for their tireless work. In addition, our nation has a serious lack of child psychiatrists, child psychologists and other mental health professionals trained to work with children who are victims of maltreatment. These professionals are crucial components of the mission to identify, treat and prevent child abuse and neglect, and Congress should take steps to support these professions and their training programs.

Prevention: The prevention of child abuse and neglect from ever taking place should be the goal of our entire society. We all have a moral obligation to protect children from harm, but unfortunately, the current child welfare system focuses the vast majority of its resources on children after neglect or abuse has occurred and the child has come to the attention of child protection agencies. Primary prevention programs that provide parents and families with the education and resources they need to successfully parent have been shown to reduce child abuse and neglect, while also reducing costs

to local, state and federal governments. Primary prevention programs require far less funding compared to the costs associated with caring for a victim of child abuse while in the foster care system and the health care costs required to treat the physical and mental health conditions that result from abuse or neglect through the child's life. There are a number of model programs for preventing child abuse and neglect, including:

- **Home visitation:** There are many evidence-based primary prevention programs in existence around the country focused on family development and parent education that have demonstrated decreases in child abuse and neglect among targeted populations. In particular, the Maternal, Infant, and Early Childhood Home Visitation Program funded through the Affordable Care Act and administered through HRSA is an excellent example of an evidence-based/evidence-informed grassroots level primary prevention program that works directly with at-risk families to provide parenting support and guidance to ensure the health and well-being of infants, children and their families. The AAP encourages Congress to protect this valuable program and maintain its funding levels.
- **Period of Purple Crying:** In addition, in many states, including my home state of Oklahoma, behavioral researchers and advocates have created the Period of Purple Crying Campaign to prevent abusive head trauma in infants. This primary prevention program is designed to educate all parents about coping with the stressors of their baby's first months of life. It is a vital educational program to reduce the incidence of abusive head trauma resulting from a child being shaken by their caregiver. This program and others that have demonstrated impacts on reducing child abuse and neglect should be supported.
- **Stop It Now!:** An evidence-informed program to prevent child sexual abuse is Stop It Now!, which relies on the public health model to create educational materials and social marketing campaigns. Using the results of interviews and focus groups with survivors,

people who have abused children in the past, and family members of both, Stop It Now! develops prevention education materials, media messaging, training tools and community-based program strategies designed to motivate and support adults to step forward, speak up, and take action to protect children.

Education, Support and Protection for Mandatory Reporters: In order to provide children with the protection they need and provide mandatory reporters with the security and confidence to report suspected child abuse and neglect, opportunities for education and training to gain a greater understanding of the child welfare system and the child abuse investigation process is necessary. In addition, although every state has a law protecting mandatory reporters who act in good faith from prosecution under state and local laws, most states do not extend these protections to other health care providers, investigators, child welfare agencies or law enforcement who cooperate or assist with the filing of a mandatory report or provide consultation services to health care providers. The AAP was pleased the last CAPTA reauthorization included a requirement for a report from the Secretary of Health and Human Services addressing potential statutory or regulatory changes needed to address this issue. However, this is only the first step and the AAP recommends Congress take steps to protect all mandatory reporters and those who consult or assist with reports of suspected child abuse from lawsuits.

Although most adults are not considered mandatory reporters by law, every individual has a responsibility to protect children from harm or neglect, as well as report any and all knowledge of maltreatment to the proper authorities. Every adult should know his or her responsibility and there are significant opportunities to communicate this responsibility, as well as the steps independent adults can take to protect children who are victims of abuse.

Better Coordination at the Federal Level: The federal government has a crucial role to play in preventing child abuse and neglect and caring for the victims of abuse. Unfortunately, child abuse prevention, treatment, foster care, and child welfare services are fragmented and responsibilities are spread across multiple agencies and offices, including CDC, HRSA-MCHB, AHRQ, Substance Abuse and Mental Health Services Administration (SAMHSA), DOJ and others. Better coordination at the federal level could improve program efficiency and effectiveness at the grassroots level across the country.

CAPTA Funding: CAPTA was originally enacted in 1974 and amended numerous times since then, most recently in December 2010. CAPTA provides the majority of federal funding to states in support of child abuse and neglect prevention, assessment, investigation, prosecution, and treatment activities, and also provides grants to public agencies and nonprofit organizations, including Indian Tribes, for demonstration projects. Unfortunately, CAPTA is chronically underfunded. The AAP strongly recommends Congress increase funding for CAPTA and its associated programs to provide states with the resources they need to prevent and treat child abuse and properly protect children.

Conclusion

Again, it is indeed an honor to provide testimony on behalf of myself and the over 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics. I appreciate the opportunity to discuss this very important national issue and would be happy to answer your questions.

-
- ⁱ U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2008* [Washington, DC: U.S. Government Printing Office, 2010] available at: <http://www.acf.hhs.gov>.
- ⁱⁱ Finkelhor D, Turner H, Ormond R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics* 2009; 124:1411-1423.
- ⁱⁱⁱ Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACE) study. <http://www.cdc.gov/NCCDPHP/ACE/prevalence.htm>.
- ^{iv} Holbrook TL, Hoyt DB, Coimbra R, Potenza B, Sise M, Anderson JP. Long term trauma persists after major trauma in adolescents: new data on risk factors and functional outcome. *J Trauma*. 2005;58 (4):764 –771
- ^v Lansford JE, Dodge KA, Pettit GS, Bates JE, Crozier J, Kaplow J. A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. *Arch Pediatr Adolesc Med*. 2002;156 (8):824 –830
- ^{vi} Zimmer MH, Panko LM. Developmental status and service use among children in the child welfare system: a national survey. *Arch Pediatr Adolesc Med*. 2006;160 (2):183 –188
- ^{vii} McEwen BS. Glucocorticoids, depression, and mood disorders: structural remodeling in the brain. *Metabolism*. 2005;54 (5 suppl 1):20 –23
- ^{viii} Landfield PW, McEwen BS, Sapolsky RM, Meany MJ. Hippocampal cell death. *Science*. 1996;272 (5266):1249 –1251
- ^{ix} Gunnar MR, Donzella B. Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology*. 2002;27 (1–2):199 –220
- ^x De Bellis MD, Chrousos GP, Dorn LD, et al. Hypothalamic-pituitary-adrenal axis dysregulation in sexually abused girls. *J Clin Endocrinol Metab*. 1994;78 (2):249 –255
- ^{xi} Pfefferbaum B. Posttraumatic stress disorder in children: a review of the past ten years. *J Am Acad Child Adolesc Psychiatry*. 1997;36 (11):1503 –1511
- ^{xii} Gunnar MR, Donzella B. Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology*. 2002;27 (1–2):199 –220
- ^{xiii} Felitti VJ, Anda RF, Nordenberg P, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14 (4):245 –258
- ^{xiv} Dietz PM, Spitz AM, Anda RF, et al. Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood. *Journal of the American Medical Association*. 1999;282:1359-1364
- ^{xv} Hillis SD, Anda RF, Felitti VJ, Nordenberg D, Marchbanks PA. Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. *Pediatrics* 2000 106(1):E11.
- ^{xvi} Flaherty EG, Stirling J, Committee on Child Abuse and Neglect. The Pediatrician's Role in Child Maltreatment Prevention. *Pediatrics* 2010;126;833
- ^{xvii} Flaherty EG, Stirling J, Committee on Child Abuse and Neglect. The Pediatrician's Role in Child Maltreatment Prevention. *Pediatrics* 2010;126;833
- ^{xviii} Kellogg ND, Committee on Child Abuse and Neglect. Evaluation of Sexual Abuse in Children. *Pediatrics*. 2005;116(2):506-512
- ^{xix} Flaherty EG, Sege RD, et al. From Suspicion of Physical Child Abuse to Reporting: Primary Care Clinician Decision-Making. *Pediatrics*. 2008;122(3):611-619
- ^{xx} Jones R, Flaherty EG. Clinicians' Description of Factors Influencing Their Reporting of Suspected Child Abuse: Report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics*. 2008;122(2):259-266