In the year 2001, child welfare authorities in the Commonwealth of Pennsylvania received 23,099 reports of suspected child abuse and neglect. Of these reports, 4,784 were substantiated. Half of the substantiated cases involved some form of sexual abuse. And a total of 8,464 children had to be removed from the settings where the abuse occurred.

In other words, it was a typical year.

Like other states, Pennsylvania relies on a kind of “early warning” system to ensure the well-being and safety of its most vulnerable citizens. Children who are being mistreated can’t always explain or even understand what is happening to them. It’s up to the adults who come in contact with them from day to day to notice troubling things. Puzzling injuries. Poor hygiene. Odd fears. No coat on a cold winter’s day. It could be nothing—or it could be an indication of something much worse. And a great deal may depend on someone’s willingness to butt in, to pose a question, to ask for an explanation. If necessary, to trigger an alarm.

Among those in the best position to detect signs of possible child abuse and neglect are front-line health care personnel—primary care physicians, nurses, and other medical staff—whose jobs give them routine contact with children and opportunities to physically examine them. These primary care providers are among the so-called “mandated reporters,” who are required by the state’s Child Protective Services Law to notify authorities whenever they have reasonable cause to suspect abuse or neglect. And yet, surprisingly few child abuse and neglect reports originate from private physicians and nurses in Pennsylvania. In fact, there is good reason to believe that signs of child abuse and neglect are often missed in private doctors’ offices—or are noticed, but not reported.

Because the consequences of a missed diagnosis or an unreported suspicion of child abuse or neglect can be disastrous—even fatal—an ambitious effort has been undertaken by the Governor’s Community Partnership for Safe Children, the Pennsylvania Department of Public Welfare, and the Pennsylvania Chapter of the American Academy of Pediatrics to train Pennsylvania’s primary care providers to recognize signs of maltreatment in their patients and to respond appropriately. It’s a community-based continuing medical education program called EPIC-SCAN—for “Educating Physicians In their Communities—Suspected Child Abuse And Neglect”—and it was developed by the Child Abuse and Neglect Work Group of the Children’s Partnership in 1999. With funding from the Children’s Partnership,
the Pennsylvania Commission on Crime and Delinquency, and the Pennsylvania Department of Public Welfare, EPIC-SCAN has already trained approximately 4,000 health care professionals in hundreds of primary care offices and hospitals across the state.

This issue of Pennsylvania Progress will examine the background and origins of the EPIC-SCAN effort, discuss the program’s goals and methods, and give an account of what has been accomplished to date.

## DEFINING CHILD ABUSE

Pennsylvania’s Child Protective Services Law defines four basic kinds of abuse of children under 18 years of age.² The parent of a child, the paramour (live-in partner) of a parent, or any other person who is either living with or responsible for the welfare of a child, is guilty of child abuse for committing any of the following:

- **Physical abuse:** Any “recent act or failure to act” that causes “non-accidental serious physical injury” to the child.

- **Mental or sexual abuse:** An act or failure to act that causes non-accidental serious mental injury to, or sexual abuse or exploitation of, the child.

- **Child endangerment:** An act, failure to act, or series of acts or failures to act creating an imminent risk of serious physical injury to or sexual abuse or exploitation of the child.

- **Serious neglect:** Prolonged or repeated lack of supervision or failure to provide the necessities of life (including adequate food, shelter, clothing, and medical and dental care), such as to endanger the child’s life or development or impair the child’s functioning.

Suspected cases of child abuse are reported to a state registry called “ChildLine,” which is operated by the Pennsylvania Department of Public Welfare’s Office of Children, Youth, and Families. Reports can also be made directly to the local county’s Children and Youth agency. In either case, county Children and Youth agency staff must open an investigation within 24 hours to determine whether the child is safe.³ An investigation is typically completed within 30 days⁴ and may involve interviews with the child, the parents, any others alleged to have committed the abuse, and any witnesses. In addition, a medical examination may be performed. The investigation focuses not only on whether the abuse occurred in the past, but also on the current risk of harm to children in the home and the family’s need for support services. Even if the investigation does not substantiate maltreatment that rises to the legal definition of abuse, the agency may provide the family with “general protective services”—preventive programs, parenting education, child care, counseling, etc.—designed to enhance the stability of the home and the safety of the children.

But nothing happens without the initial report. The whole system depends on it. Under the Child Protective Services Law, anyone can report suspicions of child abuse, but certain persons must—including all those “who, in the course of their employment, occupation or practice of their profession, come into contact with children.”⁵ “Mandated reporters” include everyone who works in a doctor’s office, as well as school teachers and administrators, police officers, social workers, day-care and hospital staff, and many others specifically enumerated in the law. All are required to notify the authorities whenever “they have reasonable cause to suspect, on the basis of their medical, professional or other training and experience, that a child coming before them in their professional or official capacity is an abused child.”

## PHYSICIAN UNDERREPORTING

During the years 1997 to 2001, 33% of all reports of suspected child abuse from mandated reporters in Pennsylvania came from schools.⁶ Another 19% came from social services providers, 18% from hospitals, and
10% from law enforcement. Only 4% came from private physicians and nurses.

Why do so few child abuse reports come from doctors’ offices? Failure to recognize the often-subtle signs and symptoms of child maltreatment during physical examinations may be one reason for underreporting among primary care providers. One study of the cases of 173 young children suffering the effects of abusive head trauma found that 54 of them—nearly a third—had been previously examined by physicians who failed to diagnose the abuse.7 Fifteen of the children were re-injured as a result of the missed diagnosis. Four of them died.

Primary care providers may well see the signs, but hesitate to make reports for other reasons. They may doubt their own qualifications to make a diagnosis of abuse. They may believe that mere suspicion is an insufficient basis for a report. They may believe that the abuse is not serious enough to report. They may tell themselves that the situation will resolve itself. And they may feel a reluctance to point fingers, particularly at hard-pressed families who will get in trouble with the system.

Some practitioners are reluctant to intervene because a report might disrupt treatment if they lose contact with the child. The attitudes of private physicians and their staff toward the child welfare system may also influence reporting. They may doubt the capacity of an already overburdened local child protective agency to intervene effectively in a case of suspected abuse. They may think a full-scale child protective investigation can only break up the family and do more harm than good. They may be unfamiliar with resources and services that are available to help families in this situation.

Besides, they’re only human. For doctors and others who work in primary care, reporting a possible case of abuse may mean losing a patient, confronting an angry family, being dragged into a legal dispute. A lack of time to devote to a lengthy child abuse examination and interviews of caregivers discourages providers from getting involved and making reports. It’s often easier to accept an explanation for a suspicious injury—and hope that things will get better on their own.

Unfortunately, things don’t always improve. Re-abuse is a disturbingly common phenomenon. One study of infants who had died as a result of Shaken Baby Syndrome found that 71% of them showed evidence of previous abuse or neglect.8 In another post-mortem study of the skeletal injuries of 31 other fatally injured infants, it was found that all but two infants had at least one healing fracture.9

MEETING THE NEED FOR EDUCATION

In the summer of 1998, the multidisciplinary Child Abuse and Neglect Work Group of the Governor’s Community Partnership for Safe Children began exploring ways to improve the child abuse reporting of primary care providers in Pennsylvania. The Work Group includes pediatricians, family physicians, attorneys, law enforcement representatives, policy personnel from the Department of Public Welfare’s Office of Children, Youth and Families, and Children’s Partnership staff. Cindy Christian, M.D., Chair of Child Abuse and Neglect Prevention at the Children’s Hospital of Philadelphia and Assistant Professor of Pediatrics at the University of Pennsylvania School of Medicine, chairs the Work Group. According to Dr. Christian, “We knew that reports from primary care physicians were inadequate... and we thought of a number of possible approaches to improving physician response to child abuse.”

It was clear, however, that part of the answer to underreporting had to be a form of education—to alert primary medical care providers to the signs of abuse and neglect, to lay out for them their legal responsibilities as mandated reporters, to familiarize them with reporting and investigation procedures, and to help them adopt a protocol for responding to the suspected abuse or neglect of their patients.
The Work Group turned to the Pennsylvania Chapter of the American Academy of Pediatrics and its already established EPIC (Educating Physicians In their Communities) model. As Dr. Christian put it: "We recognized the value in working with the PA AAP and building on a program that had a track record. We are fortunate to have a chapter that does innovative work and was willing to partner with us."

The result of that partnership was the launching of EPIC-SCAN. The program is based on a curriculum developed by members of the Work Group over a 9-month period in the fall and winter of 1998-99, and was formally unveiled at Children’s Hospital of Philadelphia in April of 1999 by then-Governor Tom Ridge and his wife Michelle Ridge, then-Chairwoman of the Children’s Partnership.

EPIC-SCAN is the nation’s first and only statewide, community-based continuing medical education program to train primary care providers and their entire office staff to identify and report child abuse and neglect.

THE EPIC-SCAN APPROACH

The heart of EPIC-SCAN is a standardized lecture/slide-show presentation on recognizing and responding to child abuse in a primary care setting. The program is primarily designed to be presented in doctors’ offices, but it works at hospital staff meetings and in academic and other settings as well. A special version of the curriculum is even being adapted for school nurses. Wherever the program goes, EPIC-SCAN is always presented by a team, consisting of a local physician and a local child protective services representative, who have volunteered to receive training in the curriculum.

It takes only about an hour and a half to get through EPIC-SCAN’s 71 slides. Presentations are typically scheduled for midday, when offices are closed for the lunch hour. And it’s all free—the Children’s Partnership even picks up lunch!

There are a number of unique features to the EPIC-SCAN approach. One is its intended target audience. Unlike most continuing medical education efforts, this one aims to change practice behavior at the office level—and to engage and educate everybody on the office team. Not only doctors and nurses, but medical assistants, receptionists, administrative and support staff all need to be alert to signs of child abuse, familiar with what is required of them under the mandated reporting law, and willing and able to take the necessary steps to protect children.

EPIC-SCAN blends state and local strengths and expertise in a way that is distinctive. Training for local professionals willing to serve as presenters in their communities has been organized at the state level, with the Pennsylvania Chapter of the American Academy of Pediatrics holding statewide “train-the-trainer” conferences in September 1999 in Carlisle and again in April 2002 in Hershey. Prospective presenters unable to attend the conferences use approved self-study course materials consisting of videotapes condensed from the training conferences, including a sample case presentation.

The program takes full advantage of the local knowledge, experience and connections of the presenters themselves—and their ability to adapt their EPIC-SCAN presentations to reflect conditions and procedures in their home counties. Dr. Christian describes EPIC-SCAN presenters as “interested, engaged and enthusiastic about participating in teaching their peers. I think their skills have improved by becoming involved, and in turn, they have become valued resources in their communities.” The 71 physicians trained as EPIC-SCAN presenters are able to deliver presentations in a total of 64 Pennsylvania counties. Among the 94 Children and Youth agency presenters, all 67 Pennsylvania counties are represented.

Finally, EPIC-SCAN is also unique in the way it brings medical and child welfare professionals together. The program is consciously designed
to forge direct, human connections between primary medical care offices and local child protective service agencies. In the words of Dr. Christian, “I can’t think of many other ways that we could get child welfare social workers into physician practices to help educate doctors. In fact, the majority of questions during presentations are directed to the social worker—not the doctor. In this way, we hope we are putting a ‘face’ to child welfare, and that physicians might be less hesitant to call when they have a problem or question.”

THE EPIC-SCAN CURRICULUM

Using a standardized slide presentation and fielding questions along the way, EPIC-SCAN presenters walk their audiences through everything they need to know to react responsibly when they suspect child abuse or neglect:

♦ **Definitions and incidence of child abuse.** After a detailed introductory case report involving missed child abuse in a three-week-old infant, the curriculum explores abuse definitions under the Child Protective Services Law and shows what types of abusive injuries are most often substantiated. During the period from 1997-2001, sexual abuse accounted for 51% of substantiated reports of child abuse in Pennsylvania. Physical abuse accounted for 38% of all substantiated cases, and physical neglect for 5%.10

♦ **The reporting system.** EPIC-SCAN presenters spell out the reporting responsibilities of physicians’ practices under Pennsylvania law, their immunity from liability for good faith reports of suspected child abuse, and the penalties that can be imposed for failing to report. They also take a critical look at the common reasons health professionals give for failing to report (“I don’t see abuse in my practice,” “I can do better than the system,” etc.).

♦ **Risk factors for abuse.** The curriculum includes characteristics of children, parents, and families associated with child maltreatment, along with social situational stressors and triggering situations which raise the risk of abuse or neglect. For instance, a child who has been born prematurely, is colicky, suffers physical or developmental disabilities, or is chronically ill is more likely to be abused. Children whose parents have problems with drugs or alcohol, suffer from depression, or were themselves abused as children are more likely to be abused as well. Although abuse cuts across all class, racial, and ethnic boundaries, it is more common in poor families, in isolated families, and in families with single or teenage parents. There is an overwhelming concurrence between violence against children and family violence: in 40-60% of the homes in which women suffer from domestic violence, children suffer as well. The presence in the household of a male who is not biologically related to the family heightens the overall risk of abuse, although in Pennsylvania most substantiated cases of abuse involve perpetrators who are mothers (27%) or fathers (23%) of their victims.

♦ **Indicators of abuse.** The EPIC-SCAN curriculum reviews common types of abusive injuries, including head trauma, abdominal trauma, fractures, bruises, and burns, and offers strategies for recognizing when they may have been caused by maltreatment. For example, bruises on non-ambulatory infants should be approached with suspicion, along with patterned or unusually distributed bruises found on older children. The same is true of immersion burns and patterned contact burns. Regardless of the nature of the child’s physical injuries, there are a number of behavioral indicators of possible abuse, including depression, anxiety, unusual fears, sleep and appetite disturbances, and sometimes odd habits like rocking or excessive nail-biting. Often the most suggestive clues can be found not so much in the injury as in the explanation for it. Serious injuries that are
attributed by the caregiver to trivial causes—or "magical injuries" with no apparent causes at all—should alert practitioners to the possibility of abuse. So should explanations that change over time, explanations that are incompatible with the child’s developmental level (such as a claim that a very young child’s injuries are self-inflicted), or unexplained delays in seeking treatment.

♦ Interviewing, examining, and testing for abuse. EPIC-SCAN’s primary focus is on influencing day-to-day office practice, and showing staff how they can work as a team to protect their young patients’ safety. That means not just being alert for indications of abuse, but methodically documenting them. It means interviewing caregivers and children separately if possible, asking detailed questions, and making sure that a staff person is present as a witness. The curriculum offers strategies for interviewing parents and physically examining children, and canvases in detail the kinds of laboratory and radiographic tests that should be ordered in various situations.

♦ Making the call. “Do not be afraid to go with your gut feelings,” EPIC-SCAN attendees are advised. The curriculum explains what to do once the abuse "reporting threshold" has been reached—not only how to make a report but what steps to take afterwards, when to contact the police as well as the child welfare authorities, what to do if the immediate risk to the child is such that he or she should not be permitted to leave the office, and how to go about informing the family that a report is being made. The advice on dealing with the family is very specific, and includes suggestions for how to phrase things as well as what general points to cover.

♦ Resources. Offices that host on-site EPIC-SCAN presentations receive free Health Care Provider Manuals containing a number of practical office tools, including a schematic illustration of an office protocol for screening and reporting child abuse, a checklist itemizing the steps to be taken in cases of suspected abuse, laminated reminder cards for display at staff stations, duplicable state reporting forms, physical abuse evaluation forms, and sexual abuse evaluation forms. Also provided are telephone numbers and referral information for national, state and local agencies that could be helpful to families in abuse situations, including general county
information and referral centers, parent support groups, county sexual violence crisis centers, counseling offices for children with special needs, and a domestic violence hotline.

FEEDBACK FROM THE FIELD

Since October of 1999, when the program began, through June of 2002, EPIC-SCAN presenters have delivered 241 presentations to a total of 4,100 health care professionals—including physicians, physician assistants, nurse practitioners, nurses, and office staff throughout Pennsylvania. Audiences have generally been appreciative, interested, and attentive, according to presenters. And feedback has been good. “The slides are informative and the written materials were comprehensive,” wrote one doctor after attending a special presentation for residents at an Altoona hospital. “Best of all, it was given by a local physician accompanied by our own county child abuse case manager. By using community resources, our residents got to know how to apply the information here in our county.”

In order to get a more precise idea of the extent to which EPIC-SCAN presentations are reaching their intended audiences and accomplishing their stated goals, the Children’s Partnership’s Child Abuse and Neglect Work Group has built in a formal evaluation component. The evaluation effort consists primarily of two statewide mail surveys, probing medical providers’ knowledge, attitudes and practices with regard to child abuse and neglect. The first wave of questionnaires, which preceded the implementation of the EPIC-SCAN program, went out to 730 providers, and elicited 427 responses (a 58.5% rate of return). A pre-program portrait of providers’ child abuse awareness and reporting behavior has been drawn from these responses. A follow-up survey will ask identical questions to members of the same group, sampling some providers who attended EPIC-SCAN presentations and some who did not, and comparing the ways in which the two groups’ knowledge, behavior, and attitudes did or did not change.

THE FUTURE OF EPIC-SCAN

EPIC-SCAN is still the only statewide, on-site training program in the country that is focused on improving child abuse reporting in primary health care settings. But other states are beginning to take notice. The Pennsylvania chapter of the American Academy of Pediatrics has received requests for information about EPIC-SCAN from 24 states to date. New Jersey is replicating the program in a high-risk county there, and professionals in Wisconsin and other states are also actively seeking funds to implement EPIC-SCAN. Workshops on EPIC-SCAN have attracted interest at both national and international child abuse conferences, and there has even been some discussion in the Executive Committee of the Child Abuse Section of the American Academy of Pediatrics of replicating EPIC-SCAN on a national level.

In the meantime, EPIC-SCAN presentations will continue here in Pennsylvania, as long as there is a need for community-based education for primary care providers in child abuse recognition and reporting. If you work in the primary health care field and would like to arrange a free presentation for your office or hospital meeting, contact: Pennsylvania Chapter, American Academy of Pediatrics EPIC-SCAN Program 919 Conestoga Road Building 2, Suite 307 Rosemont, PA 19010 Phone: (866) 823-7226 (toll-free anywhere in Pennsylvania) or (610) 520-3666 Fax: (610) 520-9177 E-mail: paaap@voicenet.com Website: www.paaap.org.
ENDNOTES

2 23 Pa.C.S.§6303.
3 23 Pa.C.S.§6334.
5 23 Pa.C.S.§6311.
6 These and subsequent figures are taken from the Pennsylvania Child Abuse Reports for 1997-2001, as summarized in the EPIC-SCAN curriculum.

10 Except where noted, these and all subsequent facts and figures are taken from the EPIC-SCAN curriculum. The source for statistics is the Pennsylvania Child Abuse Reports for 1996-2000.
11 If you’re writing, in addition to supplying your own contact information, be sure to indicate your area of practice (pediatric, family medicine, or other), list three potential dates and times when your office could be scheduled for a presentation, estimate the number that would be attending, and specify whether a slide projector would be available.

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