Child Maltreatment Toolkit

THIRD EDITION, 2025

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Acknowledgments

The 2025 Child Maltreatment Toolkit project emerged from the 2013 Child Abuse and Neglect Policy and Procedures Guidelines/Toolkit (originally developed by Illinois EMSC) to current evidenced-based guidelines for emergency department teams in Illinois. This revision would not be possible without the collaborative multidisciplinary support and sharing of expertise by so many contributing members throughout our state and beyond. The aim is to improve emergency clinical care for children living in Illinois who may have concerns for maltreatment by promoting health, wellness and safety.

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An electronic copy of this document can be accessed at https://www.luriechildrens.org/child-maltreatment-toolkit

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Abbreviations, Acronyms, Mnemonics and Terms *(Non-inclusive List)*

ANCRA: Abused and Neglected Child Reporting Act

AHT: Abusive Head Trauma

ACEs: Adverse Childhood Experiences

AFSA/DFSA: Alcohol Facilitated Sexual Assault/ Drug Facilitated Sexual Assault

AWTP: Areawide Sexual Assault Treatment Plan

CAN: Child Abuse and Neglect

CAP: Child Abuse Pediatrician

CLS: Child Life Specialist

CSA: Child Sexual Abuse

CSAM: Child Sexual Abuse Material

CST: Child Sex Trafficking

CST/E: Child Sex Trafficking and Exploitation

CAC: Children's Advocacy Center

DCFS: Department of Children and Family Services

DV: Domestic Violence

ED: Emergency Department

EMS: Emergency Medical Services

FI: Forensic Interview

GU: Genitourinary

HCP: Healthcare Provider

HCW: Healthcare Worker

HEEADSSS: Psychosocial assessment tool for patient's ≥10 years of age that addresses the child's **H**ome, **E**ducation, **E**mployment, **A**ctivities, **D**rugs, **S**exuality, **S**afety, **S**uicidality

HIV PEP: Human Immunodeficiency Virus Post-Exposure Prophylaxis

HT: Human Trafficking

IPV: Intimate Partner Violence

LE: Law Enforcement

LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and more identities

LCAST: Lurie Children's Child Injury Plausibility Assessment Support Tool

MR: Mandated Reporter

MFS: Medical Forensic Services

NCMEC: National Center for Missing and Exploited Children

NHTRC: National Human Trafficking Resource Center (which includes the National Human Trafficking Hotline)

NAT: Non-accidental Trauma

NFS: Non-fatal Strangulation

OSH: Outside Hospital

PC: Protective Custody

PRF: Psychosocial Risk Factors

QMP: Qualified Medical Provider

SA: Sexual Abuse/Assault

SAECK: Sexual Assault Evidence Collection Kit

SAFE: Sexual Assault Forensic Examiner

SANE: Sexual Assault Nurse Examiner

SASETA: Sexual Assault Survivors Emergency Treatment Act

STI: Sexually Transmitted Infection

SW: Social Worker

TIC: Trauma-informed Care

TEN-4-FACESp: Mnemonic for a physical abuse screening tool for children ≤4 years of age with bruising in the following body regions: **T**orso, **E**ars, **N**eck, any bruising in infants age <**4** months, **F**renulum, **A**ngle of jaw, **C**heek (fleshy part), **E**yelids, **S**ubconjunctivae, **P**atterned bruising

How to Use This Toolkit

Please note: Nothing in this document should be construed as providing legal advice. For a legal interpretation or opinion, users must consult an attorney. This 3rd edition toolkit aims to assist individual providers, medical teams and organizations who may be developing and/or revising their evidenced-based child maltreatment policies, procedures and guidelines. Providers must exercise their independent medical and nursing judgement in caring for individual patients depending on their presentation and the specific circumstances involved.

- This educational endeavor aims to provide awareness of appropriate emergency medical guidelines and services for all children who are possible victims of maltreatment. Careful attention was given to ensure that the information presented is accurate and consistent with current evidence-based practices at the date of publication. This information is not a substitute for any existing local or hospital child abuse and neglect (CAN) policy or procedure. These guidelines and recommendations in this toolkit may be modified in accordance with the medical judgement of the healthcare professional and do not constitute legal advice. This document also does not replace prudent awareness of evidence-based practices (i.e., CDC STI Guidelines) nor state laws (i.e., Abused and Neglected Child Reporting Act).
- Using a multidisciplinary, trauma-informed approach supports optimal care for all children. Collaborative team members may include prehospital providers, the emergency department (ED) team, hospital consultants, administrators and child abuse experts. A partnership between these various professionals is most likely to lead to successful recognition and management of a child with suspected CAN. Utilizers of this toolkit who pursue CAN self-education may indeed save a child's life.
- In addition to this document, hospital leaders and administrators need to be mindful of governmental regulations, laws and administrative codes that impact children presenting to the ED with concerns for maltreatment. This includes regulations outlined by the Centers for Medicare and Medicaid Services Conditions of Participation and any designated accreditation bodies (i.e., The Joint Commission). Also, the Illinois Joint Committee on Administrative Rules Administrative Code includes requirements (e.g., mandated reporter's resonsibilities) for Illinois hospitals, pediatric facility recognition hospitals and Emergency Medical Services.
- The resources in this document have been formatted to allow for copying and posting in clinical areas for easy reference. Some resources have QR codes.An electronic copy of this document and any revisions can be accessed at https://www.luriechildrens.org/child-maltreatment-toolkit.

GENERAL TIPS ON HOW TO USE THESE ALGORITHMS (E.G., CHILD SEX TRAFFICKING/EXPLOITATION), SCREENING QUESTIONS AND MANAGEMENT RECOMMENDATIONS)

- Understand the intended population
- Avoid biases; Be objective
- Familiarize yourself with this information before you need to use it
- Know your own professional scope of practice
- Stay up-to-date on pediatric evidenced-based practice
- Share this toolkit with hospital leaders and members of your multidisciplinary team
- Collaborate with pediatric stakeholders including those in your community
- Support legislative changes that allow for optimal healthcare delivery to children

Introduction

Child abuse and neglect (CAN) in the United States is a common cause of childhood morbidity and mortality. The National Child Abuse and Neglect Data System (NCANDS) estimates CAN in the United States through national data compiled by Child Protection Services (CPS), as depicted below. Importantly, because NCANDS data only includes children who were reported to CPS, the true number of victims is much higher.

FIGURE 1

2022 Pediatric Victims of Maltreatment[1]

(may be counted in more than one category)

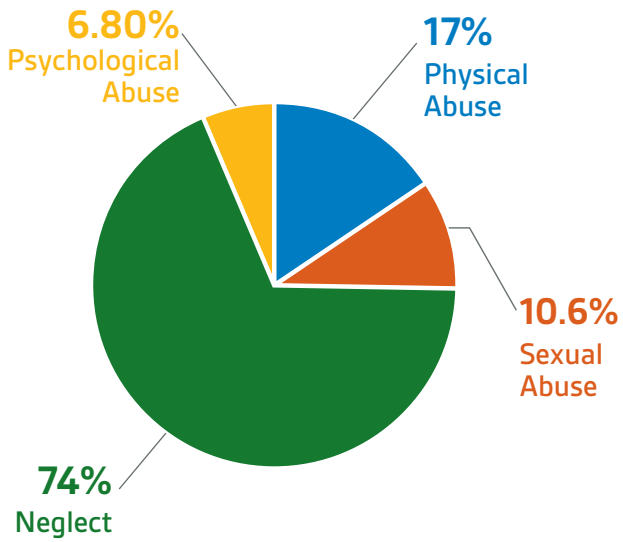


TABLE 1

2022 U.S. FEDERAL FISCAL YEAR
> 4.2 million referrals were made to CPS.[1]
One out of every 129 children was a victim of CAN, equating to 558,899 victims with 1,990 fatalities.[1]
Neglect is the leading form of maltreatment, more than physical abuse and sexual abuse combined.[1]
In the United States, children less than four years of age represent nearly 3/4 of all child maltreatment fatalities, with infants <12 months being the most vulnerable at 44.7%.[1]

Recognizing early signs of CAN is essential to prevent repetitive or escalating abuse, including fatalities. Early identification of CAN in an index patient may also prevent the victimization of other children.

Harm reduction is also critical because CAN is a known adverse childhood experience and may affect individuals through adulthood.[2] Such examples may include depression, suicidality and/or chronic disease (e.g., cancer, diabetes and heart disease).[2]

Unfortunately, various factors make the diagnosis of CAN challenging, including fabricated caregiver histories, lack of verbal ability in young children and presentations that mimic other conditions.

Because CAN is easy to miss, it is important to consider CAN anytime a pediatric patient is identified to have an injury. Remember that CAN exists in all socioeconomic and racial/ethnic groups, and any child can be affected.

As a 24-hour acute care setting, the emergency department (ED) is often the very first medical site where an injured, neglected or sexually abused child presents. ED professionals therefore have a critical role in identifying and treating children with signs and symptoms of CAN. Hospitals are uniquely positioned in the community to promote best practices and appropriately identify, diagnose and act when CAN is suspected.

Basic Definitions

Legal definitions of terms related to the maltreatment of children may vary from state to state. Most of this section includes selected text from Section 3 of the Abused and Neglected Child Reporting Act (ANCRA), as well as specific examples from the Illinois Department of Children and Family Services (DCFS) Manual for Mandated Reporters, Sexual Assault Survivors Emergency Treatment Act (SASETA) and Illinois Trafficking Victims Protection Act (TVPA). Please refer directly to the laws as applicable for further information. Additional terms and definitions will be described later in this document as applicable.

Child

According to the Illinois State Law, ANCRA **refers to any person under the age of 18 years, unless legally emancipated by reason of marriage or entry into a branch of the U.S. armed services.**[3]

IMPORTANT:

State laws, governmental agencies, professional organization and/or healthcare facilities may choose to define the term pediatric differently. For example, they may decide to include the person's age (e.g., less than 13, 18 or 21 years old) and/or physical signs of sexual maturity.

Abused child

According to the Illinois State Law, ANCRA, an abused child is **a child whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child or a paramour of the child's parent**[3]**:**

- **Inflicts, causes to be inflicted or allows to be inflicted upon such child physical injury**, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health or loss or impairment of any bodily functions[3]
- **Creates a substantial risk of physical injury to such child** by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health or loss or impairment of any bodily function[3]
- **Commits or allows to be committed any sex offense against such child**, as such offenses are defined in the Criminal Code of 2012 or in the Wrongs to Children Act, and extending those definitions of sex offenses to include children under 18 years of age[3]
- **Commits or allows to be committed an act or acts of torture** upon such child[3]
- **Inflicts excessive corporal punishment** or, in the case of a person working for an agency who is prohibited from using corporal punishment, inflicts corporal punishment upon a child[3]
- **Commits or allows to be committed the offense of female genital mutilation**, as defined in Section 12-34 of the Criminal Code of 2012, against the child[3]
- **Causes to be sold, transferred, distributed or given to such child under 18 years of age, a controlled substance** as defined in Section 102 of the Illinois Controlled Substances Act in violation of the Methamphetamine Control and Community Protection…unless dispensed to such child in a manner that substantially complies with the (controlled substance) prescription[3]
- **Commits or allows to be committed the offense of involuntary servitude, involuntary sexual servitude of a minor or trafficking in persons** as defined in Section 10-9 of the Criminal Code of 2012 against the child[3]
- **Commits the offense of grooming**, as defined in Section 11-25 of the Criminal Code of 2012, against the child.[3]

Neglect

According to ANCRA and DCFS, neglect occurs when a person responsible for the child:

- **Deprives or fails to provide the child with adequate food, clothing, shelter or needed medical treatment**[4]
- **Provides inadequate supervision of a child.**[4] This can occur when children are left either unsupervised or in the care of someone unable to supervise due to his/her condition. Children can suffer injuries that are the result of blatant disregard, which is considered neglect. Blatant disregard is a situation in which the risk of harm to a child is so imminent and apparent that it is unlikely that any parent or caretaker would expose the child to such without taking precautionary measures to protect the child.[4]
- **Creates an environment likely to cause harm to the child's health.**[3] An example includes a newborn infant whose blood, urine or meconium contains any amount of a controlled substance, except for a controlled substance whose presence is the result of medical treatment administered to the mother or newborn.[3]

Human trafficking

Multiple laws (e.g., ANCRA and Trafficking Victims Protection Acts) including reputable organizations (e.g., National Center for Missing Exploited Children) help to explain the definition of human trafficking. Human trafficking of children includes child labor trafficking and child sex trafficking. For the purposes of a child abuse and neglect (CAN) investigation, force, fraud or coercion need not be present for child sex trafficking, but it does need to be present in child labor trafficking.[5]

Definitions

- Child labor trafficking includes coerced labor exploitation and domestic servitude.[5] This differs from after-school employment or household chores that should be reasonable, realistic of a child's age and development and follow the Illinois Child Labor Law.
- Child sex trafficking (CST) includes the recruitment, enticement, harboring, transportation, provision, obtaining, patronizing or soliciting of a person under 18 years of age for the purpose of a commercial sex act.[5] No overt force or threat is needed when less than 18 years old.[5]
  - The definition of commercial sexual exploitation, an exchange of sex for something in value (e.g., food, clothing, shelter, money, drugs, video games, safety) would constitute CST.[6]
  - Unlike adult sex trafficking, CST does not always involve a third party (like a pimp). Rather, a child could encounter an adult online and meet up, for example.[6]

IMPORTANT:

The State of Illinois recognizes anyone under the age of 18 **cannot** consent to their own exploitation; these minors are considered abused or neglected children under ANCRA. Human trafficking is the only allegation in the DCFS system where the alleged perpetrator does not have to be in a typical caregiver role (e.g., parent, babysitter, teacher).

Refer to Human Trafficking is Child Abuse (p.67) and Expectations of a Mandated Reporter (p.12) for further information.

Sexual abuse/assault (SA)

According to DCFS (2020), SA occurs when a person engages in any of the following with a minor:

a. Sexual penetration including any contact between the sex organ of one person and the sex organ, mouth or anus of another person[4]

b. Sexual exploitation, which "…is the use of a child for sexual arousal, gratification, advantage or profit" (pg.17).[4] Some examples include exposing a child to pornography, masturbating in the presence of a child and possession of child sexual abuse material (CSAM).

c. Sexual conduct (i.e., sexual molestation) with a child when such contact, touching or interaction is used for arousal or gratification of sexual needs or desires.[4] Examples include fondling a child or the alleged perpetrator inappropriately touching or pinching of the child's body generally associated with sexual activity. This conduct can be underneath or through clothing.[4]

d. Causation of an acquired sexually transmitted infection (STI) because of sexual penetration or conduct by an afflicted individual.[4] STIs imply sexual contact but may be perinatally acquired. Refer to the Child SA section (p.75).

Sexual Assault Survivors Emergency Treatment (SASETA)

SASETA is the Illinois State law that mandates the care to a patient presenting for an evaluation of a sexual assault.[7] SASETA provides a glossary of definitions; listed below are three that are frequently used within this document. Further information may be found in SASETA and the SA section of this document. Refer to Child SA section (p.75).

- **Medical forensic services (MFS)** includes, but is not limited to, taking a medical history, performing photo documentation, performing a physical and anogenital examination, assessing the patient for evidence collection, collecting evidence in accordance with a statewide sexual assault evidence collection program administered by the Illinois State Police using the Sexual Assault Evidence Collection Kit (SAECK), if appropriate, assessing the patient for drug-facilitated or alcohol-facilitated sexual assault (DFSA), providing an evaluation of and care for STIs and human immunodeficiency virus (HIV), pregnancy risk evaluation and care, and discharge and follow-up healthcare planning.[7]
- **Qualified medical provider (QMP)** is a board-certified child abuse pediatrician, board-eligible child abuse pediatrician, sexual assault forensic examiner or sexual assault nurse examiner who has access to photo documentation tools and who participates in peer review.[7]
- **Areawide Sexual Assault Treatment Plan (AWTP)** is a plan developed by hospitals or by hospitals and approved pediatric healthcare facilities in a community or area to be served, which provides for medical forensic services to sexual assault survivors that shall be made available by each of the participating hospitals and approved pediatric health care facilities.[7] Refer to Child SA section (p.75).

IMPORTANT:

State laws, governmental agencies, professional organizations and/or healthcare facilities may choose to define the term "pediatric" differently. For example, they may decide to include the person's age (e.g., less than 13, 18 or 21 years old) and/or physical signs of sexual maturity.

Mandated reporters

According to DCFS (2020), *"professionals who work with children, mandated reporters, are assumed to be in the best position to recognize and report child abuse and neglect as soon as possible. Mandated reporters are the state's 'early warning system' to identify probable abuse early enough to avoid serious and long-term damage to a child. The state's primary goal is to protect the child and, whenever possible, to stabilize and preserve the family so that it may remain intact. (p.10).*[4]

"Such professionals include the following personnel groups: Medical (including EMS), social service and mental health, crisis intervention, education, recreation or athletic program or facility, childcare, law enforcement (LE), funeral home director and clergy member."[3,4]

Refer to the section Expectations of a Mandated Reporter with subsequent supporting documents (e.g., CANTS form for medical professionals) (pp.12–20) as well as the navigating ANCRA and SASETA as a Mandated Reporter section (pp.21–24).

Protective custody

Protective custody is intended for the immediate protection of the child and does not supersede parental rights. Parental consent for treatment of non-emergent conditions must still be obtained. A law enforcement (LE) agent, designated employee of Illinois DCFS, or a physician treating a child may retain temporary protective custody of the child without consent of the person responsible for the child's welfare, if:

- There is reason to believe that the child cannot be cared for at home or in the custody of the person responsible for the child's welfare without endangering the child's health or safety
  - There is no time to apply for a court order for temporary custody of the child
  - The person taking protective custody of the child shall immediately:
    - Notify the person responsible for the child's welfare
    - Notify Illinois DCFS
    - Notify the person in charge of the institution or their designated agent

Expectations of a Mandated Reporter

This section outlines helpful information and key elements that must be considered by a mandated reporter. It is also recommended to consult your hospital's policies for hospital-specific guidance, especially because child abuse and neglect policies are frequently updated to ensure compliance with current state and local regulations.

Reasonable cause

According to DCFS (2020), there are some issues that are important for every mandated reporter to consider when determining "reasonable cause" when making a report for suspected child maltreatment. Mandated reporters should be aware that safe and healthy parenting approaches can vary widely sometimes making the distinction between unfamiliar behaviors and truly concerning caregiver behavior not as obvious. Definitions in the Abused and Neglect Child Reporting Act (ANCRA) can be helpful in determining what constitutes abuse and neglect. Some questions recommended by DCFS (2020) to consider in determining "reasonable cause" include:

- Did you observe evidence that some damage was done to a child?[4]
- What information and/or communication has a child provided?[4]
- Is the information consistent and plausible with what you have observed?[4]
- Have there been past incidents which, in retrospect, may have been suspicious?[4]

A mandated reporter only needs reasonable *suspicion* of abuse or neglect to make a DCFS hotline call. The reporter does NOT need to be certain that maltreatment occurred. Investigation into concerns of maltreatment is beyond healthcare providers' scope of practice and is best left to investigative professionals such as DCFS and law enforcement (LE).

TABLE 2

EXAMPLES OF WHEN TO NOTIFY DCFS BY PHONE (1.800.25.ABUSE) INSTEAD OF USING THE ONLINE REPORTING SYSTEM
Emergent, life-threatening cases
Sexual abuse where the alleged adult perpetrator may have access to a child within the next 24 hours
Child has current injuries concerning for child abuse and neglect (CAN)
Immediate need for medical treatment (including a child who is suicidal) if a parent/guardian refuses care
Whenever you feel there is immediate risk of harm to child
If physician has taken Protective Custody
If child is in the emergency department (ED) and requires an immediate discharge disposition
Child is currently afraid to go home
Death of a child without an established medical etiology such as cancer

Immunity

According to DCFS (2020), mandated reporters have immunity from civil and criminal liability when a report to DCFS is made in good faith.[4] Therefore, even if DCFS ultimately finds your report unfounded or determines your report does not meet criteria for investigation, you cannot be penalized. Alternatively, a person who knowingly and maliciously makes a false report of CAN is guilty of disorderly conduct, which is a Class A misdemeanor for a first violation.[4]

CRITICAL CONCEPTS

Each institution is responsible for reporting CAN concerns, even if a child was transferred from an outside hospital (OSH) where a DCFS call was already made. Different mandated reporters may have different pieces of information that may need to be added, such as additional identified injuries.

CASE SCENARIO

A 3-month-old female patient presents to an OSH with her parents after parental reports of fussiness and poor feeding. In triage, the infant vomits. The OSH completes a head computerized tomography (CT) scan and diagnoses the child with bilateral subdural hemorrhages. The OSH makes a DCFS hotline report noting the primary caregivers (i.e., parents) and reports the diagnosed head injury. The infant is transferred to a children's hospital for a higher level of care. At the children's hospital, additional testing is completed, where a bruise is noted to the infant's cheek and a posterior rib fracture is found. It is also learned that the mother recently went back to work from maternity leave, and the family sends the baby to a home daycare. The children's hospital makes a DCFS hotline report with the additional injuries identified and makes note that the child has another caregiver.

DCFS and law enforcement (LE)

In general, although the only mandate for reporting is to DCFS, there are cases in which healthcare professionals (HCPs) should report to LE directly:

- A patient has suffered from (1) any injury resulting from a firearm being discharged, or (2) any injury sustained in the commission of, or as a victim of, a criminal offense
  - Reporting to LE as soon as possible in these cases is the professional duty of any nurse or physician as per The Criminal Identification Act (20 ILCS 2630/3.2)[8]
- A patient who consented to evidence collection, release and testing of the Sexual Assault Evidence Collection Kit (SAECK) — this requires a LE report number
- A parent or patient requests that LE be notified
  - Other local city or county laws mandating a call to LE for certain crimes or injuries

LE may also be involved in a patient's case in a variety of scenarios, some of which are listed below:

- DCFS notifies LE
  - DCFS categorizes reports into one or more allegations pulled from their central list of injuries/risks concerning for abuse and/or neglect (Procedures 300, Appendix B). Certain allegations trigger a report to LE, including torture, sexual penetration, sexual exploitation, bone fractures, head injuries or death
- A Children's Advocacy Center notifies LE
- A child presents to the ED with LE already notified. Common for patients who come via EMS where 911 was called
- Patients and families are brought to ED by LE

Investigation by DCFS and LE

Not every case of suspected child maltreatment will meet criteria for a DCFS investigation. The table below highlights cases where DCFS or LE will investigate; it is not uncommon for these cases to overlap. **It is not the mandated reporter's responsibility to determine which agency investigates a concern. Note: If you are unsure whether your report falls under DCFS and/or LE purview, then start by calling the DCFS hotline.**

TABLE 3

EXAMPLES OF DCFS INVESTIGATIONS	EXAMPLES OF LE INVESTIGATIONS
Perpetrator is a parent, caregiver, parent's paramour or adult family member in a caregiving role	The patient is a teenage victim, and the alleged offender is a teenage offender, but not related to the patient.
Perpetrator is a person of trust: Teacher, coach, priest, police officer, etc.	Revenge Porn and Sextortion (see page 64 for more information).
Perpetrator is a person responsible for the welfare of the child: Babysitter, daycare worker, residential facility worker, etc.	Nude photos or child sexual abuse material (CSAM) being shared via social media (e.g., Snapchat) or text messaging
When sexual violence involves an alleged child offender, DCFS may choose to investigate based on multiple factors (e.g., ages between the two parties, hypersexualized behavior incongruent with chronological age, etc.) or may decide to use a different allegation like "Inadequate Supervision" depending on the circumstance.	A minor and an adult who are not related and the adult is not in a caregiving role. For example, a teenager who is assaulted by an unknown adult while walking home from soccer practice.
Human trafficking (HT) of children. HT is ALWAYS a DCFS hotline call, even if the named perpetrator is not in a category listed above. Refer to Human Trafficking is Child Abuse (p.67).	A minor may state that they are in a "consensual" relationship with an adult, but minors younger than 17 years old cannot consent to sex with an adult. The minor may report that they are "in love" and that there is no force present, but the relationship remains illegal. This can become a DCFS issue, too, if the child's parent knows about the relationship and facilitated it; for example, the parent allows a 23-year-old male to spend the night in the 14-year-old female's room.

Action items when notifying DCFS

Legal responsibility of a mandated reporter: Has reasonable cause to suspect child abuse/neglect AND required to report.[4] DCFS reports can be made via telephone or the online reporting system (non-emergent cases only: https://childabuse.Illinois.gov).[4] As EDs are generally dealing with urgent and emergent situations, the action steps below apply more to calling the DCFS hotline.

Only a single report is required for each hospital, including the ED, to meet reporting requirements.
However, additional reports of the same incident may contribute additional important information for investigators.

ACTIONS

1. **Inform the ED provider** (e.g., ED attending physician) or supervisor of suspicions.
2. **Conduct and document a complete medical and psychosocial evaluation** of the child.
3. **Each suspected case of CAN shall be immediately reported to DCFS.**
   - 1.800.25.ABUSE or 1.800.252.2873
   - https://childabuse.Illinois.gov *(for non-emergent cases only)*
4. **Communicating with DCFS Hotline worker**
   - Let DCFS Hotline worker know you are a mandated reporter.
   - Provide demographic information about the child(ren) and adult(s) involved (e.g., names, dates of birth, address of occurrence, home address, phone, patient's siblings' information and if other children may be at risk).
   - State the facts and reasons for the Hotline call: Provide objective information and leave out subjective conclusions. For preverbal or non-verbal children, there may be injuries without a history and the mandated reporter does not know the cause of injuries. That is okay; present the facts and allow DCFS to make the determination.

- Document the DCFS notification into the medical record by adding the name of the intake worker, intake ID, outcome of call and when the Child Abuse and Neglect Tracking System (CANTS) form[4] is completed. Defer to your own hospital policies for other specifics.
- If you disagree with the conclusions of the Hotline worker, you may ask to speak with a Hotline supervisor. Explain the details of the case situation, the reasons you were given for the report being refused and why you think there are child safety concerns that need to be investigated.
- If a report is taken by the Hotline worker, an investigation is commenced within 24 hours. As a mandated reporter, you will be asked to supply a written confirmation of your verbal report within 48 hours *(See Written Confirmation of Suspected Child Abuse/Neglect Report: Medical Professionals, CANTS)*. This written report may be used as evidence in any judicial proceeding that results from the incident.

5. **Submission of completed CANTS 4 from to DCFS after Hotline phone call via email OR mail.**
   Note: A written CANTS 4 will no longer be required after January 2025.
   - Email the CANTS 4 form to DCFS.MandatedReporterForm@Illinois.gov where it will be routed to the appropriate field office.
   - Mail the original CANTS 4 form to the nearest office of the Illinois DCFS, Attention: Child Protective Services. If you don't know this information, then contact DCFS to request this information.
6. **Activate your hospital protocol and notify appropriate personnel** (including Child Abuse Protection Team, if available) that a suspected case of abuse or neglect has been reported. Notify hospital leadership, including risk manager, whenever you are subpoenaed.
7. **Let families know about your duty as a mandated reporter.**
   - It is your responsibility to set expectations at outset of the encounter.
   - Transparency with families about the need to report to DCFS is best practice in most situations.
   - This step is important even if the patient is transferred to another hospital.
     — Refer to Limits of Confidentiality and the Medical History (p.37) and Child SA sections (p.75) for further guidance.
     — If you have not told the family that you will be making a report to DCFS and you are transferring the patient to another facility for care, it is important to communicate this to the receiving facility because it may affect their plan of care or discharge disposition.
8. **Consider the need for debriefing intervention(s)** for all involved personnel (including prehospital personnel).

Additional information about mandated reporting

- The identity of the reporting person and the report shall be confidential subject to disclosure only with the consent of that person or by judicial process (i.e. DCFS administrative hearing).[4]
- When the offender is in a non-caretaker role, then the abuse or neglect is under the jurisdiction of LE where the incident occurred.
  — Note: Per Sexual Assault Survivors Emergency Treatment Act (SASETA) law for cases of sexual abuse/assault (SA), the hospital staff can report to the jurisdiction/county/city of the hospital's location. Then, the LE agency will transfer the case to the correct jurisdiction of occurrence.

QUICK TIP:

Do NOT interpret or change wording of a child's disclosure in your documentation or DCFS notification.

☑ **CORRECT EXAMPLE:** *My 6-year-old female patient said that "my papa put his peepee in my jay-jay. It hurt and I bleeded." Per the patient's mother, the child's papa is her maternal grandpa, Joe. The peepee is what the family calls a penis, and the jay-jay is the word they use for vagina.*

☒ **INCORRECT EXAMPLE:** *My 6-year-old female patient said that "my Grandpa Joe put his penis in my vagina. It hurt and there was blood after."*

Refer to Medical History Taking from Children (p.34).

Guidelines for calling the Child Abuse Hotline[4]

GENERAL RECOMMENDATIONS FOR CALLING DCFS; USE QR CODE TO ACCESS THE ENTIRE IL DCFS MANUAL

Mandated reporters are required to call the Hotline when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. The Hotline worker will determine if the information given by the reporter meets the legal requirements to initiate an investigation.

CRITERIA NEEDED FOR A CHILD ABUSE OR NEGLECT INVESTIGATION

- The alleged victim is a child under the age of 18.
- The alleged perpetrator is a parent, guardian, foster parent, relative, caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: healthcare professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.
- There must be an incident of harm or a set of circumstances that would lead a reasonable person to suspect that a child was abused or neglected.

QR code for manual for mandated reporter

INFORMATION THE REPORTER SHOULD HAVE READY TO GIVE TO THE HOTLINE

- Names, birth dates (or approximate ages), races, genders, etc. for all adult and child subjects
- Addresses for all victims and perpetrators, including current location
- Information about the siblings or other family members, if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm — for example, when the incident occurred, the extent of the injuries, how the child says it happened and any other pertinent information

If this information is not readily available, the reporter should not delay a call to the hotline.

ILLINOIS CHILD ABUSE HOTLINE
1.800.25.ABUSE (1.800.252.2873)

The Hotline operates 24 hours per day, 365 days a year. Reporters should be prepared to provide phone numbers where they may be reached throughout the day in case the Hotline must call back for more information.

If your call is not an emergency, please submit your report online through our online reporting system at https://childabuse.Illinois.gov.

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGMENT OF MANDATED REPORTER STATUS

I,_____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)

Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse and neglect Hotline number at 1.800.25.ABUSE (1.800.252.2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24 hours per day, seven days per week, 365 days per year.

I understand that in an effort to help mandated reporters understand their critical role in protecting children by recognizing and reporting child abuse/neglect, DCFS administers an online training course entitled Recognizing and Reporting Child Abuse: Training for Mandated Reporters, available 24 hours a day, seven days a week.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under, but not limited to, the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov

CANTS 22 Rev. 5/2019

Note: A written CANTS 4 will no longer be required after January 2025.

State of Illinois Department of Children and Family Services

WRITTEN CONFIRMATION OF SUSPECTED CHILD ABUSE/NEGLECT REPORT: MEDICAL PROFESSIONALS

NOTE: Hospitals and medical personnel engaged in examination, care and treatment of persons are required by the Abused and Neglected Child Reporting Act to report to the Illinois Department of Children and Family Services all suspected cases of child abuse or neglect. The Act provides that anyone participating in this report shall be presumed to be acting in good faith and in so doing shall be immune from liability, civil or criminal, that otherwise might be incurred or imposed.

Child's Name _____

Sex _____ Age _____

Address _____
Street *City* *Zip* *County*

Parent's/Custodian's Name _____

Address _____
Street *City* *Zip* *County*

Where first seen _____ Date _____

Brought in by _____ Relationship _____

Nature of child's condition:

Evidence of previous suspected abuse(s)/neglect:

Reporter's immediate plan for child including whereabouts:

Remarks:

PERSON PRESUMED TO HAVE ABUSED/NEGLECTED CHILD:

☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Sibling ☐ Other _____

PERSON MAKING REPORT

Name *(please print)*	**CHECK APPROPRIATE BOX** ☐ Attending Physician ☐ Surgeon ☐ Hospital Administrator ☐ Medical Examiner ☐ Coroner ☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Dentist ☐ Osteopath ☐ Podiatrist ☐ Chiropractor ☐ Christian Science Practitioner ☐ Social Worker ☐ Social Services Administrator ☐ Registered Psychologist ☐ Psychiatrist ☐ Advanced Practice Nurse ☐ Other _____
Medical Facility	
Address	
Signature	Date

CANTS 4 10/00

INSTRUCTIONS

The Abused and Neglected Child Reporting Act states that any hospital, clinic or private facility to which a child comes or is brought suffering from injury, physical abuse or neglect apparently inflicted upon him, other than by accidental means, shall promptly report or cause reports to be made in accordance with provisions of the Act.

The report should be made immediately by telephone to the IDCFS Child Abuse Hotline (800.252.2873) and confirmed in writing via the U.S. Mail, postage prepaid, within 48 hours of the initial report.

This form is provided for the convenience of the hospital, clinic or private facility in making the written report. A form must be completed for each child.

Enter the full name of the child, sex, age and address. Give the first and last names of the parents or persons having custody of the child. If the address is the same as that of the child, indicate by "same."

Where first seen: Give the date the child was first seen; indicate if inpatient, clinic, emergency room, doctor's office or another specified place within the hospital, and by whom the child was brought in.

Nature of the child's condition and evidence of previous suspected abuse(s)/neglect: Self-explanatory.

Reporter's plan for child: Indicate whether child is to remain in the hospital and for how long, or be released and, if so, to whom. State any other pertinent information as to the plan.

Remarks: If a report was also made to a local law enforcement agency, state to which agency report was made. Include any additional information deemed appropriate to the case.

Give the name of the attending physician, name and address of the hospital, if report is from the hospital. Signature: The report is to be signed by the person making the report.

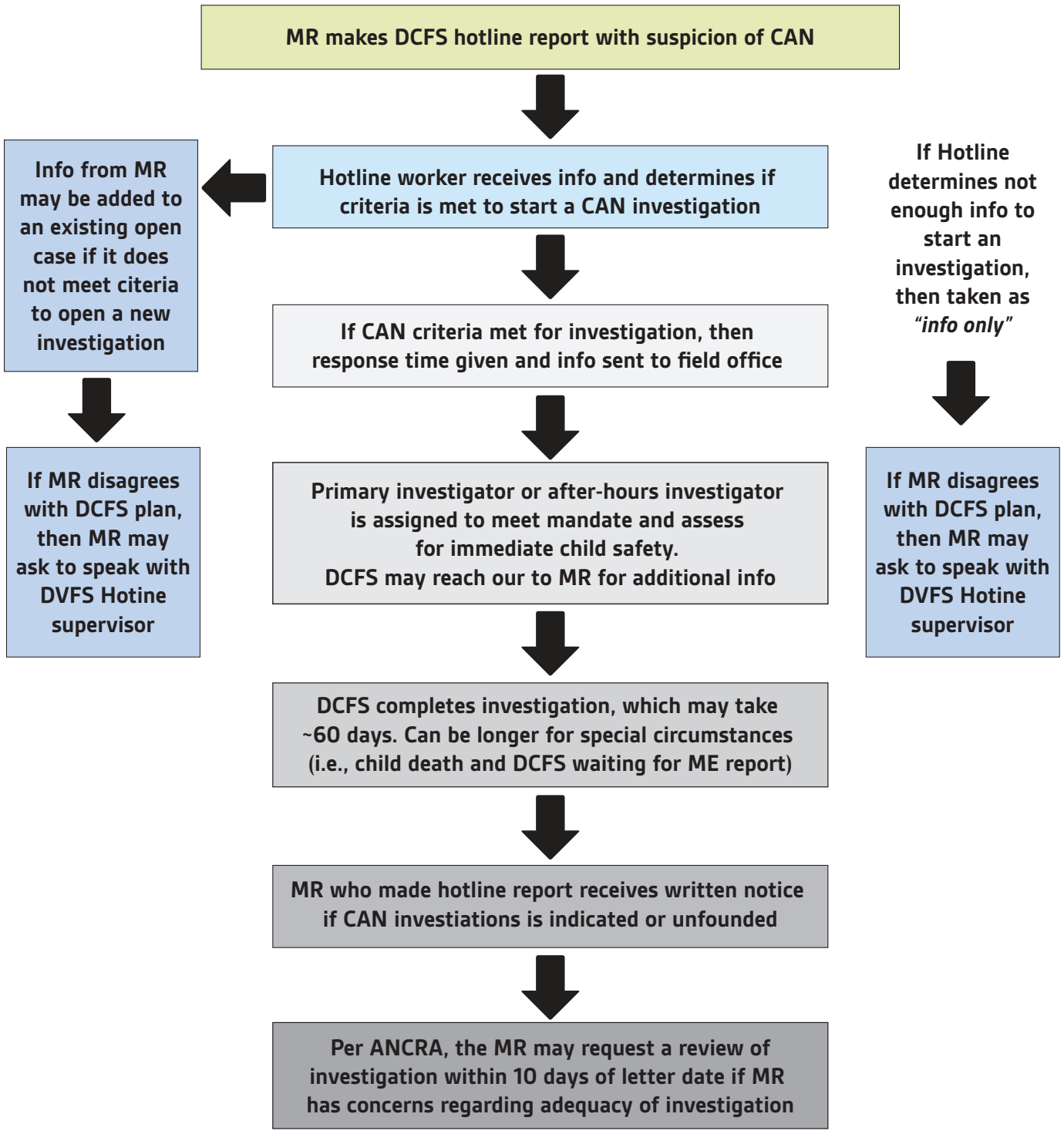
MAILING INSTRUCTIONS

Mail the original to the nearest office of the Illinois Department of Children and Family Services, Attention: Child Protective Services

DCFS is an equal opportunity employer
and prohibits unlawful discrimination
in all of its programs and/or services.

FIGURE 2

Life of a DCFS Call[3,4]



ANCRA: Abused and Neglected Children's Reporting Act
CAN: Child Abuse and Neglect
DCFS: Department of Children and Family Services
Info: Information
MR: Mandated Reporter
ME: Medical Examiner

Navigating ANCRA and SASETA as a Mandated Reporter

Important considerations *(Note: this is not legal advice. For a legal opinion or legal interpretation of the law, please consult an attorney.)*

Because sexual abuse/assault (SA) is child abuse, it is essential to know two Illinois State laws relevant in cases of SA: the Abused and Neglected Child Reporting Act (ANCRA) and the Sexual Assault Survivors Emergency Treatment Act (SASETA).

- ANCRA is an Illinois State law that aims to protect children from child abuse and neglect (CAN). Specifically, ANCRA defines CAN, dictates associated DCFS policies and procedures and provides directives for mandated reporters.[3]
- SASETA is the Illinois State law mandating medical forensic services available to survivors of sexual violence who present to an emergency department (ED) or other eligible sites.[7] Refer to Child Sexual Abuse/Assault (SA) (p.75).

It is usually possible to simultaneously meet the requirements of ANCRA and SASETA. However, complicated situations may arise in which these laws conflict. The "Mandated Reporter Clause" found on page two of the Illinois State Police Division of Forensic Service Patient Consent: Collect and Test Evidence or Collect and Hold Evidence" form[9] provides some language on the duty of a mandated reporter that must be explained prior to evidence collection for victims of emergent SA, but it does not explain the foremost responsibility of a mandated reporter to comply with ANCRA over SASETA. **In other words, ANCRA always supersedes SASETA — healthcare providers (HCPs) must always follow the rules of ANCRA while doing their best to meet the mandatory requirements of SASETA.** If HCPs find themselves in a unique situation where ANCRA and SASETA conflict, it is recommended they consult internal leaders such as ED leadership, legal services or risk management. Information might also be gained from collaboration with multidisciplinary partners, such as an expert in child sexual abuse (e.g., child abuse pediatrician), a SANE Coordinator and/or other pediatric experts.

> HCPs must carefully consider **both** ANCRA and SASETA when empowering, supporting and advocating for the child's safety. Due to the potential dire consequences associated with child maltreatment, the mandates of ANCRA supersede SASETA[3,7]

SASETA does not set forth an age threshold for consenting to the collection of evidence for lab analysis.[7] However, there is an age requirement (age 13 and above) for a child to consent to photo documentation and/or release of evidence to law enforcement (LE).[7] The Illinois State Police Division of Forensic Service consent form (e.g., Patient Consent: Collect and Test Evidence or Collect and Hold Evidence page addresses the age of consent[9], but contains two potentially problematic sections for a mandated reporter: Patient Label and Option C. The next section will further explain this predicament.

FIGURE 3

Excerpt from the Illinois State Police Division of Forensic Service, "Patient Consent: Collect and Test Evidence or Collect and Hold Evidence" form showing the Patient Label where a patient is given an option to be anonymous.[9] Refer to https://isp.illinois.gov/StaticFiles/docs/ForensicServices/6-003.pdf.

FIGURE 4

Excerpt from the Illinois State Police Division of Forensic Service, "Patient Consent: Collect and Test Evidence or Collect and Hold Evidence" form showing Option C, which allows the patient not to report to LE or participate in any investigation.[9] Refer to https://isp.illinois.gov/StaticFiles/docs/ForensicServices/6-003.pdf.

Non-Report & Hold: Option C Hold	___ At this time I am choosing **NOT TO REPORT TO LAW ENFORCEMENT OR PARTICIPATE** in any investigation. I consent only to the **collection and storage** of evidence at a law enforcement agency. I understand this means the evidence will NOT be submitted to a forensic lab for analysis. I understand I can change my mind, make a report to law enforcement and possibly have evidence analyzed at a forensic lab by contacting law enforcement or a rape crisis center at a later time. I under- stand law enforcement is only required to hold the evidence for a minimum of 10 years or until the 28th birthday of a patient under the age of 18. (See page 2 mandated reporter clause)

Sign here if patient or health care provider **report** selected

Initial here if **non-report** and hold selected

As shown in the above Figures 3 and 4, these choices allow for forensic evidence collection and storage and anonymity without moving forward with evidence analysis or a report to LE.[9]

- Anonymity is NOT a true option for minors (< 18 years old). Pursuant to ANCRA, child SA must be reported, even if the child does not consent to release of the Sexual Assault Evidence Collection Kit (SAECK) for analysis.[3]

Beyond the mandating reporting requirements of the medical professional, there are DCFS policies dictating LE notification. For example, allegations #19 Sexual Penetration and #20 Sexual Exploitation will automatically trigger a LE notification.[4] This makes Option C a moot point because LE will be notified (by DCFS) regardless to protect the child's safety. A patient's willingness to cooperate with LE is voluntary, regardless of age, but the notification of child abuse by a mandated reporter within ANCRA and other state laws is **NOT** voluntary. In addition to ANCRA, other city, county or state laws may dictate notifications to LE.

Providers cannot simultaneously meet their legal mandate with ANCRA (with an eligible perpetrator*) **AND** allow the patient to choose option C of "*Patient Consent: Collect and Test Evidence or Collect and Hold Evidence*" form to remain anonymous.[2,9]

*See p.14 for more information on types of caregivers DCFS will investigate.

Ethical and legal considerations may arise for children under the age of 13 when parent/guardian consent is needed for photographic evidence, reporting decision and evidence analysis as described on the Illinois State Police consent forms. This may occur when a parent/legal guardian:

- Is also the named perpetrator of SA; the guardian may decline consent to avoid being implicated in a crime
- Refuses to provide consent when a child discloses SA because the perpetrator is the parent's paramour, relative or friend
- Is reliant/dependent on a perpetrator to provide basic human needs (e.g., shelter, food, clothing, employment)

Due to challenging situations like these, ED HCPs need to become familiar with ANCRA and SASETA.

The next TWO pages offer FOUR different patient scenarios with strategies to meet both ANCRA and SASETA.

SCENARIO 1:

A sibling group arrives to the ED with their concerned grandmother after they made an SA disclosure about their father two days ago. The father is their only legal guardian since their mother is deceased.

Potential problems: In this scenario, the consenting guardian (father) is also the named perpetrator. Will the father sign consent to medical forensic services including a sexual assault evidence collection kit? If not, is he doing it in his own interest as the accused and not in the best interest of his children? If the father were in the ED, would the children be safe in his presence, or could they be at risk of coaching, intimidation and/or perpetration?

Solutions/Next steps: Notify DCFS immediately. Allow them to decide on (1) the child(ren's) safety including which adult(s) can be present in the ED, and (2) where the child(ren) will go after leaving the ED. In this scenario, if the father is agreeable to evidence collection, obtain medical consent using a hospital approved interpreter with two witnesses.

SCENARIO 2:

A father brings his 9-year-old child to the ED for a medical issue (not SA). During the history and physical, the child spontaneously discloses chronic sexual abuse by her paternal grandfather. The child and her immediate family (dad, mother, siblings) have been living with the paternal grandfather for the last eight months since the child's father has been out of work.

Potential problems: In this scenario, the named perpetrator is the guardian's relative and the family's source of financial/housing support. Will the father be hesitant to consent to evidence collection? Will family allegiances or family guilt impede medical forensic care? Are any other children living in this home also victims of SA?

Solutions/Next steps: (1) Collaborate with DCFS, social work or victim advocates on emergency shelter for the family; (2) Work with DCFS/LE to address the safety of other child contacts (e.g., siblings); and (3) discuss any medical/forensic needs of child contacts with parents and the medical team. Also consider that the father may be able to talk to DCFS/LE about Emergency Order of Protection options on behalf of his child(ren).

SCENARIO 3:

A 15-year-old boy arrives to the ED and disclosed that his coach sexually abused him three days ago at an out-of-state away game. The parents want evidence collection and want the teenager to speak directly to LE. The teenager prefers "Non-Report and Hold: Option C Hold" after reading the Illinois State Police Division of Forensic Service consent form.

Potential problems: Because the patient is ≥ 13 years of age, he is the one who must consent to evidence collection. A school coach is an eligible DCFS perpetrator, and the HCP must notify DCFS. Due to the nature of the DCFS allegation, LE will be notified from the DCFS hotline. The teenager cannot choose to be anonymous as DCFS (and in turn, LE) will be notified of the allegation. Also, since the incident occurred in a different state, this presents an additional dilemma of how LE will be notified.

Solutions/Next steps: Let the patient know that the mandated reporting requirement will negate his option to be anonymous. However, he may realistically choose among the following: (1) no evidence collection, (2) evidence is collected and tested, or (3) evidence is collected but not tested. The teenager does not have to talk to LE and/or if he chooses the HCP may speak to LE on his behalf. In this scenario, the teenager still has some decision-making and power, even with the HCP following ANCRA mandates. Although the SA event occurred out-of-state, local LE can be called to complete the police report because under SASETA guidelines, local LE will transfer the report to the jurisdiction where the incident occurred.

SCENARIO 4:

A 17-year-old female is brought to the ED by her parents after concerning text messages and nude photos were found on the patient's school tablet. The messages and photos were between the patient and one of her teachers. The messages alluded to sexual activity, with last known contact yesterday. When the physician assistant/medical social worker met with the patient, the patient reported learning in health class that the age of consent in Illinois was 17. This is also why her teacher told her their sexual relationship was legal.

Potential problems: With the age of consent in Illinois being 17, should this patient be offered a SAECK if the patient is reporting a consensual relationship? Is this a criminal or child protection matter requiring involvement from LE/DCFS, because parents are worried after finding the sexual message/photos?

Solutions/Next steps: In general, the age of consent in Illinois is 17 and older, but this does not apply when a "person responsible for the child's welfare," aka authority figure, is involved (teacher, coach, etc.). In the situation described, the age of consent is 18. This nuance in the law is to ensure that people with authority do not take advantage of their position in power over young people and engage in sexual relationships. Also, the adult receiving nude photos from the patient would qualify as child sexual abuse material (CSAM), mandated reporting laws should be followed and the patient should be offered medical forensic services according to SASETA. Since the patient is at least 13 years old, she can accept/decline medical forensic services, but she cannot decline the mandated reporter's duty to report to DCFS.

Illinois Emergency Medical Services For Children (EMSC)

A key program pediatric initiative for EMS resource and participating hospitals

ILLINOIS EMSC PEDIATRIC FACILITY RECOGNITION REQUIREMENTS

- **Emergency Department Approved for Pediatrics (EDAP) and Standby Emergency Department Approved for Pediatrics (SEDP)** requirements:
  - Have policies and procedures addressing the child with suspected child abuse and neglect (CAN) that include identification, evaluation, treatment and referral of victims to DCFS accordance with state law[10]
  - Monitor quality indicators that address care of all children with concerns for CAN[10]
  - Have established transfer agreements that address communication and quality improvement measures between the referral and receiving hospitals as related to patient stabilization, treatment prior to and subsequent to transfer and patient outcomes[10]
- **Pediatric Critical Care Center (PCCC) facility recognition criteria**
  Include the above EDAP requirements, and additionally require that a multidisciplinary pediatric quality improvement committee or alternate hospital committee review all CAN cases.[10]

EMS REQUIREMENTS

Considerations for hospital polices include the following:

- EMS providers are accountable to their EMS system standing medical orders related to suspected CAN and are expected to include:[11]
  - Description of the prehospital provider's responsibility as a mandated reporter and directions for responding to parent/caregiver refusal to allow transport[11]
  - Established pediatric prehospital child maltreatment protocols[11]

RESOURCES, LAWS AND RULES, AND PUBLICATIONS

This webpage also provides additional links (e.g., free pediatric educational modules as well as gudelines and resources). Refer to weblink below.[12]

- https://dph.illinois.gov/topics-services/emergency-preparedness-response/ems/emsc.html

This other website provides direct access to the Illinois EMS for Children Educational Modules that provide free CE credit for prehospital providers, nurses, advanced practice providers, and physicians. This free site does require users to register and create a password.

- https://www.publichealthlearning.com/course/

Federal performance measure

NATIONAL PEDIATRIC READINESS PROJECT

This is a federal initiative to ensure EDs have pediatric-specific champions, competencies, policies, equipment and other resources needed to provide high-quality emergency care for children.[13] The project is led by the Federal EMSC Program in partnership with the American Academy of Pediatrics, the American College of Emergency Physicians and the Emergency Nurses Association.[13] The National Pediatric Readiness Project offers free and open-access assessment opportunities as well as resources to address gaps.[13]

- https://emscimprovement.center/domains/pediatric-readiness/

Trauma-Informed Care

Trauma-informed care (TIC) is an organized approach for addressing the overall wellness and emotional safety of patients while proactively preventing undue stress and harm. TIC can be applied to all patients.[5] Anyone (e.g., prehospital, emergency department (ED) staff, security officers, housekeeping, etc.) may readily put into practice trauma-informed principles; hospital leadership can demonstrate support by becoming a trauma-informed organization.[14] Described below are steps to apply strengths-based TIC to any ED pediatric patient having concerns for child maltreatment.

What is trauma?

Trauma has been defined as *"a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing."*[14]

Traumatic events may include some of the following: child maltreatment, intimate partner violence (IPV), divorce, death of loved one (e.g., family, peer, pet), bullying, caregiver having psychosocial risk factor(s), foster care, chronic medical illness or repeated painful medical procedures, effects of poverty (e.g., housing instability, food insecurity, etc.), community violence, immigrant/refugee status, discrimination, systemic racism and natural or man-made disasters.

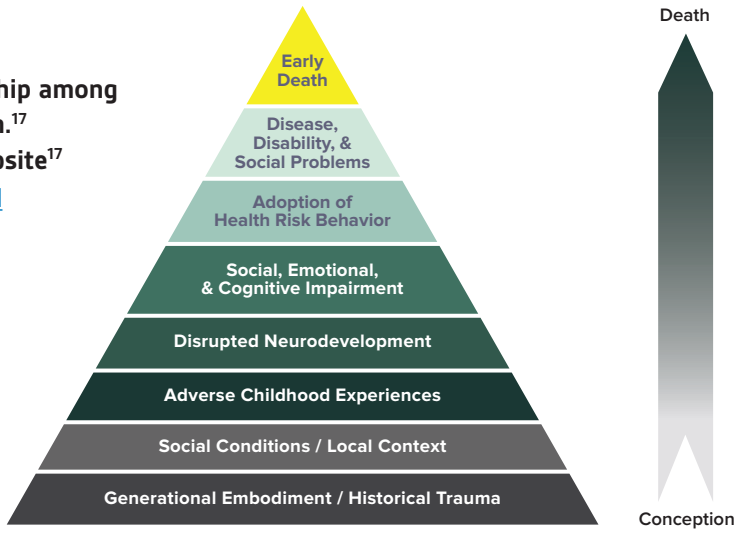
Trauma-informed approach (four Rs)

Realizing the scope and consequences of child maltreatment is a beginning step in becoming trauma-informed for this population group. The beginning of this toolkit describes the incidence and prevalence of child maltreatment. After a child experiences one or more traumatic events, these adverse childhood experiences (ACEs) may negatively impact a child's entire life (e.g., neurodevelopment, emotional impairment, adoption of risky healthy behaviors, social problems, even early death).[15-17]

The biology of trauma is how the brain perceives and reacts to a traumatic event. Recall the fight, flight or freeze response and the complex interplay of the limbic system, neurotransmitters and hypothalamic-pituitary-adrenal axis.[18,19] Then, consider how a child's brain is continuing to form into early adulthood. Biological changes stemming from these factors may lead to poor growth and development, inadequate sleep, mental illness, substance abuse and ongoing cycles of abuse/neglect throughout adulthood.[15-20] Furthermore, the potential toxic effects of stress may affect a child's brain growth, with epigenetic changes to DNA structure.[18,19] Currently, researchers are examining biomarkers to learn more about this phenomenon in children.

FIGURE 5

The figure on the right illustrates the relationship among ACEs to disease, disability and even early death.[17] This figure is further explained on the CDC website[17] at cdc.gov/violenceprevention/aces/about.html



Mechanism by which Adverse Childhood Experiences Influence Health and Well-Being Throughout the Lifespan

Recognizing signs and symptoms of child maltreatment or the traumatic aftermath is not always an easy task. **Although recommendations exist explaining signs and symptoms of trauma, some children will not experience any.**[21] Listed below are some challenges that can make recognizing trauma in children difficult.

- "Children are not little adults" is a commonly coined phrase which implies children have unique needs (e.g., physiological, developmental, psychosocial and legal), making them especially vulnerable to abuse, neglect and exploitation. Here is one example: A 4-month-old victim of abusive head trauma cannot flee from an abusive situation, understand their abusive situation or verbalize being a victim of abuse.
- Some children may not have any visible signs of abuse. For example, children who have been sexually abused commonly do not have any visible anogenital injuries.[20] Combine this with a child not displaying any behavioral changes, then neither physical nor behavioral changes are apparent.
- Children are reliant on adults to meet their basic needs and to keep them safe, which may prevent them from seeking or asking for help. In fact, a child or youth may have difficulty being upfront and honest when being questioned if they fear repercussions from their caregivers or retaliation from their perpetrator. Consider the complexities of a 12-year-old male patient presenting to the ED with suicidal thoughts. The patient may have been provoked after being sexually exploited by an adult (pretending to be someone else) they met online; the adult perpetrator is now threatening to distribute sexual images of the patient.

Response includes the proactive TIC steps taken by ED staff when caring for children having concerns for child maltreatment. Being an effective TIC clinician is an ongoing professional pursuit where one puts the health and emotional safety needs of the child first. The aim is to deliver trauma-informed, rights-based and culturally appropriate care to all patients seeking care in the ED.[5] Refer to Table 4 on p.28 for examples.

Trauma-informed care is a paradigm shift from thinking "what is wrong with you?" to "what happened to you?"[19,22]
Taking it to the next step is adding "what is strong with you?"[22]

Revictimization of patients must be prevented. Revictimization occurs when an action or lack of action has occurred, provoking a situation that replicates a prior traumatic experience, thereby causing further undue stress and potential harm to the patient.[5,14] One example includes when a perpetrator grooms and bribes a child with food and gifts; then later, a healthcare worker (HCW) bribes the child with food or a toy to elicit their cooperation during the physical exam. The next example demonstrates the need for a HCW to be unbiased and non-judgmental. Consider the needs of a 15-year-old girl who is blaming herself for being sexually assaulted after sneaking out of her house to attend a friend's party where alcohol is present. The victim of an SA is not the individual at fault. Shaming a patient for any traumatic event may further isolate them from seeking help and may even perpetuate further abuse or harm.[5,23]

Revictimization also applies to those who provide care (directly or indirectly) to children having concerns for maltreatment. Organizational support aimed at promoting self-care builds resilient healthcare team members.[5,19,20] Such strategies may include allowances and provisions for (1) informal peer support groups to formalized ones; (2) leadership to model ideal trauma-informed behaviors; (3) ongoing educational training programs for TIC; (4) personal health and wellness activities (e.g., counseling, exercise and acupressure); and (5) collaborative dialogue between management and staff for promoting healthy work-life balance.[20] Regardless, a HCW should not delay the independent pursuit of self-care activities, while waiting for organizational buy-in.[20]

Principles of trauma-informed care

The guiding principles of trauma-informed care (e.g., safety, privacy, respect) continue to evolve to assure trauma-informed, rights-based and culturally appropriate care.[5] How we respond in implementing these TIC principles will depend on the age and development of the child or youth.

TABLE 4

EXAMPLES OF TRAUMA-INFORMED, RIGHTS-BASED AND CULTURALLY-APPROPRIATE CARE FOR PATIENTS SEEKING CARE IN THE ED	
Safety and trust[5]	• Ensure a safe environment without offender access[5,19,22-25] • Build rapport[5,22,23,25] that neither blames[5,19,25] nor shames[5,25] • Determine the reason for the ED visit and promptly address chief complaints[5] • Ensure the child (per age/developmental level) knows the reason for their ED visit and concerns for abuse • Do not ask sensitive questions in front of family, visitors or companions • Provide basic comfort needs (e.g., warm blanket, quiet space)[5,25] • Offer a Rape Victim Advocate for a patient having concerns for acute SA[23-25] • If available, consult a Child Life Specialist • Limit the number of patient hand-offs • Screen for suicide, self-harm or intent to harm others[19] • If patient is appropriate to question, but uncomfortable speaking alone, then obtain a hospital chaperone[5] • Do not make promises you can't keep
Privacy and confidentiality[5]	• Do not leave the patient in the waiting room; provide timely access to provider[23-25] • Provide privacy[22-24] (e.g., signage outside of door) and limit interruptions[5] • Protect the identity of the patient from visitors as well as staff not responsible for the patient's care (e.g., visitor restrictions, computer safeguards)[25] • Offer confidentiality[12,22,24] but explain its limits (mandated reporting, charting, etc.)[5,25]
Respect[5]	• Be calm[19,25], nonjudgmental[5,19, 23-25], empathetic[5, 19, 24, 25] • Actively listen[18], be patient, do not rush or appear rushed[5,25] • Sit at or below the patient's level[5,25] and do not hover over the patient or block line of exit[22] • Validate the patient's feelings[5-25] • Openly acknowledge the patient's coping strengths and resilient behaviors[5,19,22,25] • At shift change, previous provider should introduce provider taking over care of patient
Transparency[5]	• Explain your role[5,25]; show your ID badge. Reassure best efforts in keeping them safe[25] and healthy • Provide anticipatory guidance[5,19,22,25] by explaining next steps concretely and describing sensory experiences they may hear, feel, etc.[25]
Empowerment and collaboration[5]	• Offer appropriate choices that the patient can make[5,19,22,25] • Address any questions or concerns[5,25] • Seek out the patient's and caregiver's (e.g., family) goals for the ED visit[5] • Encourage shared decision-making[5,22,25] • Obtain assent and informed consent as appropriate[5,23,25] • Prior to sharing info with the patient's primary care provider, obtain consent from the patient or caregiver
Sensitivity to culture, gender and historical issues including systemic racism and discrimination[5]	• Use hospital-approved medical interpreters (not family, visitors, etc.)[5,23,25] • Consider your own bias[5,19,25] • Avoid assumptions about gender identity or sexual orientation[5,25] • Consider race, gender and other social factors of patient, perpetrator and staff providing care to patient[19] (if possible, allow patient to choose staff of preferred race or gender)[5,25]
Minimize traumatization (revictimization)[5]	• Do not label or judge the patient[5,19,24,25] • Minimize the patient having to provide repeat histories[22,25]; only ask questions necessary for medical treatment[5] • Monitor for signs of physical or emotional distress[5,25]; offer breaks[5] • Avoid conditions that may mimic the child's abusive situation[5,19,22] • Minimize trauma to staff[5,19,24,25]

Emotionally Safe and Trauma-informed Pediatric Support for Exam Cooperation

The option to have a support person (a non-offending person) during the exam process promotes the decrease of traumatization, therefore increasing a patient's willingness to engage with clinicians.

In addition to a patient's caregiver or a victim advocate, Certified Child Life Specialists (CCLS) can provide support before, during and after the exam process. CCLSs receive specialized training to address the needs of child abuse victims and their caregivers. CCLSs are clinically-trained professionals who are college educated in child development to help patients and families cope with the stress and uncertainty of illness, injury, disability and hospitalization. CCLSs commonly work in hospital pediatric programs, collaborating with the multidisciplinary team to ensure each patient's emotional safety is prioritized at the same level of physical safety.

Depending on the hospital, child life services may not be available. Clinicians may be the only supporting role to children and/or caregivers during their visit.

Patient's communication skills, attention and tolerance for interacting with medical providers may quickly deteriorate if they are feeling traumatized, tired, apprehensive, anxious, irritable, hungry, thirsty, distracted, uncomfortable, judged, or if they perceive their concerns are being minimized. For each child, consider what measures might aid in sustaining optimal communication throughout the exam process. Acknowledge any apprehension the child has about the exam process and discuss what would help them be more comfortable.

Meeting the patient

- **Introduce yourself.** Sit or squat to be at eye level with the patient. Communicate with patients in their preferred language. Address patients by their preferred name and pronouns. Speak with the child's caregiver about additional support they may need (i.e., sensory needs, triggers).
- **Communicate.** Let the patient know why you are there and what you plan to do. Use "one voice" by designating one person to ask questions and give instructions. Multiple people speaking at once can be overwhelming and confusing. Utilizing safe and honest language can help develop a trusting relationship in a highly sensitive exam. Based on the age of the patient, different word choices may be appropriate. Explain each step by describing sensory experiences (i.e., what patients will see, hear, feel).
- **Build rapport.** Children respond best to adults they trust. Building rapport takes time; be friendly and patient. Ask caregivers for help connecting with patients.

Before the forensic exam

- **Provide preparation.** Preparation materials open the opportunity for the patient to feel more comfortable asking questions and seeking information related to the exam. Preparation materials can include photos of the room where the exam will be completed, the positions that the patient will be asked to assume and the swabs or other items that will be used to collect evidence. If time allows and it is appropriate for the patient, a doll or stuffed animal can be utilized to help demonstrate the positions and swabbing or clinicians can practice the positions with the patient in non-threatening environment.
- **Ask if the patient has questions.** Provide honest and developmentally-appropriate answers. If you don't know the answer, say that. Find someone who does and follow up.
- **Offer alternative focus.** Children cope and communicate through play. Allow patients the opportunity to engage in play while you examine them. If a child does not want to engage in alternative focus, respect their choice.

- **Offer comfort positioning.** Patients may feel more comfortable and be more cooperative sitting in their caregiver's lap.
- **Use open-ended questions.** Allows a patient to provide more detailed information. Be patient and listen, provide clarification if a child seems confused. Allow the child to tell the entire story before asking clarifying questions; moments of silence are okay.

During the exam

- **Provide appropriate choices.** "Would you like to do_____ or _____ first?" "Could you help me by _____ ?" This provides children with a sense of control over their environment and a clear role during the exam process. Only ask a child yes or no questions if they have the option to say no.
- **Provide patients with concrete information,** be specific with the task. Young children are not able to cognitively understand abstract ideas. Instead of saying, "relax," say "please place your hands on your lap."
- **Provide reassurance and praise.** "You are doing a great job." "You are a great listener."

After the exam

- **Provide patients with clear next steps.**
- **Ask patients if they have any questions.** Provide honest and developmentally-appropriate answers.
- **Provide patients with appropriate choices.** Allow the patient to change back into their clothes, have something to eat and drink, and re-engage in play if they would like.
- **Allow patient space with their caregiver to aid in coping.**

Additional

- Provide the type of care preferred by each child. Our goal as clinicians should always be family centered and trauma-informed to provide emotionally-safe care. Avoiding re-traumatization should be prioritized above evidence collection.
- Consent and assent must be clearly communicated in a developmentally-appropriate way to each child. Do not touch the child without permission.
- Avoid verbal and body language that conveys that you are blaming the child, judging or disbelieving their abuse.
- Avoid making assumptions about how the child feels about the perpetrator; do not talk disparagingly about the perpetrator.
- Commenting about a patient's body can be extremely triggering for anyone who has experienced abuse. Make sure to limit comments about the child's body to information about their medical diagnosis; for example, "your body looks healthy."
- Recognize that everyone has biases that can negatively impact their ability to provide high-quality care for all children. Consider how historical oppression (racism, sexism, ableism, audism, classism, homophobia, religious persecution, etc.) can impact care provided and identify approaches to create conditions that are most just for all children served.

Developmental Milestones

Although children grow and develop at varying rates, most children fall within a typical range of developmental milestones. Understanding pediatric developmental milestones to recognize suspicious findings and children at risk allows clinicians to intervene promptly and appropriately. Additionally, the increased risk for abuse and/or neglect to a child with a developmental disability or delay may be overlooked without a fundamental knowledge of child development.

When abuse or neglect is suspected, follow your organization's child maltreatment policies/procedures (e.g., mandated reporting). For a child with a developmental delay, who may be at higher risk of abuse/neglect, refer the parent/caregiver to the hospital social worker (when applicable).

TABLE 5

HIGHLIGHTS OF DEVELOPMENT MILESTONES FOR CHILDREN LESS THAN 5 YEARS OLD[26-28]

AGE	MOTOR MOVEMENT AND OTHER CONSIDERATIONS
2 mos.	• Holds head up briefly when in prone position • Social smile • Calms down when spoken to or picked up • May have periods of crying from 2 wks. to 4 mos.
4 mos.	• Holds head steady without support when held • Pushes up onto elbows/forearms when prone • Beginning to roll over • Places objects in mouth • Swipe at objects
6 mos.	• Rolls from front to back • Stranger anxiety • Beginning to crawl • Sits independently, leaning/using hands for support • Begins babbling "mama" or "dada"
9 mos.	• Sits without support • Has one word with specific reference • Experiences separation anxiety and may cling to parents
12 mos.	• Effective pincer grasp • Begins to show "no" behavior • Walks holding onto furniture or holding someone's hand • Turns head to own name • Pulls self to stand
18 mos.	• Drinks from cup with little spilling • Walks independently • Climbs into a chair without help • May or may not show interest in toilet training • Names a few pictures, 10 words
24 mos.	• Turns a doorknob • Strings two words together • May perceive bladder fullness • Can place small objects in a small opening • Better at removing simple clothing than dressing • May display discomfort when wearing a soiled diaper • Understands two-step command • Temper tantrums
30 mos.	• Twists jar lids and doorknobs using two hands • Stands on stool to reach things
36 mos.	• Washes and dries hands • Rides a tricycle • Walks upstairs alternating both feet • Runs and jumps • Imaginative play and magical thinking • Speaks in sentences of three words • Asks questions • Dresses and undresses self except for buttons and laces • Will state age when asked • Holds urine for two to four hours at a time • Indicates when needs to use the bathroom • Knows difference between urination and defecation
48 mos.	• Pull up a zipper • Can hop on one foot • Dresses themselves • Knows difference between fantasy and reality • Daytime voluntary control of bowel and bladder • Runs smoothly • Walks downstairs alone • Believes their thoughts can make something happen • Anticipates needs to urinate or defecate • Developing nighttime control of bowel "and bladder • Still needs assistance with toileting (e.g., wiping)

There are many great resources to learn about developmental milestones. The CDC website provides developmental milestone handouts appropriate for healthcare professionals and parents/caregivers. Refer to this website for further information: cdc.gov/ncbddd/actearly/milestones/index.html

Caregiver's Psychosocial Risk Factors

Effectively addressing a caregiver's (e.g., parent, legal guardian) psychosocial risk factors (PRF) may prevent irreparable harm to children, including death.[29] One study found prior child protection involvement in 85% of their fatal and near-fatal child physical abuses cases, and the most common psychosocial risk factor was a caregiver's positive criminal history.[29] Therefore, do not ignore key PRF which includes some of the following: parental criminal history, intimate partner violence (IPV), gun access, prior child protection involvement, child labeled with negative attributes and a caregiver with history of (untreated) mental illness or substance use.[29] Although the presence of PRF is not diagnostic of child maltreatment, it can increase a child's risk for harm due to potentially unsafe environments or situations. Therefore, a primary prevention strategy against child maltreatment is identifying and empathetically responding to a caregiver having PRF.[29-33]

Further explanation of IPV/DV being psychosocial risk factors

- Studies have explored the dangers of children being exposed to IPV or domestic violence (DV). IPV occurs among current or former partners and may involve stalking, physical or sexual violence and/or psychological aggression.[30] In Illinois, DV legally includes: (1) blood-related family members, (2) current or former partners, (3) people sharing a common dwelling, (4) people having a child in common, and/or (5) people with disabilities including their personal assistants.[34]
- DV households have higher rates of child abuse, when compared to those without DV, as much as two times higher.[35] Children are at risk of physical harm both prenatally and postnatally when exposed to DV.[31] Children less than 2 years of age were often injured by the abuser of DV, when the child was being held in a non-abuser's arms.[33] In homes where there is DV, other forms of violence may be present too.[31]
- The combination of adult IPV and access to guns is a deadly mix for children.[30,32,33] Children are known and frequent corollary victims to IPV.[30,32,33] During IPV homicidal situations involving children, more often the perpetrator is an adult male who either kills the child(ren) very likely with a gun in an attempt/completion of murdering the child's mother, or the perpetrator kills the child(ren) prior to committing suicide.[30,32,33] The place of death is often the child's home.[30,32,33] Triggers for parental intimate partner conflict include break-ups, marital separation, divorce or custody issues,[30,33] and these provoking situations may incite feelings of anger, rage and jealously in an abuser.[30]

Interventions and resources

Screening for violence offers an opportunity to intervene and provide resources for keeping the parent/caregiver safe, thereby keeping the child(ren) safe too. It is common even for women in abusive families to seek medical care for their children.[31] Therefore, it is crucial to have advance planning prior to caring for these children and their families.

- Follow hospital protocols and mandated reporting laws when identifying an immediate safety concern (e.g., chronic DV in the home, child witnessing IPV, caregiver's mental health interfering with meeting a child's basic health needs). Offer the **24-hour State of Illinois Domestic Violence Help Line (877.863.6338)** to access trained staff who can provide critical information and assistance about shelters, legal advocacy-including how to obtain an Order of Protection, counseling, and healthcare centers; post this information thoughtfully in the emergency department (ED).[31]
- Recognize that a caregiver may not be ready to leave the abuser and there are many barriers for individuals who want to leave their abusive partner.
- Discuss the potential lethal consequences of living in a household with access to guns, especially in households where IPV exists.[30] This conversation should occur, regardless if the caregiver decides to stay within an abusive relationship.
- Other resources that may be of help include local food pantries, diaper banks, local substance abuse resources and your local Illinois Department of Human Services (DHS), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Women-Infants-and-Children (WIC).

SAMPLE SCREENING QUESTION TIPS

- Questions should be asked in private (not in the presence of the patient, other children or visitors).
- Take your time; this is a conversation, not a checklist.
- Use open-ended phrasing when you can such as, "Tell me more about that."
- Be transparent in limits of confidentiality about your duty as a mandated reporter.

TABLE 6

EXAMPLES OF A PSYCHOSOCIAL ASSESSMENT SCREENING TOOL

- Do you feel safe in your relationship?
- How do you and your partner resolve conflict?
- Has there ever been a time where your partner used physical violence against you? Has your partner ever hit you… kicked you…slapped you…or choked/strangled you?
- Does your partner have access to guns or a firearm?
- Has your partner ever made threats against you? Have the threats ever included a firearm?
- Tell me more about firearms and the access to firearms in the home. (Example: Are they locked up? Do the children know how to get to them?)
- How do you feel right now?
- Do you feel like you want to hurt yourself or harm yourself?
- Do you have any thoughts of wanting to hurt or kill other people?
- Do you or anyone who cares for your child have any mental health diagnosis? By that I mean, has anyone ever been diagnosed with depression, anxiety, bipolar disorder or schizophrenia?
- Do you drink alcohol or use drugs? Do you feel that you have a problem with overusing substances?
- Is there anyone that cares for your child that you think drinks too much? Smokes too much weed or takes THC edibles? Take pills not prescribed to them?
- Do you know what the Department of Children and Family Services (DCFS) is?
- Have they ever been involved with you before as a parent?
- (If yes) tell me more about their involvement with your family.
- When you were a child, was DCFS ever involved with your parents, or did anyone ever worry that you were being abused or neglected?
- Have the police ever come to your home?
- Have the police ever been involved with anyone who cares for your child due to a violent crime (e.g., child abuse, sexual violence, domestic battery)?
- When you're having a really bad day, who are your support systems or support people?

Medical History-Taking from Children

Medical history-taking is different than a forensic interview

It is very important to understand that a medical history is different than a forensic interview (FI). A FI is completed by a trained forensic interviewer who is part of a multidisciplinary team working at a children's advocacy center (CAC). Emergency department (ED) clinicians should never attempt to perform a FI since it is beyond their scope of training and may compromise the true FI and any associated child protection or criminal investigations.

When it is developmentally appropriate, an ED clinician may ask the child questions to help guide medical decision-making. Verbal children may relay information that allows providers to understand the child's environment, potential safety threats and medical concerns. Importantly, when a child does not yet have established verbal skills or comprehension skills, the child should not be questioned.

Asking children questions in an ED requires a different approach than when speaking with adults. First, a child's comfort should be prioritized, and questions should be conversational following the child's lead. The approach will vary depending on the child's age and developmental abilities to ensure a provider's language is meeting the child's comprehension level. Therefore, it is important to gather developmental information about the child from the caregiver before attempting to speak with the patient.

If you learn that the child is chronologically/developmentally younger than 10 years, it is best to avoid any abstract questioning (e.g., "when" questions), because young children are concrete thinkers and may not understand the concept of time or episodic details. Additionally, remember that trauma affects how events are coded, retained and retrieved.

If the patient already has known concerns for sexual abuse/assault (SA), then avoid questioning the child altogether and defer this to a qualified medical provider (QMP); for example, the child made a disclosure to their mother prompting them to seek care in the ED. Refer to Determining The Need to Transfer When There are Concerns for Child Sexual Abuse/Assault algorithm on p.93.

Essential considerations

- If English is not the child's preferred language, use a hospital approved interpreter
- Ask the child questions **in private without** any family, friends or visitors present
  - This helps ensure that the child's narrative will not be influenced by others and promotes a safe environment to potentially make a disclosure
  - If the child will not separate from the caregiver, or if the caregiver declines to allow a private conversation, then a discussion with the child should NOT be pursued
- Introduce yourself and your role
- If developmentally appropriate, inform the patient about the rules of and exceptions to confidentiality
- Use open-ended questions (e.g., "tell me more about that") rather than closed-ended or leading questions
- Use words that match the child's developmental level
- Clarify any words the child uses that are not clear; do not make any assumptions about what the child means
- Direct quotes by the clinician and the patient are preferred
- Use a trauma-informed approach (refer to p.26)
  - Position yourself so you are seated at eye level
  - Actively listen to the patient following the patient's lead

- Be thoughtful about the number of people in the room
- If available or already present, let the patient know they can choose to keep the Child Life Specialist at the bedside for support
- Avoid questioning the child multiple times; if more than one clinician needs to obtain the history from the child (e.g., social worker, nurse, physician, sexual assault nurse examiner), they can obtain the history together from the patient
  - Sometimes repeating a traumatic experience causes a patient to relive it (re- victimization), which should be avoided

- It is natural for a child to want to protect his/her caregiver, even if the caregiver is the named perpetrator
- Disclosure of abuse and/or neglect is usually a process rather than a one-time event

Listed below are some documentation examples of a good history of what specific questions were asked by the clinician and what the patient's responses were.

SCENARIO 1

A 5-year-old female patient was referred to the ED after her primary care provider (PCP) noted redness and bruising to the patient's genitourinary (GU) area during a sick visit for hematuria. The parent reports that the child has begun learning how to ride a bike without training wheels. The parent denies any concerns for abuse.

With the mother's consent, the ED NP and SW met with the child privately. No one else was present during this interview.

SW: "Tell me why your mom brought you to the doctor today."

Patient: "There was blood when I went pee, it was really scary. It really hurts down there."

SW: "I hear you, it was scary. When you say it hurts 'down there' what do you mean by that?"

Patient: "It hurts down where I pee, in my gina. But it's ok, I know what happened."

SW: "Okay, what happened?"

Patient: "I am riding my bike all by myself! It's so fun, but kind of scary. I was riding my bike and I hurt myself."

SW: "Tell me more about that."

Patient: "I don't have training wheels anymore. I was trying to get the pedals to move. I was standing up to use my whole body to push the wheels. I slipped and I fell on the bike, right on my gina. It really hurt. And then next time I went pee, I saw some blood and told mommy."

In the above scenario, a brief conversation with the child was helpful in determining if the mechanism of injury is consistent with patient's history and physical examination. Because: (1) The patient made a spontaneous disclosure of an accidental injury and did not disclose abuse, and (2) The mother does not have any concerns of abuse. The child's narrative of what happened suggests that her injuries are consistent with a straddle injury rather than abuse.

SCENARIO 2

The patient's mother was questioned alone by the ED RN and MD with use of the hospital Spanish interpreter #12345. The patient was not interviewed in anticipation of transfer to a pediatric treatment hospital.

RN: "What happened that brought you and your child to the emergency department today?"

Patient's mother: "I am worried someone is abusing my daughter."

RN: "What makes you concerned that someone is abusing your daughter?"

Patient's mother: "Because last night when getting her ready for bed, she told me 'Pappa touched my cookie bad.' Cookie is the word we use for her private areas."

RN: "What do you mean when you say, 'private areas'?"

Patient's mother: "We use 'cookie' for her vagina and 'butt' for her butt."

RN: "The patient mentioned the name Pappa. Tell me who in the patient's life is referred to by that name?"

Patient's mother: "Pappa is my mother's boyfriend. My daughter spends the night at my mother's house on the weekends, while I work. And today, I picked her up this morning."

RN: "Are you worried that your daughter is having any injuries, bleeding or pain?"

Patient's mother: "I don't think so."

In the above scenario: Just enough information was obtained to determine if there are concerns for emergent acute sexual assault (SA), necessitating transfer to a treatment hospital. Further questions should be deferred to experts in child sexual abuse/assault providers (e.g., pediatric trained SANEs) at the pediatric treatment hospital.

SCENARIO 3

An 8-year-old male patient was brought to the ED after the school made a DCFS report and was questioned alone by the ED MD and SW in the presence of the Child Life Specialist at bedside.

MD: "What happened that brought you and your brother to the ED today?"

Patient: "I don't know."

MD: "It seems that someone at school is worried about you. Do you know what they would be worried about?"

Patient: "I told my teacher that my dad hit me with a belt."

MD: "Tell me more about that."

Patient: Silence. No eye contact.

MD: "Is there anything that you want to tell me or ask me?"

Patient: Patient shakes head, no. Then, says, "Can I have some juice?" No further questions were asked.

In the above scenario: (1) Those present during the history taking were listed, (2) MD and SW obtained the history together to avoid repeated patient interviews, (3) one person is leading the questions, (4) the questions are non-leading and open-ended, (5) body language is described, (6) patient is not forced to answer questions, and (7) patient is provided an opportunity to ask questions.

Limits of Confidentiality and the Medical History

EXPLAINING LIMITS OF CONFIDENTIALITY TO ADOLESCENT PATIENTS

Although limits of confidentiality apply to all children including their parents/caregivers, adolescent patients have their own unique considerations. Adolescent patients aged 12 years and older may consent to portions of their medical care (e.g., STI testing) per Illinois State law. Therefore, adolescent patients and their caregivers (e.g., parents or other legal guardians) must understand the limits of confidentiality to any information disclosed as it relates to mandated reporting laws. For example, an adolescent patient cannot disclose issues such as sexual violence or human trafficking without a healthcare provider (HCP) taking action to keep the child safe (e.g., mandated reporting). As part of the informed consent process, it should be routine practice for HCPs to have this discussion after introduction and explanation of their roles as healthcare workers(s) and prior to obtaining a patient's history.

CONSIDERATIONS WHEN DOCUMENTING SENSITIVE INFORMATION

The patient may want to instill privacy and confidentiality as much as possible in the medical record. Therefore, the matters of documenting sensitive information (e.g., concerns for child sex trafficking/exploitation) including any photo-documentation (e.g., body images) needs to be explained between the HCP and the patient. It should include the benefits of thorough documentation, such as supporting continuity of care while eliminating the need for a patient to re-explain their traumatizing event. Also, the HCP should be prepared to address the following: (1) Who can access this information (e.g., legal guardian, billing department, other staff, law enforcement (LE)); (2) Where this information will be stored; (3) How long this information will be kept; (4) What safeguards are in place to protect this information; and (5) Any other patient related concerns. Including the patient in the shared decision-making process as much as feasibly possible promotes trust between the HCP and the patient; this may provide the patient with a sense of control and autonomy after experiencing an abusive/harmful event. Obviously, it is important for the HCP to have a firm understanding of the processes in place prior to having this conversation with the patient.

EXAMPLE SCRIPT TO ADOLESCENTS EXPLAINING LIMITS OF CONFIDENTIALITY

Before we get started, I wanted to go over the rights that you have as a patient in a healthcare setting. Because of your age, there are certain things that remain confidential between you and your healthcare team. Do you know what the term confidential means? For example, if you had questions about birth control or condoms, if you were interested in testing for STIs and/or you tell me that last year you tried smoking weed, **in general** those things remain confidential and your doctor or healthcare providers do not have to include your parent or guardian in on those conversations. There are some limitations to this. For example, if you were to tell me that you had a boyfriend or girlfriend who was an adult or a lot older than you, or if someone has hurt or harmed you, or made you do things sexually against your will, that does not remain confidential. If you tell me that you want to hurt yourself, kill yourself or hurt or kill someone else, that information cannot remain confidential. The reason for this is because my job is to help keep you healthy and well, so this information needs to be shared with the healthcare team. Does that make sense? Do you have any questions about this?

If you have a question about what remains confidential and what must be shared with a parent or caregiver, then you can ask me and I can explain more.

In addition to talking with your parents or caregivers, if I learn that you or any child or teen was physically or sexually abused, then I am mandated to report to investigative agencies. Those agencies might be different based on the circumstances, but it could be LE and/or DCFS. Are you familiar with DCFS? The role of DCFS is to work with kids and teens to make sure that they are safe in their environments or with their parents.

DOCUMENTING SENSITIVE INFORMATION AND SHARED DECISION-MAKING

Scenario: A female, teenage patient disclosed their victimization to the nurse practitioner (NP) during the HEEADSSS exam. Patient reported that her adult "boyfriend" makes her have sex with friends and other men in exchange for drugs. The facts at hand are concerning for child sex trafficking and the NP discusses this with the patient. After the NP re-enforces the earlier conversation about limits of confidentiality and mandated reporting, the HCP speaks to the patient about documentation.

NP: In healthcare settings, patient information is charted in an electronic medical record (EMR). This is meant to be viewed by the HCPs who are responsible for your care. For example, me as your NP in the ED and maybe other people like your primary care provider. You also have access to see your chart and because of your age, your parents may be on your account too. There are certain protections in place so your parents may not be able to access **everything** in your EMR, like forms of birth control and drug use. In general, what you just told me is documented in some way. This information may at some point be shared with the agencies we talked about like DCFS and maybe LE. What questions do you have about this?

Patient: Well, what if I don't want any of this documented?

NP: Help me understand why you feel that way.

Patient: Well, it's my business and it's personal.

NP: You're right. This information is sensitive and very personal. I still have to document this in some way, but I understand your worry about it. A positive of documentation is that when you go see your doctor for a follow-up, the information will already be in your EMR and you won't have to reveal information all over again. Also, in terms of keeping you safe, if you choose to get an Order of Protection against your boyfriend, for example, your medical information can be documentation used in court for your safety.

Patient: I get it, I just don't want all of the details on there. Can you do that?

NP: I will keep it simple, objective and facts only. I will read it to you before I finalize it and you can tell me what you think. I will do my best to listen to your wishes and suggestions, but there may be some things I have to keep in your EMR for medical and legal reasons. Am I addressing all of your concerns?

Patient: Yes.

Illinois Hospital Association Consent Tip Sheet

Managing the complexities of obtaining pediatric assent and informed consent is challenging. It is important to have a good understanding of best practices, one's hospital policies and state laws. When difficult situations arise, healthcare providers (HCPs) should consider consulting other members of the hospital team such as legal, risk, social work and ethics. Regardless of the general information listed below, it is the provider's responsibility to ensure their care is compliant with applicable hospital rules, regulations and state laws.

The age of legal consent varies in the State of Illinois depending on the type of medical condition and/or treatment to be rendered. Such examples include medical forensic services, mental health care, drug abuse treatment, sexually transmitted infections (STIs) testing and treatment and pregnancy-related care. The Illinois Health and Hospital Association (IHA) released general guidelines to help determine at which age a pediatric patient can provide consent to certain medical services.[36] Please note, the IHA states that this information does not represent legal advice.[36]

The topic of consent is further explored in multiple areas of this document; please refer to Navigating ANCRA and SASETA as a Mandated Reporter (p.21), Medical History Taking from Children including Limits of Confidentiality and the Medical History (pp.34–38) and Child SA section (p.75).

FIGURE 6

Illinois Health and Hospital Association

Consent by Minors to Medical Treatment

Under Illinois Law, a minor is a person who has not attained the age of 18 years.[1] In general, a minor cannot consent to medical treatment, and a parent, guardian or person *in loco parentis* must consent to the treatment of a minor. However, there are statutes that permit a minor to consent that depend upon either the minor's legal status or the medical condition or treatment sought by the minor. This is an abridged summary. Please see the Consent by Minors to Medical Treatment article for important details.

LEGAL STATUS	MEDICAL CONDITION OR TREATMENT	
Minors may consent to any medical treatment if:		
Married	17+ years of age may consent	• To outpatient counseling or psychotherapy • To donate blood without written permission or authorization from a parent or guardian
Emancipated	16+ years of age may consent	• To voluntary inpatient admission to a mental health facility, but a parent or guardian must be notified • To donate blood with written permission or authorization from a parent or guardian
a Parent	14+ years of age may consent	• To primary care under certain circumstances if living separate from his/her parents or legal guardian, unable or unwilling to return to parent's residence, and managing his/her own personal affairs
Pregnant	12+ years of age may consent	• To healthcare services or counseling related to prevention, diagnosis or treatment of STD or drug and alcohol abuse • To outpatient counseling or psychotherapy; until age 17, limited to eight 90-minute sessions unless subject to an exception • To STD and HIV testing, including anonymous HIV testing • May object to involuntary inpatient admission to a mental health facility, and the minor must be discharged
	No minimum age or legal status provided	• To sexual assault or abuse diagnosis, treatment and counseling, including emergency hospital services, forensic services and follow-up treatment • To birth control services if failure to provide creates a serious health hazard, if referred by certain individuals/entity or with parental/guardian consent

1 Probate Act of 1975, 755 ILCS 5/11-1.

This document is intended to be a guide for IHA members and does not constitute legal advise. For questions, please contact the IHA Legal Affairs Department at legal@iha.org or 630.276.5506. Last Updated March 1, 2024.

Source: https://www.team-iha.org/getmedia/73752c63-f0d6-496b-8d01-c5d58d9edef2/consent-by-minors-for-medical-treatment-january-20.pdf

Sample of HEEADSSS Screening Questions

PSYCHOSOCIAL INTERVIEWING SCREENING TOOL

Completing the HEEADSSS outside the presence of caregiver (e.g., family)
The HEEADSSS exam should be performed away from the caregiver. This allows for an adolescent patient to speak freely about topics they may not want to talk about in front of their caregiver and ensures that the healthcare professional (HCP) is following confidentiality laws; refer to Navigating ANCRA and SASETA as a Mandated Reporter (p.21) and Illinois Hospital Association Consent Tip Sheet (p.39). Although most caregivers are agreeable to allow for a confidential HEEADSSS assessment, sometimes a caregiver may have a difficult time understanding the reasoning behind this confidential conversation between their child and the HCP.

Listed below are example scripts that may be used with a caregiver who is reluctant or unsure about leaving the patient's bedside:

- Help me understand why you do not want to leave your child's bedside today.
- Your child is not in trouble, but we find that patients may feel more comfortable asking and answering certain questions without the presence of their caregivers.
- In healthcare, at this age group, HCPs meet with patients privately to offer a safe space for the patient to talk more about themselves, their school life, social life and their health.
- Although some information remains confidential between the healthcare team and your child, other pieces of information can be shared with you if you'd like.

Prior to asking the patient questions
- Introduce self, share preferred pronouns, explain role and show work badge
- Explain limits of confidentiality and obtain the medical history (see p.37)
- Incorporate trauma-informed care (see p.26) for general principles
  - Questions bolded in black are from the child sex trafficking/exploitation algorithm; refer to pp.72–74.
  - Questions underlined are from the sextortion document (see p.64)
- Share responses to appropriate multidisciplinary health team members (e.g., physician, social worker, SANE, child abuse pediatrician, etc.)

Home
Please confirm the address where you live? Is this an apartment, a house or other? Who lives with you? How long have you been living there? Where do you sleep (e.g., own bedroom in own bed)? What is your preferred phone number to contact you and is this your cell phone? Do you have any other phone numbers that you use? **Sometimes kids have a hard time living at home and feel that they need to run away; have you ever run away from home?**

Education and employment
What grade in school are you? What is your favorite subject? Describe your grades? How many missed days of school this year? Tell me about where you work? How many hours do you work a week? Do you owe anybody any money?

Activities of interest
What do you like to do for fun (e.g., music, sports, drama, church)? What phone, computer or gaming device are you using and what are your preferred apps to communicate with others? What are your screen names?

Drugs
Some kids have used drugs, nicotine, drunk alcohol or tried different drugs. Have you used drugs or alcohol in the last 12 months (e.g., alcohol, vaping, smoking, marijuana including edibles, illicit drugs, over-the-counter or prescription medications)? If so, last use and frequency?

Safety
Have you ever broken any bones, had any cuts that required stitches or been knocked unconscious? Sometimes kids have been involved with police. Maybe for running away, for breaking curfew, for shoplifting. There can be lots of different

reasons. Have you ever had any problems with the police? Any guns present in or around where you live or hang out? Do you feel safe at/with (e.g., home, school, with friends/partners, and family)? Any bullying/cyberbullying? Is anyone hurting or abusing you (physically or sexually)?

Sexuality

Gender identity: Are you attracted to boys, girls or both? Have you ever met up with someone in person who you first met online? Has anyone sent you photos or videos of themselves with sexual content? **If you ever have had sex before, how many sexual partners have you had? 0 partners; 1-5 partners; 6-10 partners or > 10 partners.** Was the sexual activity vaginal, anal or oral sex? Have you ever had an STI before like gonorrhea, chlamydia or trichomoniasis?

1. **Has a boyfriend, a girlfriend or another person ever asked you to do something sexual with another person (including oral sex, vaginal sex or anal sex)?**
2. **Has anyone ever asked you to do some sexual act in public like dance at a bar or a strip club?**
3. **Sometimes kids are in a position where they really need food, clothing, a place to stay, or they want to buy something for themselves or someone else, but they don't have money. Have you ever exchanged sex for food, clothing, place to stay or anything else?**
4. **Has anyone ever asked you to pose in a sexy way for a photo or a video? Have you ever talked to someone online who asked to meet for the purposes of sex?**

As applicable, type of birth control and frequency of use, any anogenital concerns (pain, bleeding, discharge, sores, etc.), have you ever been pregnant, last menstrual period? Has anyone ever forced you to have sex when you did not want to or has touched your private parts (i.e., breasts, vagina, penis or butt)? If yes, is this the first time disclosing this has happened to you? If positive for sexual abuse/assault, was there any time that you felt like you could not breathe and has anyone ever placed anything over your neck like their hands?

Suicide/Sad

Who is your best friend? Do you have a reliable adult you can talk to and who? History of anxiety, depression, or self-injury (e.g., cutting)? When you are sad, anxious or agitated, what helps make you feel better? Any admissions for psychiatric care, inpatient, outpatient or partial hospitalizations? History of prior suicide attempts? Are you having thoughts that you want to hurt yourself or others? Do you want to kill yourself? Do you have a plan? Is there something that helps prevent you from going through with your plan?

Overview of Suspected Child Physical Abuse/Neglect

Basic points

- Concerns for physical abuse and neglect may arise at any point during the patient's ED visit.
- Collaborate/consult with multidisciplinary members of the healthcare team for optimal care (e.g., social worker, child abuse pediatrician (CAP) or other pediatric subspecialist like trauma or neurosurgeon, SANE, child life specialist).
- Follow hospital policies, procedures, transfer agreement plans and SASETA mandates.
- Follow mandated reporting laws for DCFS and law enforcement (LE); refer to Expectations of a Mandated Reporter (p.12) and Navigating ANCRA and SASETA as a Mandated Reporter (p.21).
  - Notify IL DCFS (1.800.25.ABUSE) of your concerns and expected discharge date/time. Document the DCFS intake number.
  - If the patient is expected to be medically cleared from the ED and a discharge disposition is needed, request an "action needed" response time. This alerts DCFS that a timely disposition plan is warranted.
- Communicate with the patient/family about the medical plan and keep them updated. This includes transparency surrounding reports to DCFS, if applicable.
- Provide a safe ED environment for the patient which may require visitor restrictions, a sitter and/or supervised visits per DCFS and/or hospital policy.

History

- Obtain history using a non-judgmental, trauma-informed approach; refer to the section on Trauma-informed Care (p.26).
- Document the chief complaint.
- Note who brought the child to the hospital and the mode of transportation.
  - If EMS transport, what were their observations about the scene and child?
- If concerns for child maltreatment are immediately identified, obtain history from each caregiver separately and without the patient present.
  - What is the relationship of the historian to patient?
  - Document a timeline of events surrounding the injury. Start from a few days prior to when the child was last in his/her/their usual state of health up until the hospital presentation.
  - Include the geographic location, clinical condition of child and associated caregiver timeline.
  - Who was present at the time of injury?
  - When, where and how did the injury occur?
  - What is the past medical history and associated care? Does the child have a history of abuse or neglect, repeated injuries or history of TEN-4-FACESp injuries (refer to Overview of TEN-4-FACESp, p.50)? Does the child have a history of multiple ED visits?
  - What are the child's developmental capabilities?
- Clearly document the source of your information (e.g., "mother reports that…"). Exact quotes can be very helpful.
- Objectively document the caregiver's responses, both verbal and nonverbal.
- Is the history consistent with the injury identified? May defer to CAP if consulted.
- If there are concerns for child maltreatment, identify any child contacts (e.g., siblings) because they will also need medical evaluations. What are their names/dates of birth, where are they currently and who is the caregiver?

Discussion with the child

- A verbal child can be an important information source.
- Speak with the child privately (away from any caregiver) using open-ended, non-leading questions.
- If there is a disclosure of abuse, use direct quotes documenting exactly word-for-word what the child said.
- Document everyone present during the history-taking and avoid multiple history-takings.

Physical exam *(not limited to)*

- Height, weight and head circumference (as age appropriate) and plot on standard growth charts.
- Head-to-toe exam with detailed skin assessment. See the TEN-4-FACESp section for children < 4 years of age and refer to the Overview of TEN-4-FACESp (p.50).
- Create a body chart and/or photo-document (in accordance with hospital policies) all concerning skin findings. Include location, size, color, shape, presence of tenderness and any disclosed mechanisms of injury.
- If there are concerns for sexual abuse/assault (SA), the anogenital exam should be performed by a qualified medical provider. Refer to Child SA (p.75).

Consider *early* consultation with pediatric subspecialist when indicated

Pediatric subspecialists (e.g., CAPs) can make recommendations for appropriate diagnostics, develop an overall risk assessment and help communicate with investigators if applicable.

Diagnostic testing

Should be guided by clinical findings, child's age/development and level of concern for CAN. May include:

- Imaging
  - Skeletal survey (20–22 images recommended in all children < 2 years)
  - CT scan(s) of the head, chest and abdomen
  - MRI of the brain
- Labs
  - CBC, coagulation studies, bone health studies, ALT/AST, lipase, CK, troponin, etc.
  - Toxicology screens
- If there are concerns for STIs, additional testing (e.g., chlamydia, gonorrhea, HIV, syphilis, urine hCG, etc.) may be indicated.
  - Since positive STI results in a child can have forensic and medical implications, a qualified medical provider (QMP) with pediatric expertise (e.g., CAP) should provide guidance including appropriate follow-up for the STI testing. Refer to Child SA (p.75).

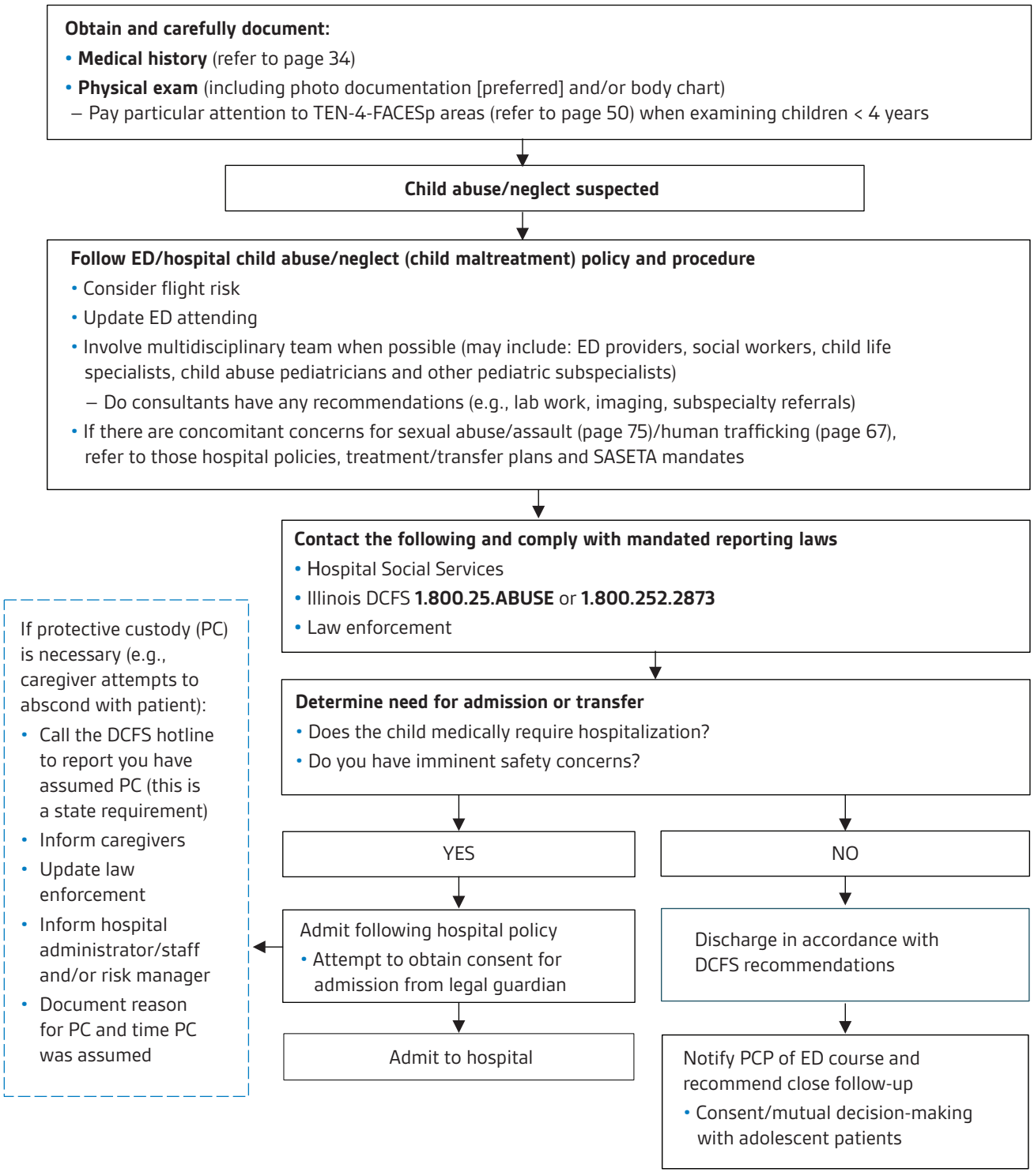
ED Disposition

- If patient is medically cleared in the ED, release the child as per DCFS recommendations.
  - If ANY problems or concerns, re-notify DCFS/LE, wait for the updated recommendations and keep pertinent hospital staff informed.
- Ensure timely disposition while following hospital's policies, procedures, transfer agreements and state mandates.

TIPS

- Document and inquire about history for any identified injury, especially in the non-ambulatory child
- Always obtain the medical history from the child and each caregiver separately
- Document any unreasonable delay in seeking care
- Refer all suspected cases of child abuse and neglect for a social work assessment, if available
- Know your scope of practice AND when to consult with a pediatric subspecialist

Suspected Child Physical Abuse/Neglect Algorithm



TIPS

- Every patient should change into a gown to facilitate a comprehensive skin exam
- Consider transfer to a facility with a child abuse pediatrician
- Hospital should update Illinois DCFS and law enforcement (LE) on admission/transfer status and identification of additional concerning injuries
- Follow DCFS recommendations and refer to hospital policies regarding visitor restrictions and/or supervised visits

Child Neglect

Neglect accounts for nearly 80 percent of child maltreatment cases in Illinois and is associated with more childhood fatalities than all other types of child maltreatment combined.[37] Neglect occurs when a caregiver fails to meet a child's basic physical, emotional and/or safety needs, placing the child at risk for harm.[38] There are multiple types of neglect, all of which are defined by acts of omission. While there are many subcategories of neglect, they often overlap or occur in combination. Subcategories include physical, medical, emotional and educational neglect, in addition to failure to supervise.[38] Due to inherent subjectivity, evaluations for neglect can be quite challenging and require a multifaceted approach. A thorough assessment for suspected neglect typically includes a barriers assessment, caregiver education, detailed documentation and care coordination. Utilization of a multidisciplinary team (e.g., social workers, primary care providers, child abuse pediatricians) is therefore extremely valuable.

Medical neglect

Medical neglect is one form of neglect and represents the "failure to heed obvious signs of serious illness or failure to follow a physician's instructions once medical advice has been sought."[39] Indicators of potential medical neglect include unreasonable delays in seeking medical care and failure to perform necessary patient care (e.g., medication regimen, nutrition schedule, appropriate use of medical equipment). Per the American Academy of Pediatrics, the following criteria are considered necessary for diagnosis:

1. "A child is harmed or is at risk of harm because of lack of healthcare;
2. The recommended healthcare offers significant net benefit to the child;
3. The anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over non-treatment;
4. It can be demonstrated that access to healthcare is available and not used; and
5. The caregiver understands the medical advice given"[39]

Other indicators of potential child neglect

- Lack of appropriate supervision
  - Young child is left unattended/abandoned
    - There is a caveat for a newborn who meets the criteria as explained in the **Illinois Abandoned Newborn Infant Protection Act*** described on the following page
  - Child is left in the care of an inappropriate caregiver (e.g., a young child, intoxicated person, known perpetrator of abuse)
- Injuries related to significant safety hazards (e.g., accessible medications, unsecured weapons)
- Inadequate provision of basic human needs such as food, shelter, clothing or hygiene
  - Poor growth/malnutrition (if medical etiologies are excluded)
  - Longstanding poor hygiene
  - Siblings with concerns for child neglect

Important components of an evaluation for neglect

- Be transparent with the caregiver about your concerns for the child's well-being
- Involve a multidisciplinary team, especially social work, if possible
- Assess barriers
  - Does the family have concrete needs (e.g., lack of transportation, lack of childcare, lack of available resources in the family's preferred language)?
  - What does the caregiver understand about the child's medical condition and needs?
  - What resources would better equip the family to care for the child?
- Discuss the patient's care with other involved providers (e.g., primary care providers, subspecialists, etc.)
- Educate caregiver if knowledge gaps about care are identified
- Document carefully
  - Include identified concerns, care expectations determined by the medical team, potential risks of caregivers not fulfilling these expectations and caregivers' responses/level of understanding

* ILLINOIS ABANDONED NEWBORN INFANT PROTECTION ACT (ILLINOIS' "SAFE HAVEN" LAW)

When the parent "…relinquishes their newborn infant who is 30 days old or less to personnel at a designated facility (e.g., hospital, police station, fire station, or emergency medical facility) AND the parent does not express or state an intent to return for the infant, then the parent may have immunity from relinquishment."[40] There are exceptions to this law, including cases in which infants are identified as maltreatment victims. For further information about this state law, including the legal responsibilities of hospital personnel, refer to link: https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1459&ChapterID=32

Abusive Head Trauma

Overview

Abusive head trauma (AHT), the newer term for shaken baby syndrome, "refers to a well-recognized constellation of injuries… caused by the direct application of force to an infant or young child, resulting in physical injury to the head, intracranial contents, and/or neck from violent shaking and/or blunt impact."[42] Because AHT is a significant cause of pediatric morbidity and mortality,[43] timely diagnosis is important to optimize outcomes. However, appropriately diagnosing AHT is difficult for numerous reasons, including: (1) an accurate and complete history is typically lacking, (2) presenting signs/symptoms of AHT can be subtle, (3) injury patterns are variable and (4) most victims are pre-verbal. Given such challenges, the involvement of appropriate pediatric subspecialists (e.g., child abuse pediatricians, neurosurgeons, neuroradiologists, ophthalmologists) is recommended, and transfer to a pediatric hospital for higher level of care may be necessary. In cases of suspected AHT, a report to DCFS is mandated; refer to Expectations of Mandated Reporter (p.12).

Clinical presentation

Victims of AHT can present with a wide variety of symptoms and injuries that may mimic other medical conditions. Infants and young children can present with subtler symptoms such as irritability and vomiting, or more severe symptoms such as unresponsiveness, seizures, cardiorespiratory compromise and difficulty feeding.[44]

KEY POINT

Appropriate recognition of AHT requires the provider to have a high index of suspicion for maltreatment — if abuse is not on the differential, the diagnosis will always be missed.

Medical evaluation

As with any maltreatment concern, a thorough history, caregiver psychosocial assessment and careful physical exam including height/length, weight, head circumference and full naked skin exam with particular attention paid to the TEN-4-FACESp regions are critical.[41] Refer to Medical History Taking from Children (p.34), Caregiver's Psychosocial Risk Factors (p.32), and Overview of TEN-4-FACESp (p.50). The broad purpose of the medical portion of the evaluation for suspected AHT is to: (1) identify the extent of the patient's injuries, which can then be managed by the appropriate medical providers; and (2) to assess for contributory medical conditions. The evaluation may vary case-to-case but typically includes skeletal imaging, neuroimaging, occult trauma labs, ophthalmology consult and bleeding disorder screen. Discussion with pediatric subspecialists is recommended to determine the appropriate medical evaluation for the specific patient undergoing assessment.

Injuries

Various intracranial, spinal and ocular injuries may occur in victims of AHT. The most common injury in each of these respective categories include subdural hematomas, spinous ligamentous and/or soft tissue injuries and retinal hemorrhages.[45] Children with AHT often also have co-occurring extracranial injuries such as bruising, subconjunctival hemorrhages and fractures,[45] reinforcing the importance of a thorough physical exam.

Indicators of Potential Child Physical Abuse

The presence of any of the following injuries should prompt consideration of abuse, especially in young or non-verbal children.

UNEXPLAINED INJURIES

☐ **Head Trauma**	• Intracranial hemorrhages • Skull fracture • Cerebral edema	• Hypoxic ischemic injury • Subgaleal hematoma • Traumatic alopecia
	NOTE: Infants may appear well (normal GCS) in the presence of severe head injury. (See p.47).	
☐ **Musculoskeletal injury**	• Any fracture in a non- ambulatory child • A poorly explained fracture in any age group	
☐ **Visceral trauma**	*NOTE: Abdominal bruising is NOT a reliable indicator of visceral injury. Children can have significant intra- abdominal injury without any associated truncal bruising.*	
☐ **Cutaneous injury**	• Any bruising in a non- ambulatory infant/child • Bruises to the face, head, ears, neck, torso, or other non- bony prominence(s) • Patterned bruising or marks	• Bruising to multiple body planes • Bites • Lacerations (not superficial abrasions) • Penetrating injury
☐ **Burns**	• Immersion pattern • Patterned contact burns	
☐ **Oral/Facial injuries**	• Eye — Subconjunctival hemorrhages (other than birth-related) — Extensive Retinal hemorrhages • Oronasal blood	• Mouth — Dental injuries — Tear to the superior labial, lingual, or inferior labial frenulum
☐ **Toxic ingestion**		
☐ **Anogenital trauma**		

IMPORTANT TIP

TEN-4-FACESp applies to children less than 4 years of age. It stands for bruising to the **T**ORSO, **E**ARS, **N**ECK, **F**RENULUM, **A**NGLE of Jaw, **C**HEEKS (fleshy part), **E**YELIDS, or **S**UBCONJUNCTIVAE; "**4**" represents INFANTS 4 MONTHS and younger with any bruise, anywhere; and "**p**" represents the presence of **P**ATTERNED bruising.[41]

See p.50 for further information about this clinical bruising decision rule. See p.51 for the Lurie Children's Child Injury Plausibility Assessment Support Tool (LCAST), a free app available for download.

HISTORY OF INJURY AND RISK FACTORS

History of Injury	☐ Inconsistent with physical findings ☐ History varies between different caregivers ☐ Inconsistent with developmental abilities of child ☐ Unreasonable delay in seeking medical care	☐ No history of reported trauma but has injuries ☐ History significantly changes over time ☐ Siblings with history of maltreatment ☐ Child discloses abuse

The following section includes selected medical conditions that may mimic abusive injuries. Organic medical etiologies/ contributors should always be considered during evaluations for child physical abuse. However, note that the presence of an underlying medical condition does not exclude physical abuse.

Differential Diagnostic Considerations: Conditions That May Mimic Abuse

Burns	• Bullous dermatitis • Chillblain • Impetigo • Senna-containing laxative induced diaper dermatitis • Staph scalded skin syndrome
Self-inflicted injuries	• Familial dysautonomia (altered pain sensitivity) • Lesch-Nyhan syndrome
Fractures	• Congenital syphilis • Copper deficiency / Menkes disease • Disuse osteopenia • Leukemia • Osteogenesis imperfecta • Rickets • Scurvy
Bruises	• Bleeding disorders (e.g., vitamin K deficiency, hemophilia, von Willebrand disease, idiopathic thrombocytopenic purpura) • Cultural practices such as coining or cupping • Congenital Dermal melanocytosis (slate gray nevi) • Ehlers-Danlos syndrome • Hemangiomas • Meningococcemia • Phytophotodermatitis • Vasculitis (e.g., Henoch-Schonlein purpura)
Intracranial bleeding	• Bleeding disorders (e.g., vitamin K deficiency, factor XIII deficiency, hemophilia) • Birth-related intracranial hemorrhage • Glutaric aciduria • Structural brain or vascular abnormalities

Overview of TEN-4-FACESp

Bruising in infants and young children

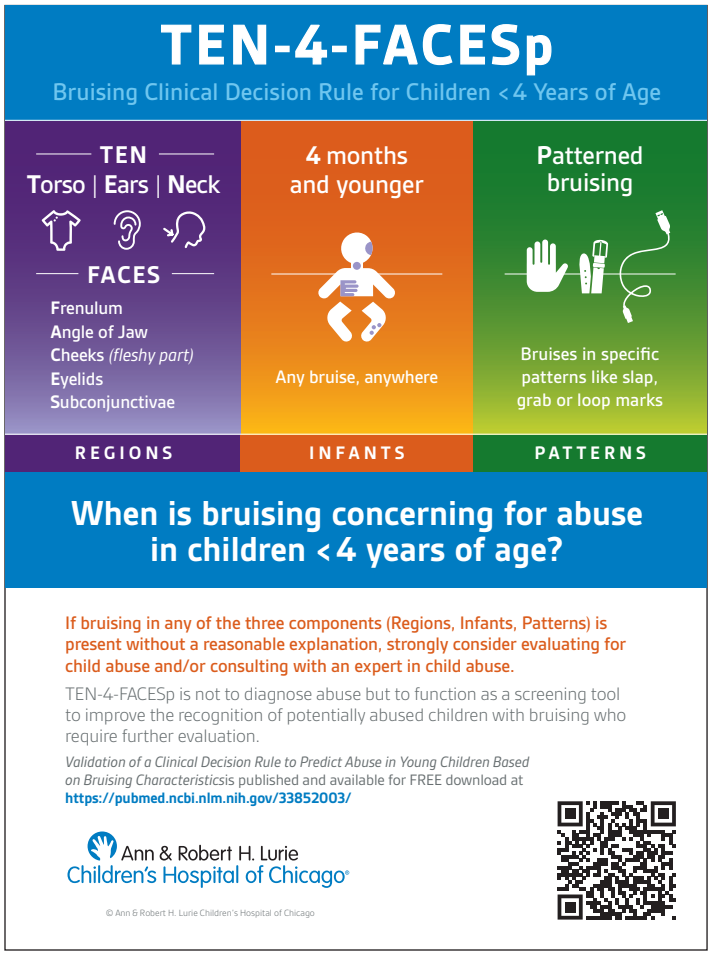
The highest rates of abuse occur among children less than 4 years of age.[1] Infants (< 1 year old) are especially vulnerable and account for almost half of all fatalities from child maltreatment.[1] Bruising caused by physical abuse is the most common injury to be overlooked or misdiagnosed prior to an abuse-related fatality or near-fatality in a young child. Recognizing common signs of abusive trauma is important to effectively advocate for the physical safety, health and wellness of children.

TEN-4-FACESp bruising clinical decision rule

The TEN-4-FACESp is a bruising clinical decision rule (BCDR) to improve the recognition of potentially abused children who require further evaluation.[41] The TEN-4-FACESp only applies to children less than 4 years of age when bruising is present.[41] If bruising is not present, alternative methods of identifying abuse are needed. Researchers studied over 2,100 children with bruising and concluded the TEN-4- FACESp had a sensitivity of 96 percent and a specificity of 87 percent when distinguishing bruising from abuse versus non-abuse.[41] In summary, the TEN-4-FACESp is a reliable valid screening tool to help the healthcare provider consider when further evaluation for child abuse is needed.

Next steps if bruising is present in any of the three components: (1) these skin findings should be shared with the medical provider (e.g., ED MD), (2) determine if a reasonable explanation for bruising exists, and (3) if there is NOT a reasonable explanation, consider consulting with an expert in child abuse.

FIGURE 7

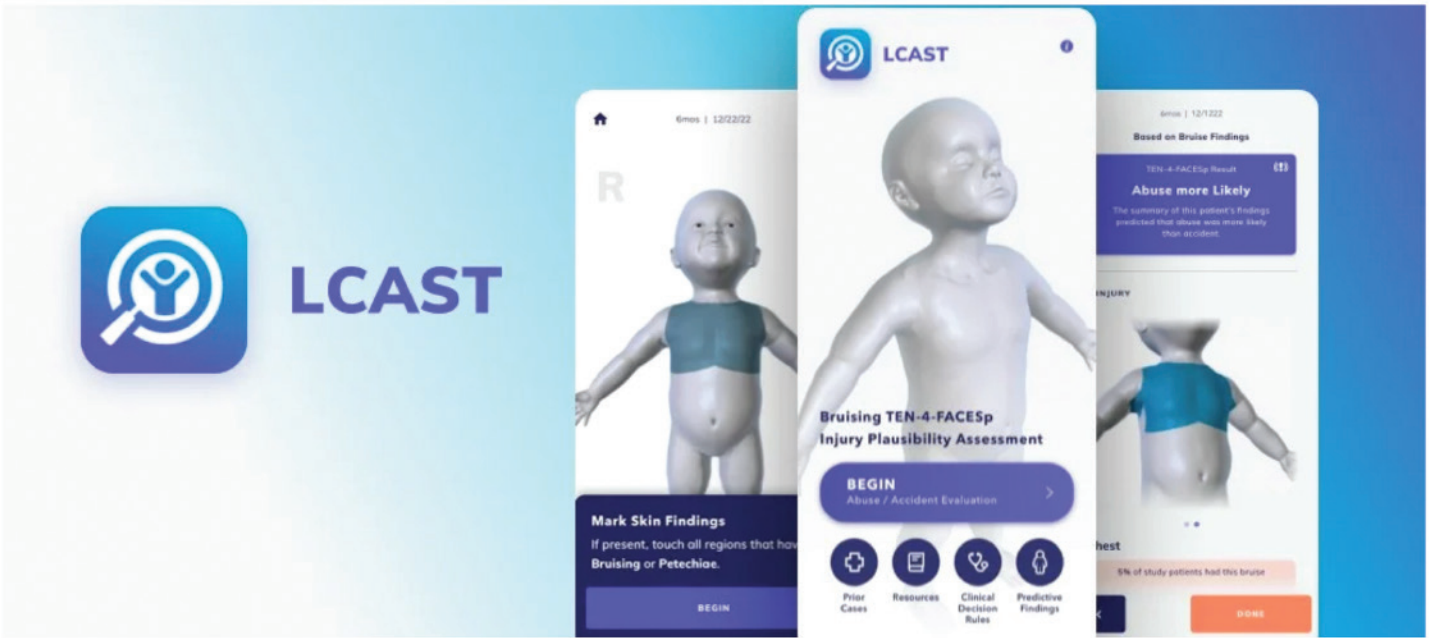


Lurie Children's Child Injury Plausibility Assessment Support Tool (LCAST)

FREE DOWNLOAD

USE QR CODE to direct you to the website for downloading the Apple or Google App

FIGURE 8



The app is strictly a screening tool to help improve recognition of abuse and cannot be used to diagnose abuse. It helps inform decision-making regarding the likelihood of abusive or accidental bruising. The app can also be used as an educational tool for learning about bruising characteristics that commonly result from abusive and accidental injury. It was developed by Mary Clyde Pierce MD, and Kim Kaczor MS, MPH, from Ann & Robert H. Lurie Children's Hospital of Chicago in partnership with Slingshot and BioDigital. More information can be found at https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health-outcomes-research-and-evaluation-center/tricam/lurie-childrens-child-injury-plausibility-assessment-support-tool-lcast/#:~:text=The%20Lurie%20Children%E2%80%99s%20Child%20Injury%20Plausibility%20Assessment%20Support%20Tool%20(LCAST)#:~:text=The%20Lurie%20Children%E2%80%99s%20Child%20Injury%20Plausibility%20Assessment%20Support%20Tool%20(LCAST)

The Period of Purple Crying® Handout

The Period of PURPLE Crying begins at about 2 weeks of age and continues until about 3–4 months of age.[46] All babies go through this period. The acronym PURPLE is used to describe specific characteristics of an infant's crying during this phase and let caregivers know that what they are experiencing is indeed normal and, although frustrating, is simply a phase in their child's development that will pass.[46]

FIGURE 9

Caregiver Resources: Child Help is 24/7 toll free number for a parent or caregiver to speak with a professionally trained counselor for getting help and support about their infants crying, as well as other development topics.[46]

CHILD HELP HOTLINE: 1.800.4.a.child

The Period of PURPLE Crying website provides educational articles and tips for caregivers at https://www.purplecrying.info/. The program approaches shaken baby syndrome/abusive head trauma and infant abuse prevention by helping parents and caregivers understand the frustrating features of crying in normal, healthy infants that can lead to shaking or abuse.[46]

The Period of PURPLE Crying is an evidence-based education program developed by the National Center on Shaken Baby Syndrome.[46] The program has two aims: (1) to support parents and caregivers in their understanding of early increased infant crying and (2) to reduce the incidence of shaken baby syndrome/abusive head trauma.[46]

Use QR code for further information and additional resources.

Non-fatal Strangulation

Non-fatal strangulation (NFS) occurs when external pressure applied to the neck impedes air and/or blood flow leading to asphyxia.[47-50] The mechanisms of injury causing NFS include: (1) manual strangulation where a perpetrator uses his/her hands on the victim's neck, (2) ligature strangulation which involves the use of a flexible object around the neck and (3) hanging strangulation where the body is suspended by the neck using a ligature device such as a rope or noose.[48-49]

Strangulation is sometimes confused with the term choking. Choking is a different phenomenon involving an esophageal obstruction (e.g., food). This confusion is likely due to the term, "chokehold," which refers to external pressure on the neck (not a choking event).[47-48]

Brain cells die rapidly when deprived of oxygen.[47] With every anoxic second, thousands of neurons and millions of synapses are lost.[48] Minimal pressure is needed to obstruct the carotid arteries, while even less is needed to obstruct a jugular vein.[47,51,52] A study of witnessed cerebral arterial blood occlusion in men lasting a few seconds to a few minutes led to their unconsciousness and subsequent cerebral arrests.[53] Multiple factors (e.g., body surface area, duration, repetitive events, amount of applied force, etc.) can influence the time frame to develop significant injury.[49]

It is important to be aware that not every NFS event is a result of physical abuse or assault. Examples of accidental NFS may include a child entangling themself in a window blind cord or a child attempting suicide by hanging strangulation.[50,54]

Diagnosing strangulation can be difficult for multiple reasons. Some examples include the following: (1) many who survive a strangulation event will not have any visible injuries either on exam or on imaging[47,50-52,54], (2) a first-hand account of the history may be impossible if the child is non-verbal or a verbal child experiences memory deficits from lack of oxygen associated with the strangulation event, and (3) literature involving pediatric NFS is currently limited. Although not every adult-based recommendation applies to children, using a systematic approach to assess for signs and symptoms of NFS (e.g., voice changes, petechiae of face/neck/oral mucosa, bruising behind the ear, patterned marks around the neck, pain) can be helpful. Of note, petechiae will not form if venous and arterial vessels are simultaneously occluded during the strangulation event. Other signs/symptoms that may occur after NFS in children include subconjunctival hemorrhages, oronasal bleeding, hypoxic-ischemic brain injury and airway edema.[49,52,54]

Important pediatric considerations

- Because pediatric victims of NFS may be preverbal or otherwise have limited communication skills, and because the caregiver accompanying the patient to the hospital may be the perpetrator, a history of strangulation may not be reported upon presentation. It is therefore important to maintain a high index of suspicion of strangulation.
- Strangulation may co-occur with other abusive injuries, especially abusive head trauma.
  - Remember to always complete a thorough physical exam, including the TEN-4-FACESp regions on every patient less than 4 years of age. Refer to Overview of TEN-4-FACESp (p.50).
- Airway edema is particularly dangerous in young children given their smaller airway diameters.
- When considering the neurological effects of NFS, remember that young children may not toilet independently, which clouds the assessment for incontinency.
- A small child's clothing may be used as a ligature to suspend the child in the air.[55]
- Intentional strangulation of pediatric victims may be associated with sexual abuse/assault (SA)[47] and other forms of maltreatment.
- Children may be corollary victims (e.g., domestic violence between household members).

Critical concept

For adult survivors of strangulation, recommended evaluation includes a computed tomography angiography of the neck (CTA-neck) with contrast to evaluate for carotid dissection.[48,49] However, no imaging gold standard currently exists for pediatric strangulation survivors.[49,54] While it may be tempting to apply adult imaging recommendations to children, this would not be appropriate. Imaging considerations unique to children change the risk/benefit profile and include the possible need for intubation/general anesthesia, higher risk of radiation exposure and lower risk of carotid dissection than adults. Alternatively, imaging may be directed by the patient's symptoms and exam findings(s) and/or may include an occult injury evaluation in cases of suspected intentional strangulation.

A pediatric imaging protocol was developed by a Level 1 Pediatric Trauma Center. Their research findings of 128 pediatric patients with hanging or strangulation injuries showed "no clinically significant cervical spine injuries or blunt cerebral vascular injuries found in any of these patients," which was consistent with other pediatric studies.[54]

Medical management may include some or all the following

- Identify qualified staff who can best medically manage the patient, which may include a pediatric-trained forensic nurse (i.e., SANE) who can perform evidence collection and photo documentation.[47,49,56]
- Incorporate a trauma-informed approach.[56,57]
- Obtain a developmentally-appropriate history, as applicable.
  - A patient may not spontaneously disclose NFS unless specifically asked.[47,56]
    - Consider the adolescent patient presenting to the ED for an SA evaluation who was strangled during the event. Since the visit can be emotional and overwhelming, the adolescent patient may be focusing on other care aspects without realizing the gravity of the strangulation event.
  - Use open-ended questions as much as possible, such as:
    - "Was there any time that you felt like you could not breathe?"[47]
    - "Was there any pressure applied on your neck?"[47]
    - "Were your mouth and nose covered in any way?"[55]
  - If patient provides a "yes" response to any of the three questions above, switch to open-ended questions as much as possible (e.g., "please tell me more about that").
  - For patient disclosures, document the patient's exact words using quotations.[47,58]
- Perform a detailed physical exam including a comprehensive skin assessment.[47,49,57-59]
  - Assess for voice changes and trouble swallowing.[47,49,58,59]
- Assess for pain.[48,55]
- Obtain photo documentation including head, eyes, ears, neck and oral cavity.[47,49,57,58] Refer to Guidelines for Photo Documentation, p.58.
- Measure and document the neck circumference.[47,57,58]
- Document all findings. Because some injuries appear and/or evolve over time, written and photo documentation is essential and can serve as a baseline.[47,58]
- Inform the investigative team (e.g., DCFS/LE) if there are concerns for voice changes, as they may want to record the sound of the patient's voice.[47]

*Although some literature recommends the use of a teddy bear or a wig head to prompt a child to demonstrate how they were strangled, this is **not** recommended. Furthermore, never place hands or objects against a child's neck to prompt recollection of the strangulation event, as this may retraumatize him/her.*

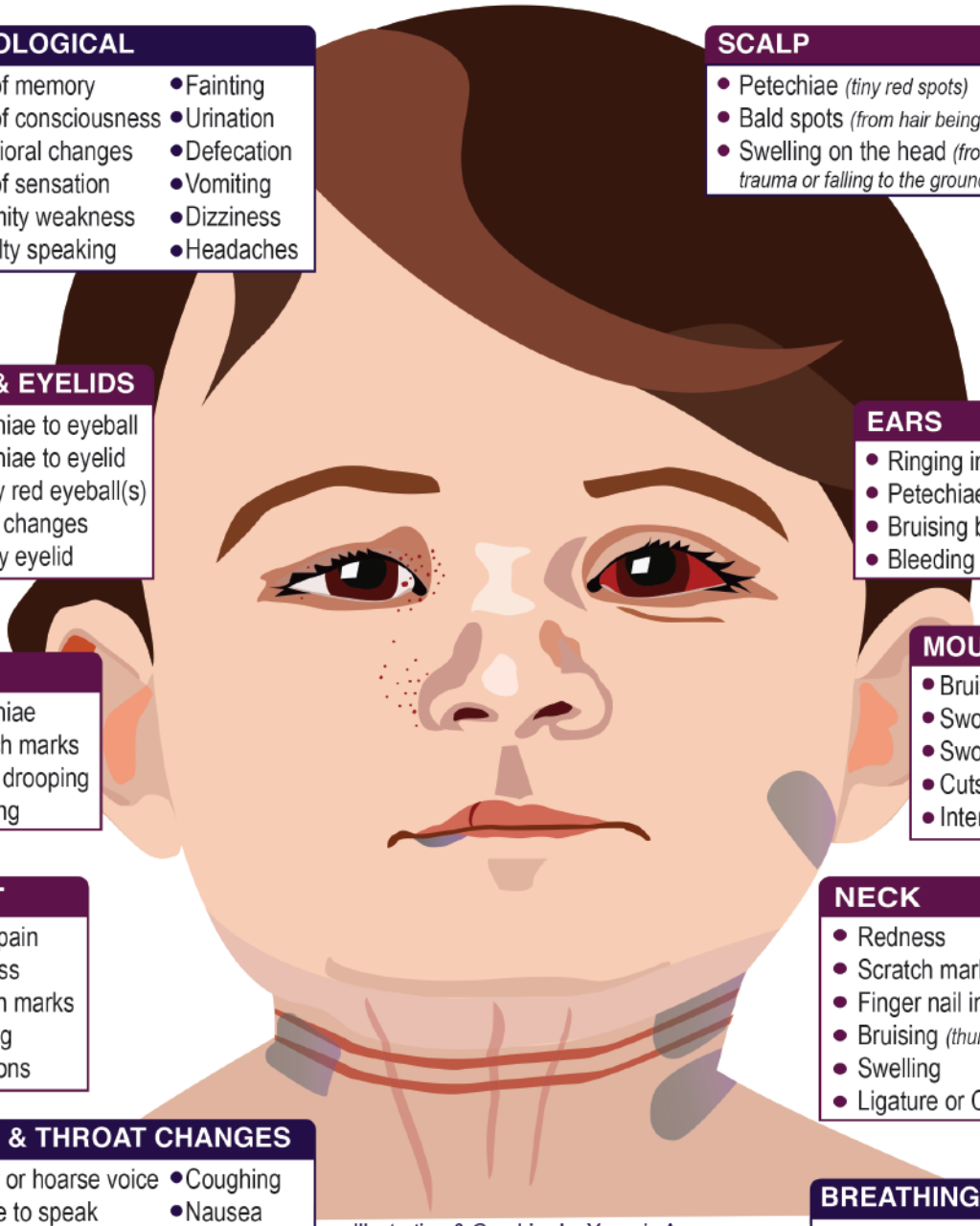
Other management needs

- Prompt notification to LE and DCFS, if indicated. Refer to Expectations of a Mandated Reporter (p.12). Scene investigations may be particularly useful in NFS cases.
- Educate the patient/family about possible delayed signs/symptoms.[47,55]
- Ensure follow-up at time of disposition that addresses the patient's medical, forensic and psychological needs.[47,55]
- Obtain leadership support for a standardized, evidenced-based approach to the emergency care of children experiencing non-fatal strangulation.

Scan QR code for International Association of Forensic Nurses Non-fatal Strangulation Toolkit

Signs and Symptoms of STRANGULATION

(VISIBLE SIGNS MAY NOT BE PRESENT)



NEUROLOGICAL

- Loss of memory
- Loss of consciousness
- Behavioral changes
- Loss of sensation
- Extremity weakness
- Difficulty speaking
- Fainting
- Urination
- Defecation
- Vomiting
- Dizziness
- Headaches

SCALP

- Petechiae *(tiny red spots)*
- Bald spots *(from hair being pulled)*
- Swelling on the head *(from blunt force trauma or falling to the ground)*

EYES & EYELIDS

- Petechiae to eyeball
- Petechiae to eyelid
- Bloody red eyeball(s)
- Vision changes
- Droopy eyelid

EARS

- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

FACE

- Petechiae
- Scratch marks
- Facial drooping
- Swelling

MOUTH

- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

CHEST

- Chest pain
- Redness
- Scratch marks
- Bruising
- Abrasions

NECK

- Redness
- Scratch marks
- Finger nail impressions
- Bruising *(thumb or fingers)*
- Swelling
- Ligature or Clothing Marks

VOICE & THROAT CHANGES

- Raspy or hoarse voice
- Unable to speak
- Trouble swallowing
- Painful to swallow
- Clearing the throat
- Coughing
- Nausea
- Drooling
- Sore throat
- Stridor

Illustration & Graphics by Yesenia Aceves

BREATHING CHANGES

- Difficulty breathing
- Respiratory distress
- Unable to breathe

Source: *Strangulation in Intimate Partner Violence, Chapter 16, Intimate Partner Violence. Oxford University Press, Inc. 2009.*

TRAINING INSTITUTE on STRANGULATION PREVENTION

strangulationtraininginstitute.com

v 10.5.2017

Example Pediatric Strangulation Discharge Instructions

There are concerns for the child being "choked" or strangled. Make sure a reliable adult (e.g., parent) stays with the child for the next 24–72 hours after this event.

Health complications can appear immediately or may develop a few days after a strangulation event. Please call 911 or go back to the emergency department if your child shows any of these symptoms:

- Problems breathing or difficulty breathing while lying down, shortness of breath, persistent cough or coughing up blood
- Loss of consciousness or "passing out"
- Voice changes or difficulty speaking
- Difficulty swallowing, a lump in their throat or muscle spasms in their throat or neck
- Swelling to their throat, neck or tongue
- Increasing neck pain
- Shows weakness in the arms and/or legs (has problems with balance/walking/crawling) or cannot move parts of his/her body
- Faints or gets very sleepy or cannot be woken up
- Pinpoint red or purple dots on the face or neck, or burst blood vessels in the eye
- Droopy eyelid
- Pupils (black part in the center of the eye) are not the same size in both eyes
- Changes in vision, dizziness or lightheadedness
- Memory loss or acts confused (says things that do not make sense, doesn't know who you are)
- Shows drastic changes in behavior or personality (irritable/moody, aggressive, impulsive, sad, etc.)
- Has a headache that is not helped by pain medication
- Has a seizure (twitching or jerking movement of part(s) of the body; may look stiff)
- Vomits/throws up more than two times and/or has forceful (projectile) vomiting
- Has bloody or clear fluid from the nose or ears
- Seems to be getting worse instead of better

If you notice any new bruising, other injury, or have any other concerns, then please return to the emergency department. Your child may need to have additional photo documentation and a repeat exam.

If you are pregnant, report the strangulation and any of the following symptoms to your doctor immediately or go to the nearest emergency department: decreased movement of the baby, vaginal spotting or bleeding, abdominal pain and/or contractions.

After your emergency department visit, please keep a list (journal log) of any changes in symptoms to share with your child's pediatrician, law enforcement and IL DCFS representative as indicated.

You may notice some bruising or mild discomfort. Apply cold pack to the sore areas for 20 minutes at a time, four times per day, for the first two days. Do not apply ice directly on the skin.

Offer cool fluids, may consider a Popsicle if age appropriate.

It is important to have a follow-up with your child's pediatrician after your emergency in the next one to two days.

Reference: International Association of Forensic Nurses. (n.d.). Non-fatal strangulation toolkit. https://forensicnurses.org/wp-content/uploads/2021/08/EXAMPLE_STRANGULATION_DISCHA.pdf

Guidelines For Photo Documentation

Photo documentation is an adjunct to the medical record and does not replace any described documentation (e.g., written, typed, etc.) of pertinent skin findings. Benefits of photo documentation include some of the following: (1) visible record of skin findings, (2) can be used when consulting with pediatric subspecialists, and (3) used during peer review.

The obtainment of anogenital photos of children presenting with concerns for sexual abuse/assault (SA) should be reserved for the qualified medical provider (QMP). This eliminates unnecessary, repeated anogenital examinations and is reflective of best pediatric practices.

Forensic photos have legal implications involving the deleting, altering or use of unauthorized equipment. The safeguarding of a pediatric patient's sensitive images should always be paramount. A process needs to be in place describing who is allowed to take photos, view stored images and/or share these images with outside agencies (e.g., DCFS or law enforcement). Therefore, a collaborative approach with the support of hospital leadership (e.g., IT, legal, risk, SANE coordinator) is advised when developing, implementing and updating any photo documentation policy or procedure. More information can be found at https://illinoisattorneygeneral.gov/Page-Attachments/PhotoDocumentationandSampleDigitalPhotographyPolicy.pdf.

IMPORTANT TIPS

Obtain appropriate assent and consent as legally and ethically required. Provide age/developmentally appropriate explanation of the purposes of the photo documentation. Maintain a child's privacy by only uncovering body parts needing to be photographed. Children may choose to have their caregiver, child life specialist or a rape victim advocate present for support, as needed. Finally, always maintain a child's dignity throughout the entire procedure knowing that a child may decline photo documentation at anytime. Positive findings concerning for child maltreatment should be reviewed by an expert in child abuse.

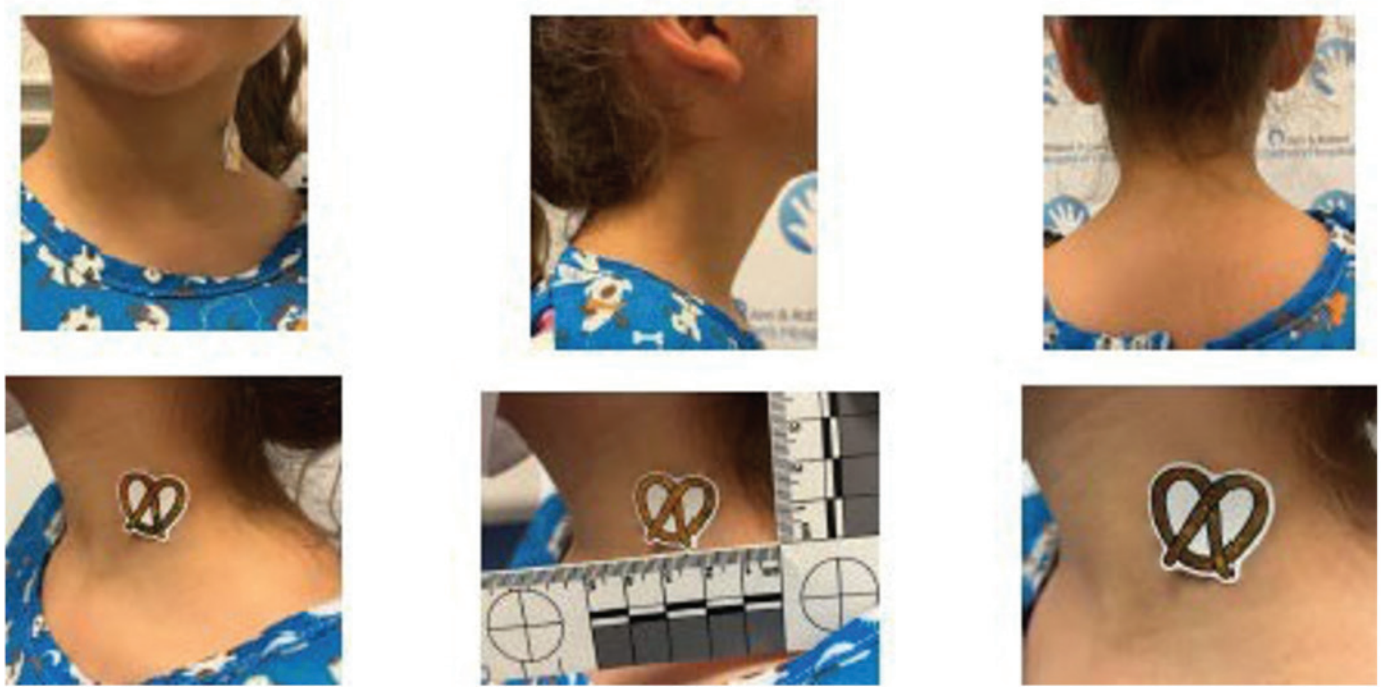
Basic considerations for photo documentation

- Review best practices
- State law (e.g., SASETA)
- Type of equipment
- Hospital policy and procedure
- Who is allowed to take photos
- Training of staff
- Storage of photos
- Retention of photos
- Who has access to photos
- Dissemination of photos (e.g., DCFS or law enforcement)

General principles when taking photos

- Prior to taking any photos of concerning skin findings for non-accidental trauma (NAT), one should obtain a beginning "bookend" photo. This is a photo of the patient identifier (e.g., medical identification band). At the end of the photo series, a final "bookend" photo of the patient's identifier must be obtained too. This process helps to confirm the series of photos taken were indeed the "correct" patient.
- Then, three photos are usually taken of concerning skin findings for NAT (i.e., overall photo, close-up photo without a ruler and close-up photo with a ruler). Some body parts like the neck require a circumferential approach; therefore, more than three photos are usually needed. Remember, anogenital photos concerning for SA should be reserved for the QMP. Consult a SANE from a pediatric treatment hospital if having any questions or concerns about this above recommendation.

FIGURE 10



There are free and low-cost opportunities to obtain hands-on experience for taking high-quality photos. Here are a few ideas: (1) partner with a treatment hospital with a well-established SANE program, (2) attend conference workshops, (3) request onsite demonstration from forensic camera companies, (4) complete online training programs, (5) refer to photo documentation and sample digital photography policy prepared by the SASETA Implementation Taskforce[60], and (6) participate regularly in peer review.

The technique of photos series from a simulated pediatric patient (see above) were replicated from the online free 2023 Pediatric Non-Fatal Strangulation Photo Documentation Protocol.[57]

Scan here for Pediatric Non-Fatal Strangulation Photodocumentation Protocol[57]

Scan here for IL Attorney General Photo Documentation and Sample Digital Photography Policy[60]

Illinois EMSC

Child Abuse and/or Neglect
Emergency Department Quality Improvement Monitor Tool[12]

INJURY SCREENING IN CHILDREN

Medical Record #: _____ Age: _____ Diagnosis: _____

Date of Service: _____ Date of medical record review: _____

	YES	NO	NA	N/D	REVIEWER'S COMMENTS
1. Head-to-toe physical exam completed?					
2. History consistent with documented injuries (per developmental stage of child)?					
3. History consistent with diagnostic findings?					
4. Histories consistent within ED (Triage, RN, Physician)? (N/A can be entered if child seen by only one health care provider during ED visit (e.g., APP)					
5. Has there been a delay between injury and seeking medical care? (If yes, please explain)					
6. Previous history of injuries? (e.g., documented in medical record and/or per retrospective visit review by medical record auditor)					
7. If the child is < 4 years old, is there evidence of bruising on body regions using the TEN-4-FACESp bruising clinical decision rule?[1]					
8. Did the injuries sustained require hospitalization or transfer of child?					
9. Was child screened for abuse and/or neglect?					
10. If screening was positive for suspicion of child abuse and/or neglect, was Illinois DCFS notified?					

Monitor follow-up/loop closure steps

Was follow-up action needed? ☐ Yes ☐ No

If YES, complete the following:

- Date/Action taken _____
- Date/Follow-up _____

Illinois EMSC

Child Abuse and/or Neglect Emergency Department Quality Improvement Data Dictionary[12]

INJURY SCREENING IN CHILDREN

INCLUSION CRITERIA

- This retrospective medical record review may assist in identifying potential opportunities for improvement with pediatric management of suspected cases of child abuse and/or neglect in an emergency department (ED) setting.
- Review the patient's entire ED medical record to collect the necessary data (e.g., physician and RN notes)
- N = Maximum of 10 records of diagnosis/presenting complaint, per quarter.
- Sample population includes:
  - All age children
  - Children who present with the following conditions should be assessed for potential abuse or neglect
    - Cutaneous injuries (e.g., patterned bruises or marks; bruises to regions of the TEN- 4-FACESp; bruises on non-ambulatory child; bruises/lesions on multiple body parts; bites; lacerations; penetrating injuries)
    - Burns
    - Oral/facial injuries
    - Head trauma (e.g., intracranial hemorrhage; skull fracture; cerebral edema; retinal hemorrhage; loss of gray/white differentiation; subgaleal hematoma)
    - Musculoskeletal injury (any fracture in non-ambulatory child; any fracture poorly explained)
    - Visceral trauma
    - Genital/anal trauma
    - Poison ingestion
    - Failure to thrive
    - Old untreated or inappropriately treated injuries that the average non- medical person would have sought care for (e.g., burns, fractures, or wounds)
    - Lack of appropriate medical care based upon the need of the child
    - Malnourishment or concerns for growth

Answer the questions on the next page using the following acronyms (unless otherwise directed)

Y = Yes/Present

N = No/Not Present

N/A = Not Applicable

N/D = Not Documented/Unknown

1. **Head-to-toe physical exam completed to determine issues other than presenting injuries?**
2. **History consistent with documented injuries (per development stage of child)?**
   - Yes is entered if medical record auditor determines that history is consistent or if ED Physician/ED RN documents in medical record that history is consistent.
   - No is entered if history is not consistent with documented injuries
   - N/A is entered if undetermined
   - N/D is medical record lacks documentation
3. **History consistent with diagnostic findings?**
   - Yes can be entered if films, CT, or MRI results confirm consistent history
   - No if history not consistent with diagnostic findings
   - N/A if diagnostic tests are not ordered or patient transferred for CT
   - N/D is entered if medical record lacks documentation
4. **History consistent within ED (e.g., Triage, RN, Physician)?**
   - Yes can be entered if medical record auditor determines that history is consistent within the medical record or documentation found in the medical record stating that history is consistent
   - No is entered if medical record auditor determines that history is not consistent within the medical record or documentation found in the medical record stating that history is inconsistent
   - N/A is entered if child is only seen by one health care provider during ED visit (e.g., APP).
   - N/D is entered if medical record lacks documentation
5. **Has there been a delay between injury and seeking medical care?**
   - Yes is entered if a delay was documented in the medical record. Please comment further in the reviewer's section the cause of delay if known.
   - No if the medical record auditor determines that there was not a delay
   - N/A is entered if undetermined
   - N/D is entered if medical record lacks documentation
6. **Previous history of injuries?**
   - Yes can be entered if documented in medical record and/or per retrospective visit review by medical record auditor
   - No is entered if medical record auditor determines there was no previous history of injuries (either by documentation in medical record or per retrospective visit review)
   - N/A is entered if undetermined
   - N/D is entered if medical record lacks documentation
7. **In children age < 4 years old, is there evidence of bruising on the TEN-4-FACESp regions?**
   - Yes is entered if documentation in the medical record notes bruising on non-bony prominences using TEN-4-FACESp Bruising Clinical Decision Rule[1]. See body parts below that should be assessed using this screening tool.
     - » For children less than 4 years of age identify if bruising is present to the following areas:
       - ❖ Torso (chest, abdomen, back, buttocks, genitals)
       - ❖ Ears
       - ❖ Neck
       - ❖ Frenula (superior labial, lingual, inferior labial)
       - ❖ Angle of Jaw
       - ❖ Cheek (fleshy part, not zygoma)
       - ❖ Eyelids
       - ❖ Subconjunctival Hemorrhage
     - » Is there is a bruise anywhere on the body of an infant 4.99 months or younger?
     - » Are there patterned bruises anywhere on the body?

- No is entered if medical record auditor determines no evidence of bruising or injury as identified above.
- N/A is entered ≤ 4 years of age
- N/D is entered if medical record lacks documentation

8. **Did the injuries sustained require hospitalization or transfer?**
   - Yes is entered if child was hospitalized or transferred
   - No is entered if child was dispositioned to home
   - N/A is entered if child was not discharged to home, transferred or hospitalized
   - N/D is entered if medical record lacks documentation
9. **Was the child screened for child abuse and/or neglect as documented in the medical record?**
   - Yes is entered if documented in medical record (or if charting by exception is acceptable per hospital policy)
   - No is entered if medical record auditor determines child was not screened appropriately
   - N/A is entered if undetermined
   - N/D is entered if medical record lacks documentation
10. **If screening was positive for suspicion of child abuse and/or neglect (from Question #9), was Illinois DCFS notified as documented in the medical record?**
    - Yes is entered if documented in medical record
    - No is entered if medical record auditor determines DCFS was not notified appropriately
    - N/A is entered if undetermined
    - N/D is entered if medical record lacks documentation

For further info: https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health-outcomes-research-and-evaluation-center/tricam/ten-4-facesp/#:~:text=TEN-4-FACESp%20is%20a%20useful%20acronym%20to%20help%20screen,to%20be%20caused%20by%20abuse%20than%20accidental%20injury.

Child Sextortion

What is child sextortion?

According to the National Center for Missing and Exploited Children (NCMEC), "Sextortion is a form of child sexual exploitation where children are threatened or blackmailed, most often with the possibility of sharing with the public nude or sexual image(s) of them, by a person who demands additional sexual content, sexual activity or money from the child."[61]

REALIZING THE PROBLEM

Child sextortion is a largely unrecognized pediatric healthcare problem having dire and even irreversible consequences ranging from sexual abuse/assault (SA), bestiality, self-harm and even suicide.[62] Since 2016, over 262,573 calls were placed to the NCMEC CyberTipline (this category includes sextortion).[63] In 2022, the Federal Bureau of Investigation (FBI) in partnership with NCMEC and Homeland Security Investigations received over 7,000 reports related to the online financial sextortion of minors; these investigations revealed at least 3,000 victims, primarily boys, and more than a dozen suicides.[64]

Physical boundaries of a child's home or school no longer shield them from sexual predators.[65] Sextortion can occur anywhere there is internet access;[65] for instance, a child may be threatened into sending sexual content even when at school. Online child abusers have weaponized the internet for grooming multiple children simultaneously using a variety of different computer applications and platforms.[65] Through technology, online sexual abusers can change their identities and appearances to deceive and coerce children.[61,65] Using fake photos and profiles is just one way a perpetrator lures their victims and establishes their trust.[61,65] On the other hand, blackmailers may be known to their victim(s); for instance, a disgruntled boyfriend,[66] teacher, or coach. Either way, technology is used by the perpetrator to stalk, groom and threaten children into sextortion.[65] Ultimately, every child/youth is potentially at risk for sextortion, only needing internet access (e.g., smart phone, gaming device, computer, etc.).[61,65,66]

Due to feelings of shame and fear, a child may not disclose the occurrence of online SA and may falsely believe they can handle the problem themselves.[61,66] The sending of one sexual content may trigger a cycle of daily ongoing threats and demands for further sexual content.[66] Demands from perpetrators may vary or even escalate; listed are some examples: (1) sending additional sexual content, (2) engaging in sexual acts via webcam, (3) meeting the perpetrator in person, (4) insisting the child hurt themselves, (5) remaining in a romantic relationship, (6) providing sexual content of other children, and/or (7) sending monetary funds.[66] Sextortion, of any type, can make the victim feel further isolated and helpless in stopping this type of abuse.[61,66]

KEY CONCEPTS

Do not underestimate the negative impact that online sexual abuse may have on a child. The Illinois Abuse and Neglect Child Reporting Act describes grooming behaviors as a form of child abuse.[3]

Sextortion is a form of child abuse, even if the offender and child never meet. Online sexual abusers can be personally known to the victim and acquaintances can be met online. Education about safe online behaviors is vitally important for children/youth and their caregivers.

These screening questions are for healthcare professionals (e.g., physicians, nurses and social workers) working in an ED setting who can commit the time and effort to engage with the patient in a trauma-informed manner.

Sample screening questions for on/offline sexual abuse, exploitation or solicitation
If any "yes" responses, then ask opened-ended questions as much as possible, like "Please tell me more about what happened?"

- Have you met a person offline who you met online?[65]
- Has anyone ever asked you to pose in a sexy way for a photo or a video?[67]
- Has anyone sent you photos or videos of themselves with sexual content?[65]
- Have you ever talked to someone online who asked to meet for the purpose of sex?[67]

INTERVENTIONS AFTER IDENTIFYING A CHILD VICTIM OF SEXTORTION

- Ensure a trauma-informed approach, be non-judgmental. Avoid blaming the child.[64,68]
- Multidisciplinary approach is preferred.
- Determine if patient has any concerns for sexual assault and/or child sex trafficking/exploitation. If so, notify ED provider, follow hospital policy, SASETA mandate and contact a pediatric treatment hospital as indicated. See pp.73–74, p.93.
- Follow mandated reporting laws.
- Consider trauma-based mental health therapy.[65]
- The FBI has resources and dedicated staff trained to help children who have experienced sextortion and when unwanted images have been posted online. Contact your local FBI field office, **call 1.800.CALL.FBI, or report it online at tips.fbi.gov.**[69]

NCMEC website contains educational materials and resources. Anyone can access these materials for free to help and support patients and their families when there has been concerns for sextortion.

Recommendations for the child/youth from NCMEC[68]

- Remember, the blackmailer is to blame, not you.[68]
- Get help before deciding whether to pay money or otherwise comply with the blackmailer.[66]
- Cooperating or paying rarely stops blackmail.[68]
- Report the account via the platform's safety feature.[68]
- Block the suspect but DO NOT DELETE your profile or messages because that can be helpful in stopping the blackmailer.[68]
- Let NCMEC help remove images from the Internet. Visit missingkids.org/IsYourExplicitContentOutThere to learn how to notify companies yourself, or visit https://report.cybertip.org/ to report to us for help with the process.[68]
- Ask for help. The problems can be very complex and require help from adults or professionals. If you don't feel that you have adults in your corner, you can reach out to NCMEC for support at gethelp@ncmec.org or you can call us at 1.800.THE.LOST[68]

Despite Illinois law requiring schools to provide education about sextortion,[70] nothing replaces open and ongoing communication between parents and their children regarding internet safety. Recommend making internet safety as routine as looking both ways before crossing the street or wearing a seatbelt when in a car. Importantly, parents should warmly and regularly encourage their children to come to them for help, no matter what the problem is.[65]

The **FBI website** is another great website that offers recommendations that may help mitigate the risk. As explained above, any child having internet access is a child potentially at risk for sextortion. Listed below are some of their recommendations for internet safety.

FBI's Six Important Education Tips for Children[71]

- Be selective about what you share online. If your social media accounts are open to everyone, a predator may be able to figure out a lot of information about you.[71]
- Be aware of anyone you encounter for the first time online. Block or ignore messages from strangers.
- Be aware that people can pretend to be anything or anyone online. Videos and photos are not proof that people are who they claim to be. Images can be altered or stolen. In some cases, predators have even taken over the social media accounts of their victims.
- Be suspicious of everyone you meet on a game or app; be extra suspicious if this person asks you to talk using a different platform.
- Be in the know. Any content you create online — whether it is a text message, photo or video — can be made public. And nothing actually "disappears" online. Once you send something, you don't have any control over where it goes next.
- Be willing to ask for help. If you are getting messages or requests online that don't seem right, block the sender, report the behavior to the site administer or go to an adult. If you have been victimized online, tell someone.

FBI's Important Parental Tips[72,73]

- Educate yourself about the websites (forums, software, games, computer applications, etc.) that your children use.
- Supervise your child's Internet activity by checking their social media and gaming profiles and posts.
- Have conversations about what is appropriate to say or share.
- Use security features to detect malware and utilize privacy settings limiting access to online profiles.
- Keep computers up to date.
- Choose appropriate screen names; create very strong passwords and don't share them.
- Turn off the computer and cover webcams when not in use.
- Do NOT open attachments from unknown senders.
- Kids need to know that once images or comments have been posted online, they never truly disappear.
- Tell your children to be extremely wary when communicating with anyone online who they do not know in real life.
- Make it a rule: kids can't meet up with anyone they met online without your knowledge and supervision.
- Stress to your children that making any kind of threat online — even if they think it's a joke — is a crime.
- Report any inappropriate contact between an adult and your child to law enforcement immediately.
- Notify the website of any inappropriate contact, too.

Human Trafficking is Child Abuse

Below are four possible scenarios describing the human trafficking/exploitation affecting children and adolescents.

- A 15-year-old transgender female who reports living at multiple different residences "couch surfing" and is currently staying at a male friend's house (she won't provide name or address). She states that she will have sex with his friends to have a place to spend the night.
- An 11-year-old male patient who recently entered the United States about three months ago and has been staying with his "uncle" who is not biologically related. Patient reports he does not attend school since he must work at his "uncle's" restaurant to pay off his debt. Currently, his parents live in Guatemala.
- A 13-year-old female promised a paid modeling job by an adult in exchange for sex.
- A 14-year-old female who meets her 30-year-old "boyfriend" on social media. She runs away from home and has sex with him in exchange for housing, money and drugs.

To better care for children who are suspected victims of human trafficking/exploitation, we need to realize that human trafficking/exploitation is a problem affecting children living in the United States, including Illinois, not an abstract problem only affecting children in different countries. While data from the National Human Trafficking Hotline (NHTH) reflects that human trafficking exists in every state, it is difficult to know the full extent due to the absence of a standardized data collection base, barriers to identification and the hidden nature of this type of crime.[74] We do know the typical age of entry into sex trafficking is between 11 and 17 years of age;[5,74] and, 15.8 percent of labor trafficking cases involve children.[75] Human trafficking and exploitation is an under recognized pediatric problem.

According to the Trafficking Victims Protection Act of 2000, human trafficking is defined as the use of force, fraud or coercion to obtain labor or a commercial sex act. Importantly, force, fraud or coercion do not need to be present if the person performing the commercial sex act is under the age of 18 — a minor performing a commercial sex act is automatically defined as a victim of human trafficking.[76] Additionally, the Justice for Victims Trafficking Act of 2015 added the penalization of individuals who patronize or solicit minors for commercial sex — the buyers.[77] This is key in cases where minors are sexually exploited with no third party trafficker. In such cases, the child/youth is exploited directly by his/her buyer,[5] and there is no "pimp" or person who is facilitating the exploitation. An example is a youth who has sex with an adult in exchange for something of value from that adult (money, housing, drugs, employment, etc.), though many other possible scenarios exist.

By contrast, child labor trafficking requires the presence of force, fraud or coercion to distinguish trafficking from legal child employment, child labor or child labor exploitation, the latter two of which are also crimes.[5,78,79] The Illinois Child Labor Law regulates employment of children under 16 years of age.

> *Despite the distinction between sex trafficking and labor trafficking, note that both can, and often do, co-occur in the same person.*[75,80]

HUMAN TRAFFICKING LEGISLATION IMPACT[81]

- In August 2010, the Illinois Safe Children Act was signed into law. This legislation provides police and prosecutors the tools to aggressively tackle this crime. The Illinois Safe Children's Act made the following changes in the criminal code:
  - Provides for the transfer of jurisdiction over children who are arrested for prostitution from the criminal system to the child protection system, with special provisions to facilitate their placement in temporary protective custody if necessary
  - Makes crimes that penalize the commercial sexual exploitation of children applicable to all minors under 18 as child victims, in conformity with Illinois' human trafficking law and federal law
  - Removes references to "juvenile prostitutes" in the criminal code. This is in recognition of the fact that children have no capacity to consent to their own commercial sexual exploitation and, thus, are not prostitutes but rather are victims of a serious sexual offense.
  - Protects minors by limiting the affirmative defense that pimps or traffickers "believed" that the prostituted child was at least 18 years old to only those pimps and traffickers who had no reasonable opportunity to see the victim (in accordance with federal law and constitutional requirements of due process).
- Allegation #40/90 Human Trafficking of Children, including both labor and sex trafficking, has been added to the Abused and Neglected Child Reporting Act (ANCRA) and incorporated into the Illinois DCFS Allegations system.
- The National Human Trafficking Resource Center (NHTRC) has a hotline at 1.888.373.7888 that operates 24/7 with access to 170 languages. The Hotline provides assistance with assessment questions.

Recognizing children at risk for human trafficking

There is no "typical" trafficking victim nor a "typical" trafficker — anyone can be a victim or a perpetrator. Additionally, be aware that sex and labor trafficking may occur in the same victim.

MANY BARRIERS TO IDENTIFICATION AND DISCLOSURE EXIST[5]

- Many victims do not recognize they are being exploited
- Trafficked victims often feel a great deal of shame and guilt; they may also perceive judgment and bias from healthcare workers
- Trauma-bonding: a patient is bonded psychologically to their abuser/perpetrator
- Fear of trafficker: physical and psychological threats to the victim or victim's loved-ones
- Fear of arrest or deportation, being sent back to an undesirable location or reported to social services
- Lack of trust in others, people of authority or people of different cultures; victims' lack of trust in systems
- Victims' lack of awareness of their rights or resources available to them

Children are uniquely at risk because of their developmental immaturity, dependence on adults in their lives and lack of life experiences and resources. Developmentally, adolescents are impulsive, more likely to take risks and more subject to peer pressure. Because self-disclosure cannot be relied upon as the sole method for determining risk for or victimization of trafficking or exploitation, a clinician must be aware of vulnerabilities which place a child at higher risk.

Listed on the following page are some known individual, relational and community risk factors.

TABLE 7

INDIVIDUAL RISK FACTORS[5,78]
History of abuse, especially sex abuse, multiple adverse childhood experiences (ACEs)
Homelessness or runaway status
LGBTQIA+ youth
Involvement in social services, foster care or juvenile justice system
Disabilities
Gang involvement
Substance use/misuse
Mental health issues (especially untreated/undertreated)
Unaccompanied minor immigrant, undocumented immigrant
Limited English proficiency, limited education

TABLE 8

RELATIONAL/COMMUNITY RISK FACTORS[5,78]
Family dysfunction and/or violence; caregiver mental health concerns, drug/alcohol concerns
Unstable housing
Lack of economic opportunity or resources, poverty
Community violence, neighborhoods with high crime rates
Forced migration, asylum-seeking

While the chief complaints of children who are labor trafficked might overlap with those who experience sex trafficking or exploitation (see pp.72–74), the following is a list of additional high-risk chief complaints for children who might be experiencing labor trafficking:

TABLE 9

CHILD LABOR TRAFFICKING HIGH RISK CHIEF COMPLAINTS[5]
Work-related trauma or toxic exposure
Evidence of malnutrition
Untreated acute or chronic disease or injury
Evidence suggestive of inflicted injury
Dental trauma or evidence of neglect

TABLE 10

CHILD LABOR TRAFFICKING RED FLAGS[5,78]
Lack of control over documents
Lives in housing provided by employer
Lacks basic work-related protective gear
Accompanied by unrelated adult
Delay in seeking medical care
Recent immigration, does not speak local language, undocumented immigrant status

SCREENING QUESTIONS FOR CHILD LABOR TRAFFICKING

Currently, there are not any validated screening tools for child labor trafficking in the healthcare setting. However, below are some screening questions that may help identify a child experiencing labor trafficking. It is best to develop rapport first and continue a trauma-informed, patient-centered interaction. Furthermore, the provider should take time to explain what is meant by "work" or "job" since a child may have a restricted view and may not consider work in a family business, in a home or in the informal or illegal sectors as being "work."[78] Although chores are considered normal contributions to the family household, chores should not be excessive or unrealistic for the child's age and development.

- Tell me about where you live/who you live with.
- Tell me about where you work.
- Is the job what you expected, or is it different than what you were told or expected?
- Does anyone at work scare or hurt you or threaten to hurt you or your family?
- Can you leave the place where you work?
- Do you go to school?
- Has anyone ever threatened you or your family if you were to leave your place of employment?
- Have you ever worked without getting paid when you thought you would?
- How many hours do you work a week?
- Do you owe your boss money?

FOR MIGRANT CHILDREN, HERE ARE SOME ADDITIONAL CONSIDERATIONS

- Travel – from where and through which countries[5]
- How and with whom the child came to the United States[5]
- Current living situation[5]
- Immigration status[5]
- Possible family debt[5]
- School enrollment, attendance[5]
- Employment/work status[5]
- Prior abuse, trafficking or persecution in home country and during travels[5]

RECOGNIZING TRAFFICKING AND EXPLOITATION PERPETRATORS

Recognizing a person trafficking or sexually exploiting a child presents its own challenges as traffickers can be family members, intimate partners, peers, employers or strangers.[74,82]

Trafficking victims and perpetrators can be any gender, socioeconomic status, race/ethnicity, age or citizenship. They may look just like any of us. There is no "typical" trafficking victim or perpetrator. Some trafficked/exploited children or adolescents may have none of the red flags that are listed in this document. If you have a suspicion that a child might be trafficked/exploited, even without any red flags, use your multidisciplinary team and follow your protocol.

Response to children with concerns for trafficking

MULTIDISCIPLINARY TEAM (MDT) APPROACH

Once you have identified a child with a concern for sex or labor trafficking/exploitation, follow your institution's protocol. For an appropriate response for a patient experiencing sex trafficking/exploitation, please refer to the algorithm on pp.72–74. Make sure to separate the child from the potential perpetrator, if possible, without causing suspicion, and use a facility-approved interpreter. Many facilities explain that it is hospital/organizational procedure to talk with a patient alone and with an interpreter, if needed. For a child labor trafficking victim, alert your multidisciplinary team which will most likely include, at a minimum, the healthcare team, child protective services, social work, law enforcement and local human trafficking organizations.

A multidisciplinary team is essential to holistically assist a child or youth who has been trafficked or exploited. The team may include, but is not limited to, healthcare workers, social workers, law enforcement, the local children's advocacy center, child protective services, interpreters, child life specialists, sexual assault forensic/nurse examiners, mental health providers, legal experts, immigration experts, local human trafficking organization(s).

TIPS

- Develop relationships with your local partners
- Have a list of organizations and contacts that you can use when you have a patient who is trafficked or at high-risk for trafficking
- The National Human Trafficking Resource Center (NHTRC) has a Hotline at 1.888.373.7888 that operates 24/7 with access to 170 languages. The Hotline helps with assessment questions

SPECIAL CONSIDERATION TO DOCUMENTATION

Do not document a patient's legal status in the medical record and reassure the patient of this. Additionally, it may be necessary to generate a confidential medical record to prevent potential traffickers from accessing a victim's medical record, which may endanger the patient; refer to Medical History Taking from Children including Limits of Confidentiality and the Medical History (pp.34–38) for further documentation tips.

TRAUMA-INFORMED APPROACH

All children with concerns for human trafficking deserve care that is trauma informed. Please refer to page 26, which discusses trauma-informed care.

AVOID REVICTIMIZATION

There is no "perfect" patient. Human trafficking/exploitation victims, because of their traumatic backgrounds, may be tough patients to engage. Most of these patients have had multiple traumatic experiences, and it is helpful to view their behaviors through a complex developmental trauma lens. Behaviors that once were lifesaving on the street or in abusive environments may be maladaptive at other times. Human trafficking/exploitation victims are often judged and will look for judgment in your demeanor and words. They may reject your help or resist your attempts to interact. They may get angry or have volatile emotions. They may engage in the stress responses of fight, flight or freeze while interacting with you and your team. Remind yourself to not take their behaviors personally.

Finally, you may do everything possible and ask all the "right" questions, and the child/adolescent still may not disclose or want your help. This is common and may be for multiple reasons. Again, your goal is not clear disclosure, but to treat medically, make proper referrals and ensure safety of the child.

Your interaction with the child/adolescent may be one crucial step in their long process of healing.

How to use the Child Sex Trafficking/Exploitation Screening Tool

Please refer to the Child Sex Trafficking/Exploitation Screening Tool on pp.72–74. The screening tool provides a detailed algorithm to assist in identifying a child who may be sex trafficked or exploited, as well as appropriate steps to take if you suspect your patient to be experiencing or have experienced sex trafficking or exploitation. Included in this algorithm are tips on how to screen pediatric patients, a list of high-risk chief complaints, red flags and a validated screening tool. One of the limitations of this tool is the pediatric patient must be at least 10 years old. Furthermore, responses may vary widely if the questions are not asked in a trauma-informed manner.

The first set of questions can help identify a patient who needs further screening for CST/E by a trauma-informed clinician (e.g., social worker, nurse or physician). Negative and positive responses should always be shared with the treating ED provider. Furthermore, a consultation with a hospital social worker may still be needed, even if only one positive response is elicited. For example, a 10-year-old with any sexual partner should raise concerns for a mandated report and the need to notify DCFS and/or law enforcement.

Although it is very important to pay attention to the "Red Flags" section, the items are not diagnostic for CST/E. For example, a red flag could be a patient with a tattoo. Many patients may have tattoos and that does not mean they are all victims of CST/E. Instead, think of tattoos that refer to money, ownership by a trafficker or allude to sexual innuendos or sex work. The same could be said for patients who are acting fearful or anxious. Some patients will have anxiety in the medical setting or "shut down" in front of authority figures such as HCPs due to prior negative experiences or cultural differences. Their fearful and anxious behavior does not necessarily mean they are involved in CST/E. Some of the red flags may be more specific for CST/E. For example, if a patient was brought in by LE after being found at a motel concerning and known for sex trafficking, that collateral information should be taken seriously. Red flags need to be explored but weighted with the whole presenting picture of the patient.

More research is needed, and this CST/E algorithm is a beginning in applying evidenced-based recommendations when screening for and managing pediatric patients who may have concerns for CST/E. Remember to always use trauma-informed skills when interviewing and treating your patient. The goal is not to obtain a clear disclosure, but to assess risk, administer appropriate medical care and referrals and ensure safety as much as possible.

Child Sex Trafficking Exploitation (CST/E) Screening Tool

ED PEDIATRIC PATIENT ≥10 YEARS OF AGE

National Human Trafficking Hotline
24/7 Can Help With Screening
1.888.373.7888

HOW TO SCREEN PATIENTS

- Use hospital approved interpreter for language barriers
- Speak with patient alone without family, companions, or cell phones
- Be trauma-informed
- Be non-judgmental and open to unfamiliar narratives
- Explain limits of confidentiality
- Only make promises you can keep
- Many people abused and exploited in trafficking do not self-identify as victims

HIGH RISK CHIEF COMPLAINTS

- Acute sexual assault
- Traumatic assault (e.g., neck/jaw injury from forced oral sex)
- Injury or illness presenting late with evidence of unsanitary or unsafe home remedies
- Pelvic/genital pain
- Requests for STI or pregnancy testing
- Suicidality
- Behavioral/psych concerns
- Intoxication
- Any high-risk sexual or social behaviors that the ED provider is worried about regardless of chief complaint

RED FLAGS

- A controlling companion (may identify themselves as family or significant other) or accompanied by peers and only 1 other adult
- Found unconscious or at location concerning for sex trafficking
- Has a secret cell phone or app with multiple cellphone numbers
- History scripted or inconsistent
- Signs of child maltreatment
- Reluctant to explain injuries
- Acting fearful, anxious, PTSD, submissive, or tense
- Unaware of location, date, or time
- Microchipping or concerning tattoos (sexual innuendo money reference, branding)
- In possession of expensive items inconsistent with rest of presentation
- Inappropriate clothing for weather/venue
- Language of sex trade
- Concerning disclosure
- Witnessed event/recorded images
- Parental or law enforcement concerns for trafficking
- Multiple visits to ED
- Multiple injuries
- Child who disappears for a period of time
- Running away, homelessness, or family dysfunction

SCREENING QUESTIONS

1. Have you ever broken any bones, had any cuts that required stitches, or been knocked unconscious?[5]
2. Some kids have a hard time living at home and feel that they need to run away. Have you ever run away from home?[5]
3. Some kids have used drugs or drank alcohol, and different kids use different drugs. Have you used drugs or alcohol in the last 12 months?[5]
4. Sometimes kids have been involved with the police. Maybe for running away, for breaking curfew, for shoplifting. There can be lots of different reasons. Have you ever had any problems with the police?[5]
5. If you have had sex before, how many sexual partners have you had?[5] 0 partners; 1-5 partners; 6-10 partners; or > 10 partners
6. Have you ever had a STI before like gonorrhea, chlamydia, or trichomoniasis?[5]

- Question 5 is considered "positive" if child reports > 5 sexual partners[5]
- Positive answer to 2 or more questions is considered a "positive screen" (e.g., high risk). *However, further info is needed to determine if the child is being trafficked or not.*[5]
- Any positive response still needs additional assessment so a consulting a social worker is still warranted. For example, a 10-year-old with any sexual partner is cause for concern and a mandated reporter must notify DCFS and/or Law Enforcement (LE).

≥2 positive answers

Needs follow-up questions to assess level of risky behaviors

YES

NO

Notify ED provider of CST screen results. If still worried, consult social worker and/or pediatric treatment hospital

If YES, readdress immediate life-threatening dangers; follow hospital protocols and state laws; notify ED Provider and consult social worker. If no social worker available, have a trauma- informed ED MD, ED RN, or ED Advanced Practice Provider ask follow-up questions.

- Stay within your scope of practice. The purpose is to identify risk and connect patient to appropriate services. Do NOT elicit every traumatic detail as this may cause re- traumatization or vicarious trauma.
  - If patient is going to be transferred to a pediatric Treatment Hospital, then defer further questioning to them.

1. Sometimes kids are in a position where they need food, clothing, a place to stay, or want to buy something for themselves or someone else, but they don't have money. Have you ever considered trading sex for food, clothing, place to stay or anything else?[5]
2. Has a boyfriend, a girlfriend or anyone else ever asked you to do something sexual with another person (including oral sex, vaginal sex, or anal sex with someone else)?[5]
3. Has anyone ever asked you to do some sexual act in public, like dance at a bar or a strip club?[5]
4. Has anyone ever asked you to pose in a sexy way for a photo or a video?[5]
5. Have you ever talked to someone online who asked to meet for the purpose of sex?[5]
6. If any "yes" responses to screening questions or follow-up questions, then ask opened-ended questions as much as possible like "please tell me more about what happened?"[5]

FURTHER ASSESS IMMEDIATE SAFETY RISK

- Is the trafficker present in the ED?
- What does the patient believe will happen if they do not return?
- Does the patient believe anyone else (family/friends) is in danger?

NEXT PAGE FOR INTERVENTIONS

Child Sex Trafficking Exploitation (CST/E) Interventions

ED PEDIATRIC PATIENT ≥10 YEARS OF AGE

Developing plan after identifying CST/E

Multidisciplinary approach preferred; Keep ED team up to date as indicated

Readdress safety, medical and psychosocial needs including identification of other risks (e.g., labor trafficking, SA, suicidality)

When medical forensic care services are needed, follow hospital policy, SASETA mandates and contact pediatric treatment hospital if indicated

Follow hospital policy if behavioral health needs

Follow Mandated Reporting Laws (e.g., DCFS/Law Enforcement)

In Illinois, individuals under the age of 18 involved in CST are viewed as victims and cannot be criminally prosecuted for prostitution as minors cannot consent to their own exploitation

DCFS (1.800.25.ABUSE)

Whenever CST is identified or disclosed, a DCFS hotline call must be made

- Each institution is responsible for their own DCFS hotline call(s) to meet their mandate requirement
- DCFS hotline will determine which allegations they may investigate based off the cumulative information provided, which may include more than CST/E
- DCFS has a numbering allegation system to indicate type of child maltreatment; CST is #40/90 Human Trafficking allegation

Law Enforcement (LE)

- 20 ILCS 2630/3.2 Duty of healthcare providers to report to LE if any injury was sustained as a victim of a criminal offense
- Your local LE agency can be notified, even if the CST occurred in a different jurisdiction. Local LE can transfer the case to the correct jurisdiction for investigation
- Police report number will be needed when there is a SAECK. Third party reports can be accepted by LE; for example, the patient can request the medical provider to make the report on the patient's behalf. Refer to p.13–14 for LE involvement

- Follow all of IL DCFS recommendations for patient's discharge plan, as indicated
- CST victims typically go to their local Children's Advocacy Center (CAC) for a forensic interview so LE is not completing a full interview and DCFS interviews might just be for the purpose of discharge/safety planning
- Either DCFS or LE will coordinate with the local CAC

Page primary care provider (PCP) for follow-up (with consent of patient); If no PCP, then provide a referral

National Human Trafficking Hotline 24/7 with access to 200+ languages
1.888.373.7888 or Text HELP to 233733 (BEFREE)

General Resources/Referrals

- Comprehensive Community Based Youth Services (CCBYS) provides 24/7 crisis interventions for youth ages 11–17 years (e.g., locked out of their parents' homes, run away from home, homeless without parents or beyond parental control and in immediate physical danger). Call 1.877.870.2663
- National Runaway SafeLink. Online Chat: 1.800.RUNAWAY.org OR call 1.800.786.2929 or text 66008
- LGBTQ Youth Crisis line 24/7 1.866.488.7386 or text "START" to 678-678 Aunt Martha's crisis response/drop-in center: 708.679.8100
- Text "4HELP" or "44357" for immediate help from National Safe Place, 24-hour text support service for youth in crisis who will provide the closest Safe Place location. If you reply with "2Chat" you can confidentially text with a professional one-on-one
- Call or text "988" for the National Suicide and Crisis Lifeline, which provides 24/7 immediate crisis intervention and support
- Planned Parenthood or other birth control services
- For help locating a therapist knowledgeable about CST contact **or** if you need help removing images, video and comments online **or** if you want family services, call National Center for Missing and Exploited Children (NCMEC): 877.446.2632 ext. 6117
- Local psych/behavioral and/or local alcohol/substance abuse programs, 2-1-1, a national program to locate local resources (e.g., mental health or substance problems, housing and utility expenses, food programs and health care expenses): Call 211

Specific CST Resources/Referrals

- Reclaim13 Safe House for minors and has trauma therapy, support groups and mentorship: 24/7 hotline 312.462.3306
- STOP-IT has a drop-in center in Chicago for trafficked/exploited female-identifying individuals ages 14–29: 24/7 hotline 877.606.3158
- Restoration61 has case management for teens in Chicagoland area and southern IL. 773.550.7239
- Center for Prevention of Abuse is in central and southern IL, helps HT victims: hotline 1.800.559.SAFE (7233)
- Eden's Glory (central IL): 314.312.3539
- Legal help:
  - **Legal Aid Society:** 312.986.4105
  - **Heartland Alliance:** 312.660.1300

Child Sexual Abuse and Assault

Medical care that is developmentally appropriate, trauma-informed and evidence-based may be the first step in helping children heal from sexual abuse/assault (SA). Child sexual abuse (CSA) refers to sexual activity with a person younger than 18 years "that violates law or social taboos of society and that the child does not fully comprehend, does not consent to or is unable give informed consent to, or is not developmentally prepared for and cannot give consent."[83] This includes a wide range of types of contact which can occur between a child and another person or persons regardless of age or relationship to the child.

Identifying SA is challenging since most children will not have any physical findings.[21] Additionally, late disclosure and even non-disclosure are common. Children may present to the emergency department (ED) with another complaint (e.g., abdominal pain, depression, suicidal ideation) and may screen positive for SA after a brief psychosocial assessment (e.g., HEEADSSS). While there are some groups who are at higher risk of experiencing SA (e.g., LGBTQIA+, youth with runaway behaviors, foster youth, patients with multiple caretakers), SA impacts all racial/ethnic and socioeconomic groups. It is therefore important to remain unbiased when screening for SA.

> *There are significant challenges to the provision of evidence-based care to pediatric patients requiring evaluation for SA in Illinois. These next sections will help the reader navigate some of these challenging circumstances by explaining important pediatric terms and concepts as well as providing general guidelines for care.*

Important pediatric considerations

To meet the health and safety needs of children who require medical evaluation for SA, it is important to recognize that pediatric and adolescent patients have unique needs that make them different than adults. Care approaches must include consideration of the age and development of a patient. A young child's care may be different from the care of a teenager, and both may be different from adult-based care.

Important evidence-based considerations related to the care of a pediatric or adolescent patient who may have experienced SA include:

- **Definition of "Pediatric":** In the context of SA medical evaluations, "pediatric" means prepubescent or prior to the onset of secondary sex characteristics. Illinois state law (i.e., SASETA) defines pediatric patients as children with a chronological age of less than 13 years.[7] There will be times when the chronological age of 13 years and the onset of puberty do not exactly align; thus, healthcare providers (HCPs) should be familiar with evidence-based medical care to support the overall health and safety of children.
- **Adolescents:** The care of an adolescent patient is influenced by additional considerations such as sexual maturation stage, developmental needs and more complex-legal issues such as age of consent to sexual activity and rights to confidential healthcare.[36,84] Refer to sections on Navigating ANCRA and SAETA as a Mandated Reporter (p.21), Sample HEEADSSS Screening Questions (p.40) and Limits of Confidentiality and the Medical History (p.37).
- **Consent to medical forensic services (MFS):** State laws define when and under what circumstances children can consent for various medical and forensic services.[36] Refer to sections on Navigating ANCRA and SASETA as a Mandated Reporter (p.21), Limits of Confidentiality and the Medical History (p.37) and Illinois Hospital Association Consent Tip Sheet (p.39). Patients of any age should never be forced, coerced, medicated or restrained to complete a medical forensic exam. In keeping with trauma-informed care practices, even if written consent has been obtained, an exam or portion of the exam can be stopped at any moment if a patient of any age chooses not to participate. Lastly, regardless of age a patient must have decision-making capacity to consent for MFS. In high-risk situations (e.g., intoxication, developmental delay, psychosis, semi-consciousness, etc.), it is prudent to consult your hospital leadership and/or risk management.

- **Developmentally appropriate care in a child-friendly setting:** EDs can be overwhelming and scary, especially for children. Every effort should be made to provide a private, child-friendly environment to minimize additional trauma and promote emotional safety. Refer to Trauma-informed Care (p.26) and Emotionally Safe and Trauma-informed Pediatric Support for Exam Cooperation (p.29). Incorporating a multidisciplinary and collaborative approach with other pediatric-focused team members (e.g., child life specialists, social workers) contribute to an optimal experience for patients and their families. Because Children's Advocacy Centers (CACs) and child abuse clinics are specifically designed for the care of potential child victims of SA, these facilities represent the preferable setting for pediatric SA evaluations. Refer to the Children's Advocacy Center Patient/Family Handout (p.97).
- **Specialized providers required:** Both state law and medical research reflect the importance for providers with specialized training to conduct pediatric medical forensic evaluations. SASETA defines "qualified medical provider" (QMP) as a:
  - Board-certified or board-eligible child abuse pediatrician (certification by American Academy of Pediatrics)
  - Illinois-verified sexual assault forensic examiner or a sexual assault nurse examiner (verification by Illinois Attorney General's SANE Program)
  - Nationally-certified SANE-P (certification by International Association of Forensic Nurses)[7]

> *"Illinois QMPs must have access to photo documentation tools and participate in peer review."*[7]

- **Child safety and mandated reporting:** HCPs must meet mandated reporting obligations whenever there are concerns for CSA. A DCFS report must also be made when a caregiver facilitates or is aware of the SA but fails to take protective action. Refer to Expectations of a Mandated Reporter (p.12).
- **Disclosures:** Children may not disclose SA in an immediate or linear fashion. Disclosure is often a process, and not a clear single event. This can make an SA evaluation more complicated and reinforces the need for a developmentally-appropriate forensic interview. If a child makes a spontaneous disclosure during the ED visit, the disclosure should be documented using direct quotations along with the circumstances surrounding the disclosure.[85,86] See Medical History-taking from Children including the Limits of Confidentiality and the Medical History (pp.37–38) and Overview of Suspected Child Physical Abuse/Neglect (p.42).
- **Forensic Interview (FI):** During a FI, an expert will interview a child in a forensically sound (i.e., non-leading, permissible in court) and developmentally appropriate manner, allowing a child(ren) to provide their narrative of events and details about the abuse or neglect they experienced. FIs are a critical part of the investigation but are outside the scope of practice for HCPs. ED HCPs are not forensic interviewers and should avoid directly questioning young children about their potential abuse to avoid potentially compromising the FI unless there is not enough information to determine the need for a medical forensic exam or a mandated report. Please refer to the sections on Medical History-taking from Children including Limits of Confidentiality and the Medical History (pp.34–38), and Overview of Suspected Child Physical Abuse/Neglect (p.42).
- **Type of SA contact:** In cases of CSA, most often young children experience sexual contact that is different than adolescents or adults.[87] Physical contact often occurs on the outside of the body, typically does not produce any visible physical injuries, and may not involve any exchange of bodily fluids.
- **Most physical exams are normal:** There is often undue emphasis placed on the presence or absence of physical exam findings during an SA evaluation. There are multiple reasons why children and adolescents presenting to the ED with concerns for SA may have normal physical exams; for example, no sexual contact occurred, delayed disclosures, rapid healing of mucosal tissues and type of sexual contact.[90] Therefore, a normal exam does not prove or disprove SA even if vaginal and/or anal penetrating trauma did occur.[21,89,90]
- **Time frames for evidence collection:** The yield of evidence collection depends on the type of SA contact and the time elapsed since the SA event. The sooner evidence is collected, the more likely DNA will be recovered.[21,91] This is especially true for prepubertal children.[91-96] Providing up-to-date evidence-based information on the timing of evidence collection will help patients/families make the best-informed decision when deciding to collect evidence or not. Refer to Factors Potentially Affecting DNA Recovery (p.85).

- **Multidisciplinary approach:** For optimal patient experience and health outcomes, it is important to coordinate and communicate with community partners. This facilitates timely initiation of appropriate medical care while also avoiding unnecessary/duplicative testing, impedance to exams and inaccurate diagnoses. Community partners include:
  - **Prehospital providers:** Prehospital providers, such as EMS, are in a unique position to potentially see the child's home environment or hear initial statements (i.e., outcry), which can be shared with treatment providers. They may also be the first contact the family has with the medical system, and initial rapport building can set the stage for other positive interactions with HCPs.
  - **Transfer hospital staff**: May communicate with the QMP at the treatment hospital to develop an appropriate plan of care.
  - **Community stakeholders:** May respond to a child abuse allegation and are vital to the investigation outside of the hospital setting. Community stakeholders include DCFS, law enforcement (LE), advocate agencies and legal professionals (e.g. state's attorney).
- **Children's Advocacy Center:** Within a CAC, a dynamic multidisciplinary team of pediatric SA experts (e.g., HCPs, LE, DCFS, advocates, legal professionals) provide coordinated, evidence-based, trauma-informed services for patients and their families at a single location within the community. CACs are accredited by the National Children's Alliance, which sets minimum guidelines for HCPs who conduct child abuse medical evaluations through CACs.[97] Refer to Children's Advocacy Center Patient/Family Handout (p.97) and IL CAC Map with QR Code (p.99).
- **Advocacy services:** Advocacy services offer resources to help patients and their families cope with and heal from trauma. They can provide resources both during (e.g., crisis intervention, emotional support, immediate safety planning) and after the ED visit (e.g., long-term safety planning, counseling, support groups, crime victim compensation application support, accompaniment during further medical appointments or legal proceedings). National Sexual Assault Hotline: 1.800.656.4673.
- **Family-centered care:** Caregivers play a critical role in (1) identifying and reporting concerns for SA, (2) offering support during the medical evaluation, (3) ensuring the safety measures recommended by DCFS and LE are in place for the child, and (4) scheduling follow-up services.

> **IMPORTANT**
>
> Caregivers may have their own history of trauma which may affect their ability to provide ongoing care. Supporting and addressing the needs of families is essential to a child's healing.

- **Follow up services and support:** It is important that both verbal and written resources are provided to patients and their families upon discharge from the hospital. The initial evaluation is a mere step in the larger investigation and healing process. It is important for patients and families to be aware of the next steps and feel supported after they leave the ED.

State Laws: ANCRA and SASETA

There are two important state laws for HCPs to understand when caring for children who are potential SA victims. Sexual abuse is child abuse. ANCRA requires that certain professionals (mandated reporters) are required to immediately report suspected child abuse or neglect (CAN) to DCFS.[3] Refer to p.21 for more information about ANCRA.

Child Abuse Hotline: 1.800.25.ABUSE

The Sexual Assault Survivors Emergency Treatment Act (SASETA) is the Illinois State law that mandates the care and services to be provided to a patient presenting for an SA evaluation.[7] The law includes:

- Definitions of terms as they apply to the law: There are definitions within SASETA that have implications for how, when, where, and by whom MFS are provided to children in Illinois.
- Facility treatment and transfer plans: Staff should have an awareness of their facility's treatment plan to initiate the appropriate plan of care for a patient having concerns for SA. Refer to Determining The Need Transfer When Concerns for CSA (p.93).
- Medical forensic services (MFS) to be provided to those presenting for evaluation of SA: SASETA mandates specific services that are to be offered to patients presenting with concerns for SA.[7] See Basic Definitions section (p.8). MFS specified within the law include:
  - Medical history-taking
  - Photo documentation
  - Physical exam, including anogenital area
  - Assessing the patient for evidence collection
  - Collecting evidence in accordance with a statewide sexual assault evidence collection program administered by the Illinois State Police Sexual Assault Evidence Collection Kit (SAECK)
  - Assessing for drug-facilitated or alcohol-facilitated sexual assault
  - Providing an evaluation for sexually transmitted infection (STI) and human immunodeficiency virus (HIV)
  - Pregnancy risk evaluation and care
  - Discharge and follow-up healthcare planning
- **Rape crisis advocate access:** Facilities that provide services to patients that have acute SA concerns are required to have an agreement with a local rape crisis center.
- **Ongoing training requirements:** ED staff at hospitals providing care to SA survivors are required to participate in ongoing training related to SA care.
- **Billing practices:** Those presenting for an evaluation after acute SA cannot be billed for those services. Treatment facilities enroll patients in the Illinois Sexual Assault Survivor Registration System (ERSASS). A voucher is provided to the patient and can be used to cover costs of the ED visit and related follow-up services for 180 days after the ED visit.

Facility Treatment and Transfer Plans

Every hospital required to be licensed by the Illinois Department of Public Health (IDPH) pursuant to the Hospital Licensing Act or operated under the University of Illinois Hospital Licensing Act that provides general medical and surgical services must provide SA survivors medical forensic services (MFS) or transfer to a facility where the patient may receive MFS.[7] Furthermore, facilities are required to submit a Sexual Assault Treatment Plan indicating their designation type for approval by IDPH.[7] See Table 11. It is important for hospital staff to be familiar with their hospital designation type and the details of their facility's sexual assault treatment plan and related facility policies. An updated hospital list with SASETA plan type is available at https://dph.illinois.gov/topics-services/health-care-regulation/hospitals/saseta/hospital-listings.html.

TABLE 11

HOSPITAL DESIGNATION	
Treatment hospital	Hospital with an approved plan to provide medical forensic services to patients of any age
Transfer hospital	Hospital with an approved plan to transfer ALL patients who present for medical forensic services
Treatment hospital with approved pediatric transfer	Hospital with an approved plan to treat patients ≥ 13 years and transfer pediatric patients (i.e., patient < 13 years) to an approved pediatric facility
Approved pediatric healthcare facility	A healthcare facility other than a hospital with an approved plan to provide medical forensic services to patients under the age of 18 years
Out-of-state hospital	Hospital located in a county that borders Illinois with an approved plan to provide medical forensic services

AREAWIDE SEXUAL ASSAULT TREATMENT PLAN

In accordance with SASETA, any hospital or healthcare facility that transfers or receives patients for a SA evaluation must be part of an areawide sexual assault treatment plan (AWTP). An AWTP is "a plan, developed by hospitals or by hospitals and approved pediatric healthcare facilities in a community or area to be served, which provides for medical forensic services to SA survivors that shall be made available by each of the participating hospitals and approved pediatric healthcare facilities."[7] The AWTP becomes part of each hospital's SA treatment plan that is submitted to and approved by IDPH.

Facilities with SASETA Transfer Hospital Designation

(This subsection highlights considerations of care provided at transfer hospitals)

It is important to follow all facility, local, state and federal requirements (e.g., EMTALA and Memorandums of Understanding). This includes being mindful to any special considerations of children requiring MFS presenting to a designated transfer hospital or treatment hospital with approved pediatric transfer hospital. As with any ED patient, the first step is to address any emergent healthcare needs. A patient's emergent clinical needs should always be prioritized over any forensic needs. A patient may require transfer for emergent medical, surgical or psychiatric care regardless of the need for forensic care. When it is determined that immediate health and safety issues have been resolved, HCPs who may transfer a patient for MFS should perform certain steps to ensure appropriate initial care, preservation of evidence and decision to transfer. This toolkit contains algorithms that may be useful to facilities transferring pediatric or adolescent patients requiring SA care.

ALGORITHMS

- The **Determining the Need to Transfer When There are Concerns for Child SA: Assisting Hospitals Who Transfer Children Needing MFS** algorithm assists the HCP in determining when transfer to a treatment facility is indicated in Illinois. (p.93).
- The **Medical Management of Children with Non-Emergent Concerns of SA algorithm** supports evidence-based practice by known pediatric experts in the community using a multidisciplinary approach to care for children having non-emergent concerns for SA (p.92).

What if transfer is indicated, but is declined?

Interfacility transfer requires the legal guardian's consent and/or the patient's consent. A HCP may encounter a situation in which the legal caregiver and/or patient is declining to transfer despite the staff's obligation to offer transfer according to their hospital's SA treatment plan and AWTP. Depending on the individual circumstance, this can pose risk of harm to the child or may be an appropriate choice reflective of evidenced-based practices. See below for further explanation.

- **Declination of transfer poses risk to child:** If there is significant risk that the declination to transfer could cause harm to the child (e.g., child's presentation is within evidence-based time frames for DNA recovery, if there are physical symptoms or injuries, child will be in contact with the named perpetrator), then DCFS must be immediately notified. If DCFS was already notified regarding the concerns for SA, an additional phone call to DCFS is warranted upon declination of transfer. A DCFS response should be requested whenever a guardian is making a decision that fails to protect the child. DCFS will then determine patient disposition, which may include taking protective custody or eliminating barriers with the family to ensure transfer to a treatment facility.
- **Declination of transfer is appropriate:** There are times when declining transfer is appropriate. In some cases, outpatient care (e.g., care provided at a CAC, child abuse clinic, etc.) is best practice. Such cases include patients who do not have any emergent physical, psychological or forensic needs. An example could be an asymptomatic pediatric patient without immediate psychiatric needs who was touched by a perpetrator who has not resided in the home nor had contact with the child within the last seven days. Care would be best deferred to a pediatric expert in CSA in the outpatient setting (e.g., CAC) since acute MFS would not likely be beneficial. Even in cases where transfer is declined, mandated reporting of the SA is still indicated and there should be a clear follow-up plan. Consultation with a pediatric expert (CAP or SANE-P) is recommended before making decisions to interview a child, perform an anogenital exam or complete STI testing on pediatric patients who decline transfer.

When there are questions about potential transfers to treatment facilities or whether certain MFS (e.g., anogenital exam, STI testing, child interviewing) should be provided at a transfer hospital, consultation with a pediatric QMP is recommended

Preserving evidence prior to a medical forensic exam

As soon as concern arises that a patient may require an emergent medical forensic exam, it is important to protect any evidence that may be useful for the investigation. If evidence is collected at a facility that will transfer a patient, the transferring facility should consider contacting the QMP at the treatment facility who may help advise proper collection and release to LE. It may be preferred for a facility to collect the evidence and release it directly to LE following their own facility's forensic evidence policy and procedures to prevent lapses in chain of custody. The following section details how HCPs can assist in maintaining evidence integrity prior to the medical forensic exam.

PHYSICAL EVIDENCE

Care should be taken to avoid any activities that could destroy physical evidence, including DNA evidence or foreign material, that may scientifically support SA or that links a patient and/or the perpetrator to a crime scene. Activities that destroy evidence and should be avoided prior to the medical forensic exam include:

- **Playing with toys/items that may leave residue.** Prior to the exam, avoid toys such as Playdoh, paints, bubbles, etc. that may stick to or stain the skin, hair and fingernails.
- **Eating, drinking and chewing gum.** If possible, initiate NPO status (i.e., nothing to eat/drink) for patients with concerns for SA until after the medical forensic exam has been completed.
- **Washing or wiping any body parts.** Using water or baby wipes to clean any part of the body will likely wipe away evidence in that area. Avoid activities such as washing hands, wiping face, etc. until after the medical forensic exam.
- **Urinating and defecating.** Often, especially in the case of pediatric patients and/or if medical MFS are delayed (e.g., awaiting transfer or consent), this cannot be avoided.

— DO NOT collect clean midstream urine samples or catheterize a patient prior to the medical forensic exam. A timely reason to collect urine prior to the medical forensic exams is when there are concerns for suspected drug facilitated sexual assault (DFSA). See page 86. Otherwise, urine is used for medical testing as needed.

— Avoid changing diapers, sanitary napkins or tampons. If these items are removed, they should be placed in a paper bag and secured as evidence.

— If the patient must urinate prior to evidence collection, consider collecting a pre-void wipe. Instruct the patient to wipe the urogenital area with a sterile gauze using a front-to-back technique.

Since this pre-wipe gauze will need to be secured as evidence, follow hospital policies, recommendations from the Illinois Office Attorney General, and contact the QMP at the treatment facility.[98] Consultation with hospital leaders, including risk management, may be required. **At the date of this Child Maltreatment Toolkit's publication, the state is finalizing their process and beginning to provide education regarding their pre-void wipe recommendations. Refer to the Illinois State Police website where prepackaged pre-wipe ordering forms can be found.[98]**

Resources for guidance on evidence collection include: Hospital policies, SANE Coordinator, Illinois State Police Forensics webpage[98], the QMP at the Treatment Hospital, and/or Illinois Office of Attorney's SANE Coordinator.

- **Changing clothing.** If the patient removes an item of clothing prior to the medical forensic exam (i.e., takes it off in the ED or brings the item to ED) each item should be placed in a separate paper bag and secured and labeled as forensic evidence.
- **Notify LE of evidence disclosed by patient or caregiver.** At times a patient or caregiver may disclose items that the provider realizes may be important to an investigation such as unwashed clothing, bedding or a soiled diaper. Advise the caregiver to secure the item and notify LE so that it can be retrieved as evidence.

VERBAL DISCLOSURES

A child's verbal disclosure is considered an important piece of evidence and may be the sole evidence in cases of SA. Tips to ensure evidence integrity include the following:

- **Avoid directly interviewing pediatric patients.**
  Responding HCPs should obtain information related to the SA concern from the caregiver (e.g., parent) without the child present. An FI will likely be obtained as part of the investigation, so the HCP only needs to obtain enough information for reporting and the provision of relevant medical forensic services.
- **Document disclosures in quotations and include circumstances of the disclosure.**
  Refer to Medical History-taking from Children (pp.34–38).

  Example documentation of a spontaneous disclosure (outcry): *During the exam while helping patient change out of clothing and into a hospital gown, the patient stated spontaneously, "My uncle takes my clothes off. I am naked then and he touches my pee-pee when I am on the couch."*

Medical forensic services at facilities with treatment hospital designation

(This subsection highlights considerations of care provided at treatment hospitals)

Medical Forensic Services (MFS) by a QMP are to be offered to patients with concerns of SA within the last seven days who present to the ED of a hospital with treatment hospital designation.[7] Although it is the responsibility of the QMP to be proficient in providing MFS, the facility will need to provide appropriate resources for the proper provision of care. This next section provides a non-exhaustive list of guidelines, resources and tools that may be useful to a QMP. SASETA-specific resources are also listed in the weblinks section at the end of this toolkit.

The "Medical Forensic Services Provided to a Patient with SA Concerns that Presents to a Treatment Facility" algorithm provides an overview of the services provided at a treatment hospital. Refer to p.94.

MULTIDISCIPLINARY CARE

SA is a complex healthcare and community issue. A collaborative multidisciplinary approach engaging all members of the ED team (e.g., social work, child life specialists), subspecialists (e.g., trauma surgery, psychiatry, infectious disease) and community partners (e.g., DCFS, LE, advocacy) is necessary to ensure optimal health and safety outcomes for patients and their families.

> *For any HCP, including QMPs, it is important to recognize individual scope of practice and limitations. There may be times when the QMP must consult a child abuse expert (e.g., CAP or SANE-P) for a second opinion when directly caring for a child having concerns for SA. Facilities should keep a regularly updated resource list identifying expert resources available to the QMP. Given the national shortage of CAPs and shortage of QMPs in Illinois, telehealth can be a fruitful option in creating access to pediatric experts.*

History-taking by the QMP at a treatment hospital

The goal of the history completed by the QMP in an ED setting should be to obtain information necessary to determine MFS recommendations and to guide mandated reporting. Because a child's disclosure is considered crucial evidence, it is important to protect the patient's words. When there is significant concern for SA, children often are referred by investigators to have a FI. Forensic interviewers are specially trained to interview children in a developmentally appropriate and forensically sound manner. The QMP should make every effort to obtain information from the parent without the patient present in order maintain the integrity of the child's disclosure and information that will be obtained during the FI.

Sometimes a caregiver (e.g., parent) is not able to provide sufficient information to appropriately determine whether to proceed with a DCFS report and medical forensic exam. In these cases, the QMP may need to obtain information from other relevant sources (e.g., caregivers, LE, DCFS). If a provider must speak with a child, care must be taken to only ask open-ended questions. Refer to Medical History-taking from Children and Limits of Confidentiality and the Medical History (pp.34–38). If a SAECK will be performed in an older child/adolescent, directed questions may be appropriate to maximize the possibility of DNA recovery and to inform medical decision-making based on the patient's individual risk. History-taking should be done with care and in consideration of the patient's developmental level.

> *Whenever possible, the QMP and social worker should collect the history together at the same time. The combined effort reduces the patient's/family's trauma of repeatedly providing sensitive information and enhances the team's shared understanding of the SA concerns.*

This sample template includes relevant information that can be used to guide the ED visit including necessary information for reporting and determining which MFS to offer to the patient and family. This sample template suggests relevant information to document in the medical record regardless of SAECK completion. Additional screening questions may be needed (e.g., concerns for non-fatal strangulation, child sex trafficking/exploitation, suicidal ideation).

Sample template for medical history-taking

- **How did the patient present?** (e.g., walk-in, transfer from another facility, via EMS)
- **Who referred the patient?** (e.g., transferring hospital, self, DCFS, PCP, EMS, LE)
- **From whom was the history obtained and was the patient present?**
- **Were there interpreting services used?** If yes, document language and name of the interpreter
- **Specific details describing the concerns for SA:**
  - Was there a disclosure of SA? Document a disclosure using exact words in quotations.
  - Was there a concerning event? (e.g., witnessed event, sexually explicit images on a cell phone, inappropriate text message/social media conversation)
  - When did this happen? (including last contact with named perpetrator)
  - Where did this happen?
  - Did it happen more than once?
  - Are there injuries or physical symptoms concerning for SA? (e.g., pain, bleeding, discharge)
  - Are there any additional SA disclosures or concerning events?
- **Details related to the named perpetrator:**
  - Name of perpetrator, age of perpetrator (i.e., is this an adult?) and relation to the patient
  - Does the perpetrator live in the home or have access to the child?
  - Are other children at risk? (e.g., does the named perpetrator have access to any other children at home, work, etc.?)
  - Perpetrator risk factors: Known sex offender, history of STIs including Hep B and HIV, men who have sex with men (MSM), intravenous drug use (IVDU), etc.
- **Significant social history:**
  - Developmental history/concerns:
    - Is the patient meeting their developmental milestones?
    - Are there any behavioral changes? Is the patient experiencing any changes in sleep, appetite, school performance, sexualized behaviors?
  - Toilet training: At what age was the patient toilet trained? Any urinary/stool accidents? Does the patient require toileting or bathing assistance? Any recent changes?
  - Has there been prior concern for sexual or physical abuse?
  - Prior involvement of DCFS or police
  - History of intimate partner violence or domestic violence in the home
  - Drug or alcohol use by anyone in the home
  - Mental health concerns about anyone in the home
- **Medical and surgical history**
  - Record all past and current medical and surgical issues
  - Allergies
  - Vaccination status (specifically tetanus, HPV, Hep B)
  - Medications
  - Recent antibiotic use
- **Additional anogenital health questions:**
  - History or current anogenital rash, bleeding, discharge, infection, injury, pain or surgery
  - History of UTI or constipation and treatments provided
- **Mental Health History**
  - Patient and family history
  - Screen for suicidal ideation, homicidal ideation and self-injurious behavior

- **Additional adolescent history including an HEEADSS assessment.** Refer to Sample HEEADSSS Screening Questions (p.40)
  - Female anatomy: Menarche, LMP, any menstrual irregularities, history of pregnancy, birth control
  - Consensual sexual activity including type and date of last encounter
  - Prior STIs and treatment

General principles to the medical forensic exam at a treatment hospital

- Patients of any age should not be physically restrained (e.g., manually held down) or chemically restrained/sedated (e.g., diphenhydramine) to collect forensic evidence (e.g., SAECK).
  - There may be rare instances when an examination needs to be performed under sedation in the operating room (e.g., retained foreign body or severe anogenital trauma). For these instances, the pediatric SANE can collaborate with the ED attending who can help facilitate the care with appropriate pediatric subspecialists (e.g., trauma, gynecology, CAP) which may include transfer to a higher level of care for emergent medical needs.
- Limit the anogenital exams to QMPs whenever a child is having concerns for SA.
  - There should be consistency in examination techniques including documentation reflective of best practices.[90]
- Perform a detailed examination of the oral cavity including photos whenever there are concerns for oral trauma.[90]
  - Use appropriate secondary confirmation techniques (e.g., prone knee chest) to confirm positive or inconclusive exam findings.[90]
  - Avoid using TEARS and TBARS acronyms when documenting the physical examination and interpretation of findings. These are not validate or evidenced-based acronyms. For example, redness (i.e. erythema) is a finding that can be caused by other medical conditions besides trauma or sexual contact.[90]
- Consult a child abuse pediatrician or other pediatric expert in child SA in real time whenever there are questions (e.g., unclear or questionable examination findings) or clinical concerns.
- High-quality photo or video documentation is critical for confirmation of findings by an expert in CSA.[90] This may also help avoid unnecessary repeat examinations which reflects trauma-informed care.
- Regular participation in multidisciplinary peer review with a pediatric expert in CSA is essential to maintaining forensic skills.[90]

Sexual assault evidence collection kit (SAECK) at treatment hospitals

SASETA indicates the QMP must offer a SAECK to any patient with concerns of an SA event occurring within the last 7 days or to a pediatric patient who has disclosed past SA but was in the presence of a named perpetrator within the past 7 days.[7]

FACTORS POTENTIALLY AFFECTING DNA RECOVERY

State law (SASETA) indicates that providers must offer MFS including SAECK completion to all patients who present to an ED for evaluation of SA within seven days of last known/suspected contact with a perpetrator, regardless of age or circumstance.[7] Therefore, it is important that QMPs are well versed in evidence-based time frames for meaningful DNA recovery to provide accurate and relevant information during the informed consent process. Performing an unnecessary SAECK procedure can exacerbate a child and/or family's trauma.

Pediatric (prepubescent) patients: Research demonstrates that DNA evidence collection from pediatric/prepubescent patients can yield results if collected within 24 hours of SA contact.[91] Sometimes DNA can be recovered up to 72 hours post incident.[91] After 72 hours, DNA recovery is almost never achieved from a prepubescent patient.[91]

- Consider a 4-year-old child brought to the ED by their parents due to a spontaneous disclosure of being touched over clothing by an adult cousin five days ago. Although it is within the seven-day time frame, yield of results would be very low due to type of contact and last known time with the named perpetrator. Completing a SAECK would likely add emotional distress and anxiety for the patient, is not consistent with evidenced-based care, and is not trauma-informed.
- Even when evidence collection is not clinically indicated, consider the emotional toll on a caregiver who must sign a legal document declining MFS.

Type of contact: Genital-to-genital contact and exchange of body fluids (e.g., semen, saliva, blood) increases the likelihood of DNA recovery.

Post abuse/assault activities: Activities such as bathing, voiding, diaper changes, etc., decrease the likelihood of meaningful DNA recovery.

Adolescent/adult (post-pubescent) patients: In adolescent and adult patients, DNA recovery can occur within more extended time frames (seven days or more) when there is genital-to-genital contact and/or exchange of body fluids. This is largely due to the older victim's ability to make a clear and, often times more immediate, disclosure. During the informed consent process, the likelihood of DNA recovery should be discussed based on type of contact and post-assault activities.

Unwashed clothing/bedding: DNA can persist on unwashed clothing and bedding for the longest time frames. Anytime there is notice of unwashed bedding or clothing, those items should be collected if available or referred to LE for collection.[91-96]

Illinois State forensic forms

Illinois State Police forensic forms are available at

- Medical Forensic Documentation Forms[98]
- Patient Consent for Evidence Collection[98]
- Drug Facilitated Sexual Assault Forms[98]
- Patient Discharge Materials[98]
- Ordering forms for pre-wipe packets and sexual assault evidence collection kits[98] refer to link: https://isp.illinois.gov/Forensics

Sexual assault evidence tracking

Entering the SAECK information correctly into CheckPoint as well as giving the patient their confidential pin number is essential for the patient/family to track how the SAECK is being processed by the Illinois Crime Lab. Users of the Illinois SAECK system can find further information and access to SAECK order forms on the Illinois State Police website, Division of Forensic Services page.[99] Refer to link: https://isp.illinois.gov/Forensics

Drug facilitated sexual assault (DFSA)

DFSA occurs when alcohol or drugs are used to compromise a person's ability to consent to sexual activity. The substances make it easier for a named perpetrator to commit SA because they lower a person's ability to resist and can inhibit memory. Alcohol is the most used drug in cases of DFSA.

Signs and symptoms that someone may have been drugged:

- Nausea[100]
- Loss of bowel or bladder control[100]
- Difficulty breathing[100]
- Feeling drunk without alcohol consumption or with minimal alcohol consumption[100]
- Sudden dizziness, disorientation or blurred vision[100]
- Sudden body temperature change that could be signaled by sweating or chattering teeth[100]
- Waking up with no memory of recent events or missing large portions of memories[100]

Illinois specific forensic forms (e.g., Consent to Toxicology form; Medical Personnel Instruction Sheet and Patient Info Sheet) can be found on the Illinois State Police website.[98] Refer to link: https://isp.illinois.gov/Forensics

Testing for sexually transmitted infections (STIs)

Indications to consider STI testing in a pediatric patient include:

- Concern for genital-genital, genital-anal or genital-oral contact[90,101]
- Signs or symptoms of any STIs[90,101]
- Legal caregiver or pediatric patient requests STI testing[90,101]
- Pediatric patient has limited verbal skills and is unable to provide SA details[90,101]
- Named perpetrator is a stranger[90,101]
- Named perpetrator is known to be infected with an STI or is at high risk for STIs (e.g., IVDU, MSM, multiple sex partners, or history of STIs) [90,101]
- Pediatric patient has a sibling, relative or household contact with an STI[90,101]
- Pediatric patient lives in an area with a high rate of STIs in the community[90,101]
- Concerns for child sex trafficking and exploitation[90]
- If a patient tests positive for any STI, he/she should be screened for all other STIs[90,101]
- Witnessed SA, including SA captured by photo/video[90]

TYPE OF TEST

- A method of testing that minimizes pain and trauma to the child and that maximizes sensitivity and specificity is preferred. Facilities that treat children should ensure that testing types appropriate for children are available. Use of standardized order sets can help ensure appropriate pediatric choices are available and utilized.
- Consider that children may have incomplete disclosures so testing pharyngeal, urogenital and rectal sites are recommended even if only one type of contact was disclosed.[90] Also, there may be contiguous spread of chlamydia from genitals to anus (most often in patients with vulvas) so testing of multiple sites (e.g., rectum, vagina) is recommended even when only vaginal to penile penetration is disclosed.[90,101]
- NAAT testing including urine samples and extragenital testing are now preferred due to their high sensitivity. All providers should ensure a testing strategy that maximizes specificity[90,101] Furthermore, confirmatory testing should be obtained prior to administering treatment to prepubertal patients and adolescents who are not sexually active due to the potential forensic significance.[90]

Implications and reporting

The presence of certain STIs (see Figure 12) is indicative of sexual contact if perinatal transmission is excluded. Because pediatric patients do not have the capacity to consent to sexual activity, the presence of certain STIs in a pediatric patient is indicative of sexual abuse. The forensic significance of a positive test may be impacted when an adolescent is having consensual sex with a similarly aged peer; therefore, a HCP may need to consult with an expert in CSA.

Reporting STI as indicator of SA in infants and prepubertal children

The following table from the CDC STI Treatment Guidelines, 2021, is helpful in determining the significance of an infection and the recommended reporting action. Consultation and follow-up with a pediatric expert in CSA is recommended.

FIGURE 12

IMPLICATIONS OF COMMONLY ENCOUNTERED SEXUALLY TRANSMITTED OR SEXUALLY ASSOCIATED INFECTIONS FOR DIAGNOSIS AND REPORTING OF SEXUAL ABUSE AMONG INFANTS AND PREPUBERTAL CHILDREN[101]

INFECTION	EVIDENCE FOR SEXUAL ABUSE	RECOMMENDED ACTION
Gonorrhea*	Diagnostic	Report†
Syphilis*	Diagnostic	Report†
HIV§	Diagnostic	Report†
*Chlamydia trachomatis**	Diagnostic	Report†
*Trichomonas vaginalis**	Diagnostic	Report†
Anogenital herpes	Suspicious	Consider report†,¶
Condylomata acuminata (anogenital warts)*	Suspicious	Consider report†,¶,**
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

Sources: Adapted from Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics 2005; 16:506–12; Adams JA, Farst KJ, Kellogg ND. Interpretation of medical findings in suspected child abuse: an update for 2018. *J Pediatr Adolesc Gynecol* 2018;31:255–31.

* If unlikely to have been perinatally acquired and vertical transmission, which is rare, is excluded.
† Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect.
§ If unlikely to have been acquired perinatally or though transfusion.
¶ Unless a clear history of autoinoculation exists.
** Report if evidence exists to suspect abuse, including history, physical examination or other identified infections. Lesions appearing for the first time in a child aged >5 years are more likely to have been caused by sexual transmission.

TABLE 12

STI PROPHYLAXIS AND TREATMENT (GONORRHEA, CHLAMYDIA, AND TRICHOMONIASIS)	
Patient is prepubertal	Do NOT provide prophylaxis. Prepubertal patients are not at risk of STI sequelae such as pelvic inflammatory disease. Since a positive test result is forensically important in this population, patients should be treated only after a positive test result and confirmatory testing.
Patient is pubertal	DO provide prophylaxis. While the presence of an STI may have forensic implications, the risk of medical complication is significant.

Medications and dosing for prophylaxis and treatment

- Before providing medications for prophylaxis or treatment, consultation with an expert in CSA is highly recommended.
- Refer to CDC Sexually Transmitted Infections Treatment Guidelines or The Red Book for up-to- date medication and dosing recommendations.[101,102]

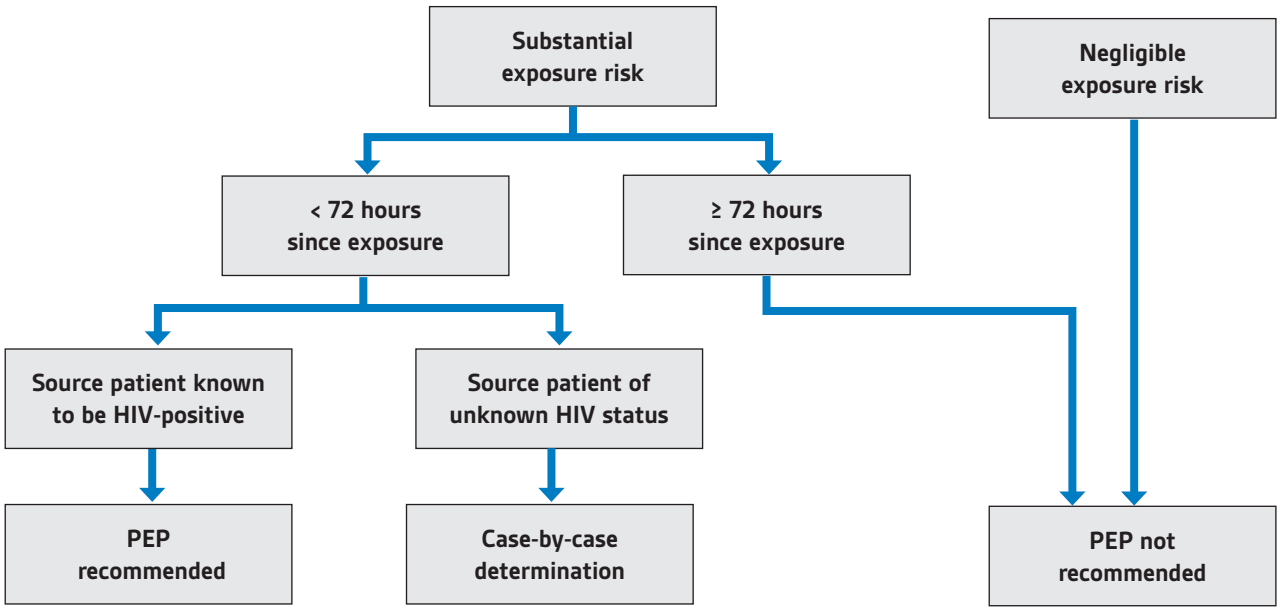
Because of medical, forensic, and social implications, it is recommended that STI testing, interpretation of results, and treatment of prepubescent children be done in consultation with a pediatric expert in SA (e.g., child abuse pediatrician).

HIV post exposure prophylaxis (PEP)

- The decision to recommend HIV prophylaxis depends on multiple factors, not limited to:
  - Risk of HIV infection in the named perpetrator
  - Characteristics of the SA that might increase the risk of transmission such as nature of contact, or presence of an acute genital injury
  - Timing of contact (must be < 72hr)
  - Ability of the patient/family to successfully complete the medication course as prescribed
- Consultation with a HIV specialist is recommended, as needed
- If patients are eligible for HIV PEP, discuss the risks and benefits with the patient (depending on age/developmental appropriateness) and family
  - Most common side effects include GI symptoms and fatigue
  - Counsel regarding the importance of adhering to the medication exactly as prescribed and discuss whether the patient/family feels this is feasible. This includes providing information on what to do if the patient experiences a medication side effect.
- Perform baseline complete blood count, serum chemistry and HIV testing
- Provide enough medication to last at least three to seven days and discharge the patient home with a prescription for the remainder of the 28-day medication course
- Recommend that patient follow up with a provider (e.g., pediatrician, CAP, infectious disease physician) comfortable in managing the patient's clinical response and compliance with HIV PEP

FIGURE 13

Algorithm for Evaluation and Treatment of Possible Nonoccupational HIV exposure[101]



SUBSTANTIAL RISK FOR HIV ACQUISITION

Exposure of
vagina, rectum, eye, mouth or other mucous membrane, non-intact skin, or percutaneous contact

With
blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

When
the source is known to be HIV-positive

NEGLIGIBLE RISK FOR HIV ACQUISITION

Exposure of
vagina, rectum, eye, mouth or other mucous membrane, non-intact skin, or percutaneous contact

With
urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

Regardless
of the known or suspected HIV status of the source

Source: Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual Injection-Drug Use, or Other Nonoccupational Exposure to HIV — United States, 2016. MMWR *Morb Mortal Wkly Rep*, 2016. 65(17): p.458.

Discharge and follow-up healthcare planning

Follow-up is best determined in conjunction with a specialist in CSA. In general, follow-up may include a visit with the pediatrician within one to two weeks to check in regarding any outstanding medical or psychiatric needs. In some cases, repeat STI testing may be indicated and may be performed by a child's PCP. For adolescents, prophylactic medications given and history of consensual sexual activity help to guide future medical decision-making about repeat testing. Sometimes pediatric patients need close follow-up related to concerns for SA (e.g., resolution of injuries, medication tolerance to HIV PEP, suicidal ideation due to SA, etc.).

Standardized discharge instructions (e.g., a Medical Forensic Fact Sheet[98]) will likely need tailoring to meet the patient's individual needs. For example, a child who disclosed low-risk contact (e.g., digital-genital contact) would not need repeat labs. Connect patients with specific follow-up providers and services in the community while considering and addressing anticipated barriers to accessing such referrals.

Peer review

Peer Review is a professional quality improvement activity that improves clinical practice through knowledge-sharing and discussion. High quality photo or video documentation should be included to ensure diagnostic accuracy.[90] Having a CSA expert as a part of the peer review process will help to ensure best practices.[90] The IL EMSC Sexual Assault Peer Review Monitoring Documentation Tool may be useful to ensure an objective, standardized approach (p.95). Reach out to your hospital leadership for further support and guidance.

Self-care of staff (i.e., preventing vicarious trauma)

Maintaining a resilient healthcare team requires a joint effort between front-line staff and organizational leadership. Promoting a healthy and achievable work-life balance requires commitment and effort from both the employee and the workplace. Participating in self-care activities that promote wellness is essential for the employee. Leadership can help by modeling ideal trauma- informed care behaviors, maintaining open dialogue among staff, offering support (e.g., individual and/or peer), hosting educational trainings and providing opportunities for self-care.[20]

Advocacy opportunity

It is important to support legislative changes that reflect pediatric evidence-based practices (e.g., time frames for evidence collection).

Interpreting Exam and Lab Findings

Kellogg et al's Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2023 is an evidence-based guideline that summarizes how to determine the significance of anogenital exam findings and positive infectious testing in cases of suspected child sexual abuse (CSA).[90] While this article is an excellent resource, it is not an appropriate replacement for consultation with a child CSA expert (i.e., child abuse pediatrician.) In addition, clinicians should be aware of their scope of practice as it relates to diagnosing and treating medical conditions. Very few medical findings (i.e., pregnancy) are independently diagnostic of sexual contact. In addition, a normal anogenital exam with negative STI testing never excludes sexual contact. Therefore, identified medical findings must be interpreted within the context of all available information and in consultation with an expert in CSA.[90]

Below are select physical exam findings that are commonly caused by conditions other than trauma or sexual contact as per the Kellogg et al article. We highlighted these conditions because they may be mistaken as markers for CSA to non-experts.

FINDINGS COMMONLY CAUSED BY CONDITIONS OTHER THAN TRAUMA OR SEXUAL CONTACT *(ADAPTED FROM TABLE 1, SECTION 1B)*

- Erythema, inflammation, fissuring, and/or maceration of perianal, perineal or vulvar tissues related to poor hygiene or other irritant dermatitis (e.g., vulvovaginitis, diaper dermatitis, balanitis)[90]
- Increased vascularity of vestibule and hymen[90]
- Labial adhesion[90]
- Friability of the posterior fourchette[90]
- Vaginal discharge that is not associated with a sexual transmitted infection (e.g., discharge secondary to a foreign body)[90]
- Anal fissures[90]
- Venous congestion or venous pooling in perianal area[90]
- Complete/immediate anal dilation in children with pre-disposing conditions (e.g., constipation, child under anesthesia)[90]

SOME IMPORTANT HIGHLIGHTS OF THE 2023 GUIDELINES

- Multidisciplinary peer review with experts in CSA is essential
- Due to challenges with interpreting anogenital findings, high-quality photos or videos are important to allow a CSA expert to confirm an accurate diagnosis
- Exam and documentation should include a careful evaluation for oral injuries, as findings may be suggestive of forced oral-penile contact
- Avoid acronyms using redness to indicate a finding concerning for trauma or sexual contact (e.g., TEARS or TBARS) since redness can be caused by other medical conditions

Please refer to the Kellogg et al article for additional information: https://pubmed.ncbi.nlm.nih.gov/37734774/

Medical Management of Children With Non-emergent Concerns of Sexual Abuse/Assault

A child is determined to have non-emergent medical needs if all the following are true:

There are concerns for an event of sexual abuse/assault (SA) occurring greater than seven days ago.

AND

The child's last known contact with the named perpetrator has been greater than seven days ago.

AND

The named perpetrator will not have any future access to the child.

AND

There are no reported symptoms on medical screening that raise concern for SA (e.g., abdominal or anogenital pain, bleeding, discharge) and there are no current signs of injury that raise concern for physical abuse or other medical issues requiring emergent management.

If all criteria met, then recommend deferring the medical evaluation and management to a children's advocacy center (CAC) and associated multidisciplinary team including pediatric medical experts. However, a DCFS report is still mandated **(should not be deferred)** if there are concerns for SA.

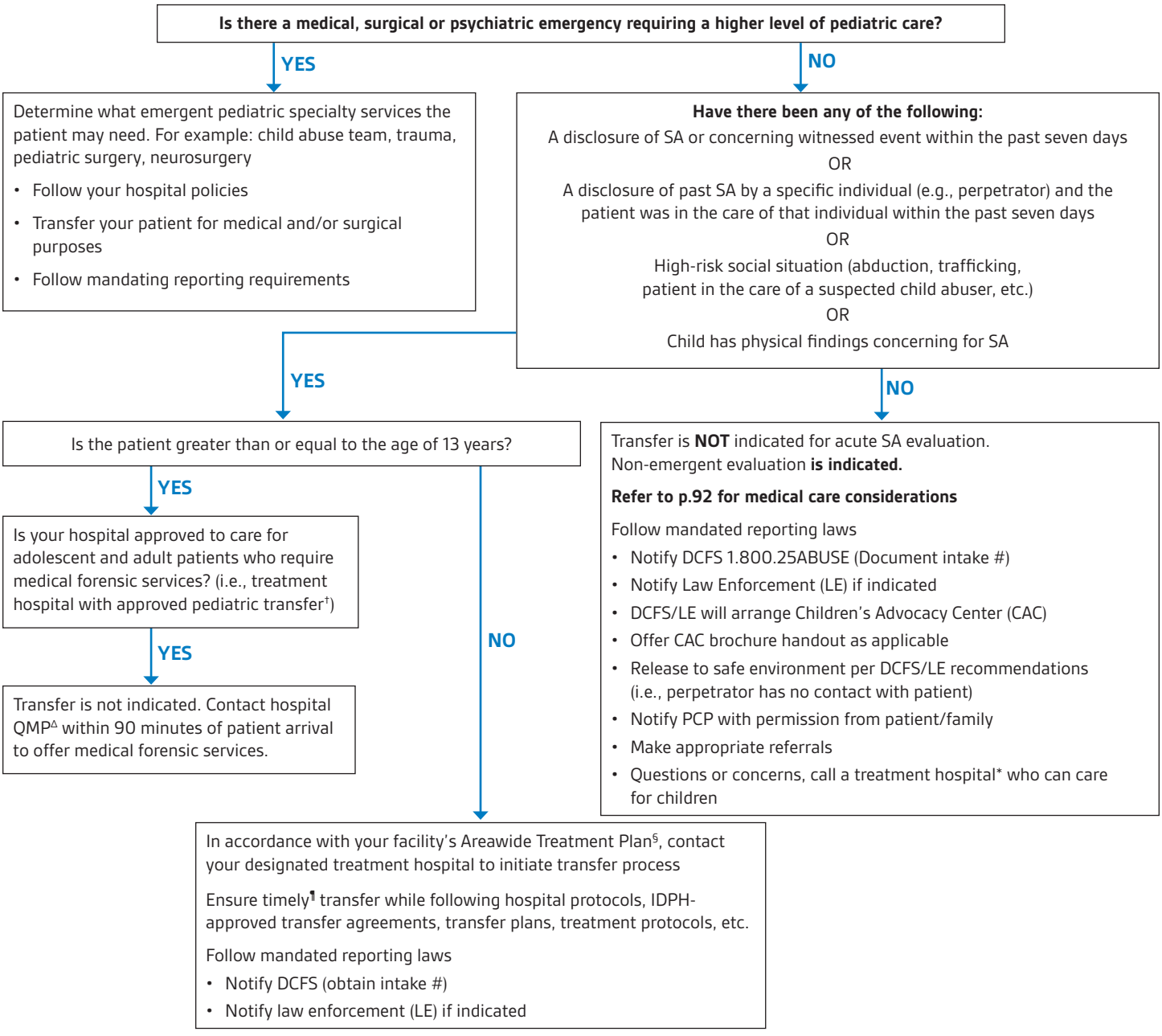
- ☐ When notifying the DCFS hotline and local LE, provide them with the following information:
  "Since the patient is presenting with non-emergent concerns for SA, an ED evaluation is not medically indicated. This is not a determination that abuse has or has not happened. Instead, an outpatient evaluation is recommended with a child abuse specialist, which should be coordinated with the local childrens' advocacy center (CAC)."
- ☐ Inform the patient/family about the need to notify DCFS/LE.
- ☐ Update the patient/family of any recommendations made by DCFS/LE.
- ☐ Discharge the patient per DCFS recommendations.
- ☐ Provide the patient/family with the handout, *Following an Emergency Department Visit What to Expect when Visiting a Children's Advocacy Center in Illinois* and inform them that either DCFS or LE will arrange this if indicated. Refer to the Children's Advocacy Center Patient/Family Handout. (p.97).
- ☐ Discuss the benefits of the patient/family receiving care at a CAC. This includes:
  - — The CAC is staffed by pediatric experts who specialize in CSA.
  - — Care will be tailored to each individual child, avoiding unnecessary testing or repeat examinations.
  - — Your child will receive child-friendly, developmentally appropriate and compassionate care to promote your child's physical and emotional health and safety.
- ☐ Notify the child's PCP after discussing the plan with the patient/family. Asking permission and mutual-decision-making between patient/family is recommended.[103]
- ☐ Make any other appropriate referrals (e.g., behavioral health).
- ☐ If questions or concerns remain, contact the treatment hospital with whom your organization has a pediatric sexual abuse/assault areawide treatment plan or transfer agreement.

FOR THE ED CLINICIAN

Pediatric forensic examinations should be conducted by clinicians with expertise in the medical evaluation of CSA. The medical care coordinated by the CAC is under the direct oversight of such providers. These pediatric experts can interpret exam findings and test results to determine if there are any medical and/or forensic related implications. Because every county has access to a CAC, every child has access to a multidisciplinary team of pediatric experts specializing in CSA.

Determining the Need to Transfer When There are Concerns for Child Sexual Abuse/Assault (SA)

For assisting hospitals who transfer children needing forensic medical services



* Treatment hospital: Has a SA treatment plan approved by IDPH for providing medical forensic services (MFS) to all SA survivors presenting with a complaint of SA within seven days after the assault.[7]

† Treatment hospital with approved pediatric transfer: Hospital with a treatment plan approved by IDPH for providing medical forensic services (MFS) to SA survivors 13 years old or older[7]

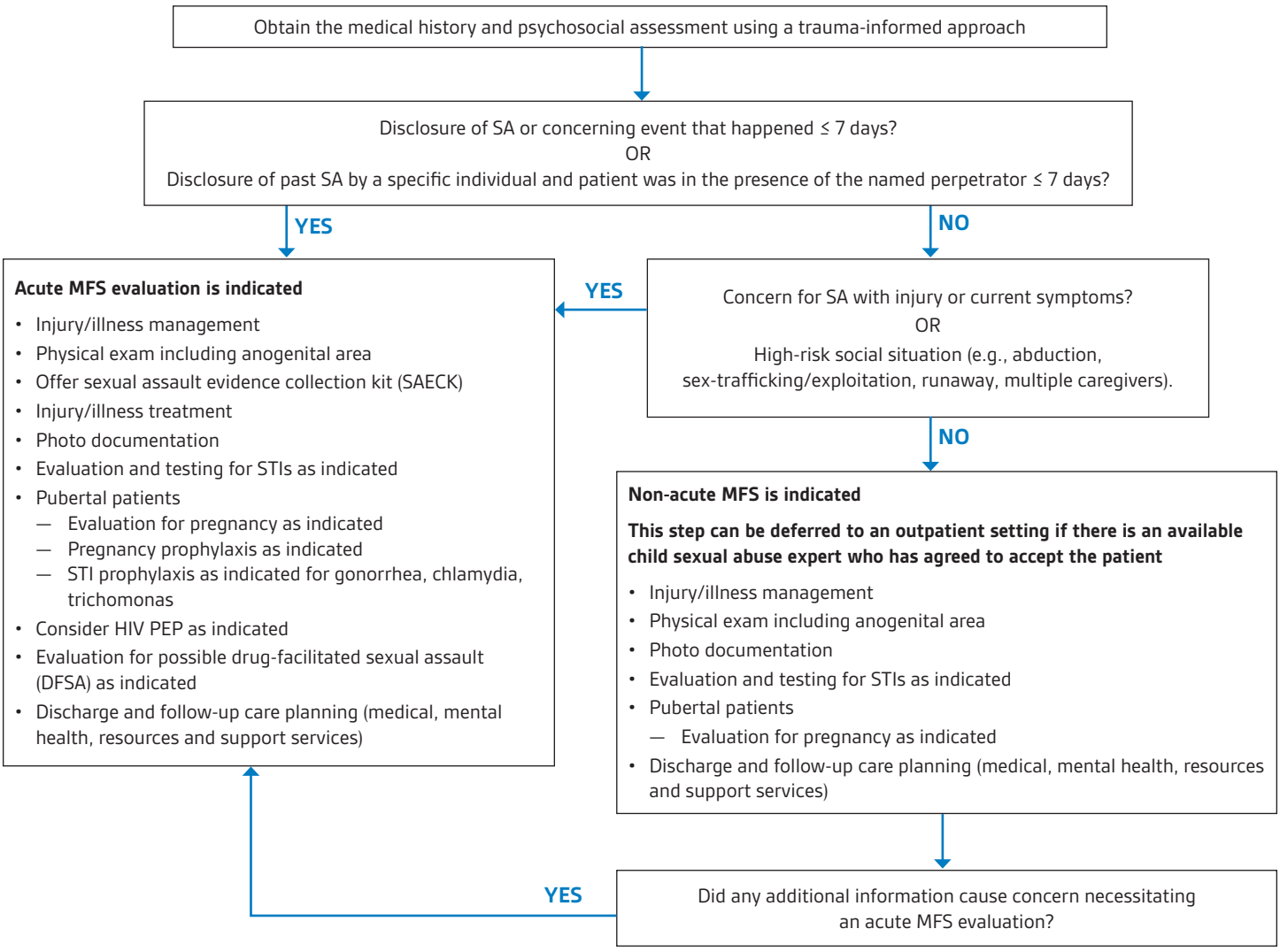
Δ Qualified medical provider (QMP): Per SASETA, may be a board-certified child abuse pediatrician (CAP), board-eligible CAP, sexual assault forensic examiner (SAFE), or sexual assault nurse examiner (SANE) who has access to photo documentation tools and who participates in peer review.[91]

§ Areawide sexual assault treatment plan or areawide plan: Developed by hospitals or by hospitals and approved pediatric health care facilities in a community or area to be served, which provides for MFS to SA survivors that shall be made available by each of the participating hospitals and approved pediatric health care facilities[7]

¶ Ensure timely, expedient transfer as best pediatric evidenced-based practices support a 72-hour evidence collection time frame.[91] Reference: https://www.ilga.gov/commission/jcar/admincode/077/077005450000200R.html

Overview of Medical Forensic Services (MFS) Provided by a Qualified Medical Provider (QMP) at the Treating Facility

COMPLETE MANDATED REPORTING REQUIREMENTS



IMPORTANT TO KNOW

- According to SASETA, a "qualified medical provider" (QMP) is a board-certified child abuse pediatrician, board-eligible child abuse pediatrician, a sexual assault forensic examiner or a sexual assault nurse examiner who has access to photo-documentation tools and who participates in peer review.[7]
- The QMP initiates MFS within 90 minutes of patient's arrival to the treating facility when the SA concern is ≤ 7 days ago [7]
- Advocacy services must be offered to patients and their families in accordance with the treatment facility's agreement with a rape crisis center.[7]
- For any positive or inconclusive examinations findings, consult with/refer to an expert in child sexual abuse.[90]

INFORMATION ON THIS FORM IS CONFIDENTIAL AND INTENDED FOR QUALITY IMPROVEMENT PURPOSES ONLY

Child SA ED Quality Improvement Monitoring Tool

(PEER REVIEW FORM)

SANE/QMP: **Date of Service:**

Auditor: **Date of Audit:**

HISTORY	YES	NO	N/A	COMMENTS
Was the history obtained by the appropriate person considering the patient's age and development?				
Was the history of the incident appropriately obtained and documented (EX: mother provided history of concerning event not in the presence of the patient or other visitors)?				
If known, is the last patient contact with the named perpetrator documented?				
Is the relevant past medical history listed (e.g., urinary tract infections, constipation, anogenital procedures, STI, pregnancy, prior abuse, prior injury)?				
Are positive/negative relevant anogenital physical symptoms documented (e.g., dysuria, discharge, bleeding, pain)?				
If indicated, are other positive/negative physical symptoms related to other forensic concerns (e.g., AFSA/DFSA, non-fatal strangulation, child sex trafficking, TEN-4-FACESp) documented?				
MEDICAL FORENSIC SERVICES INCLUDING EVIDENCE COLLECTION	**YES**	**NO**	**N/A**	**COMMENTS**
Rape Victim Advocate services offered and documented in chart				
Medical forensic services offered in accordance with SASETA including informed consent?				
Photo documentation offered.				
Is the kit # documented as being entered into Illinois State Checkpoint system?				
Is SA kit documentation complete and accurate (including additional forms like DFSA, if applicable)?				
Was chain of custody maintained/documented including the time the SAECK was picked up?				
Medi-voucher provided and scanned into chart?				
PHYSICAL EXAM	**YES**	**NO**	**N/A**	**COMMENTS**
Are photos diagnostic (i.e., structures visible and clear, bookended, etc.)?				
Was correct technique and positioning used to perform the anogenital exam?				
Is there an accurate anogenital exam noted in the chart including Tanne stage, positioning, techniques, findings, who was present during the exam?				
Were the physical exam findings appropriately interpreted (e.g., differential diagnoses considered, referring to J.A. Guidelines as indicated)?				

(Continued)

TESTING AND TREATMENT	YES	NO	N/A	COMMENTS
If DFSA obtained, was the chain of custody of DFSA specimen documented?				
Were appropriate hospital labs/cultures/tests obtained and were they interpreted appropriately?				
Was STI prophylaxis appropriately recommended and prescribed?				
Was pregnancy prophylaxis appropriately recommended and prescribed?				
Was HIV prophylaxis appropriately recommended and administered?				
Patient given at least three days of HIV PEP if indicated?				
OTHER	**YES**	**NO**	**N/A**	**COMMENTS**
Mandated reporting requirements to DCFS documented?				
Mandated reporting requirements to law enforcement documented?				
Were other appropriate services consulted, if indicated (e.g., mental health, child abuse pediatrician, social worker, child life specialist)?				
Shower offered?				
Transportation needs of patient addressed?				
FOLLOW-UP	**YES**	**NO**	**N/A**	**COMMENTS**
Are discharge instructions complete and accurate with appropriate final diagnosis?				
Patient made aware they will not be receiving a bill for medical forensic services?				
Does the patient have follow-up with appropriate providers (e.g., pediatrician, HIV follow-up, mental health, CAC, etc.)?				

Yes = Yes/Present No = No/Not Present N/A = Not Applicable N/D = Not Documented/Unknown

ADDITIONAL FEEDBACK_____

_____

_____

_____

_____

_____

TERMS FOR THIS FORM

AFSA/DFSA: Alcohol Facilitated Sexual Assault/Drug Facilitated Sexual Assault CAC: Children's Advocacy Center

DCFS: Department of Children and Family Services ED: Emergency Department

HIV PEP: Human Immunodeficiency Virus Post-Exposure Prophylaxis

Physical Interpretation Link: https://pubmed.ncbi.nlm.nih.gov/37734774/#:~:text=This%20review%20will%20summarize%20new%20data%20and%20recommendations%20regarding%20the

QMP: Qualified Medical Provider

SA: Sexual Abuse/Assault

SAECK: Sexual Assault Evidence Collection Kit

SASETA: Sexual Assault Survivors Emergency Treatment Act

TEN-4-FACESp Link: https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health-outcomes-research-and-evaluation-center/tricam/ten-4-facesp/

INFORMATION ON THIS FORM IS CONFIDENTIAL AND INTENDED FOR QUALITY IMPROVEMENT PURPOSES ONLY

Children's Advocacy Center's (CAC) Patient/Family Handout: What to Expect at an Illinois CAC

The Children's Advocacy Center (CAC) partners with local law enforcement and DCFS to support your child and work towards ensuring your child's safety. CACs help children feel more comfortable during an investigative process, while supporting them and their caregivers. All CAC services are completely free.

Information for parents and/or caregivers:

This may be a challenging time for you and your family. The best thing you can do is make sure your child feels loved and supported. Here are a few tips to help:

- If your child wants to talk about the incident, you can listen and say, "I'm really glad you told me that," or "thank you for telling me." But please do not ask follow-up questions or comment on the incident, as it could interfere with the investigation or a child's ability to accurately recall what happened.
- Your child may be feeling ashamed or that they are to blame for what happened, but a child is never responsible for the actions of the offender. You can say, "It's not your fault," and remind them of how brave they are.
- It's important to be honest with your child and tell them about their upcoming visit to a CAC, so they know what to expect.
- **What to tell your child or teenager before their CAC visit:**
  - We are going to a Children's Advocacy Center. The center is a place where you can talk about things that have happened and receive support. The person meeting with you talks to a lot of kids and teens about many different things every single day. It's okay to talk to them about anything and it's important to be honest. You might have some different feelings about your visit, and that's OK. The people who work at the center are there to help.

An overview of your day at the CAC:

- You will meet with a family advocate.
- Your child will have a forensic interview.
- You will talk to the team investigating your case.
- Your child may be referred for a follow-up medical exam.
- Your child may be referred for trauma focused therapy/counseling.

Forensic interview

The forensic interview is a very important part of your child's visit to the CAC. A forensic interview is a structured conversation that is designed to obtain information from the child about an event they have experienced or witnessed. Interviews are conducted by specialized forensic interviewers, who have advanced training on how to talk to children about difficult subjects in a neutral and fact-finding manner. CAC interviewers move at a pace that is comfortable for your child and developmentally appropriate. They will follow your child's cues about when to listen and when to ask follow-up questions. They never force a child to talk to them.

Only professionals directly involved in the investigation are allowed to observe the interview. No one else — including parents, caregivers or extra members of staff — are allowed to be in the room with the child or observing the interview. This is done to reduce your child's stress and to provide a neutral setting for the child and the investigation. It's important that any details about the alleged abuse come from the child. You and your child will have the opportunity to become familiar with the CAC space and ask any questions about the process prior to the interview. You may stay with your child up to the point they are interviewed, and you will be reunited afterwards. Your child will be in a safe environment and be in the care of highly trained and qualified individuals for the brief time that they are separated from your care.

During the interview

Your family advocate will gather information about you and your child to understand the best way to contact you and to provide you and your child with follow-up support as appropriate and necessary after you leave the CAC. This is also a good time to share your concerns and questions about what you are experiencing and what to expect.

After the interview

After the interview, you will be able to meet with those working on the case, and this may include the detective and, if needed, a DCFS Investigator. They will tell you in general terms what they learned from the interview and the next steps in the process. If the case is eligible for prosecution, it will be the State's Attorney's decision to move forward with the case. Remember, your advocate is also available to help whenever you have questions about the progress of your child's case.

Medical exam

Some children may need a follow-up medical exam. This specialized medical examination is a developmentally sensitive, trauma-informed medical assessment to care for children who have experienced sexual abuse, physical abuse or other types of harm. Experts (e.g., child abuse pediatrician), SAFE (sexual assault forensic examiner) provider, or a SANE (sexual assault nurse examiner) trained in recognizing signs of child abuse will complete the medical exam.

These specialized medical exams are not invasive, include a head-to-toe inspection of your child's body and are not like adult exams. The doctor or nurse will only look on the outside of the genital area to assess health and development, as well as provide any needed testing for infections (e.g., STIs).

Many children who come to a CAC are worried that their bodies are "damaged" or permanently harmed. Seeing our specialized healthcare professionals help children understand that their bodies are OK, and they feel less worried or anxious afterwards.

Therapy/Counseling

The CAC helps to identify children who will benefit from counseling or therapy services. Your family advocate will gather information about any mental health concerns that your child, your family or you may be experiencing, explain the referral process and recommend trauma therapy/counseling, if necessary.

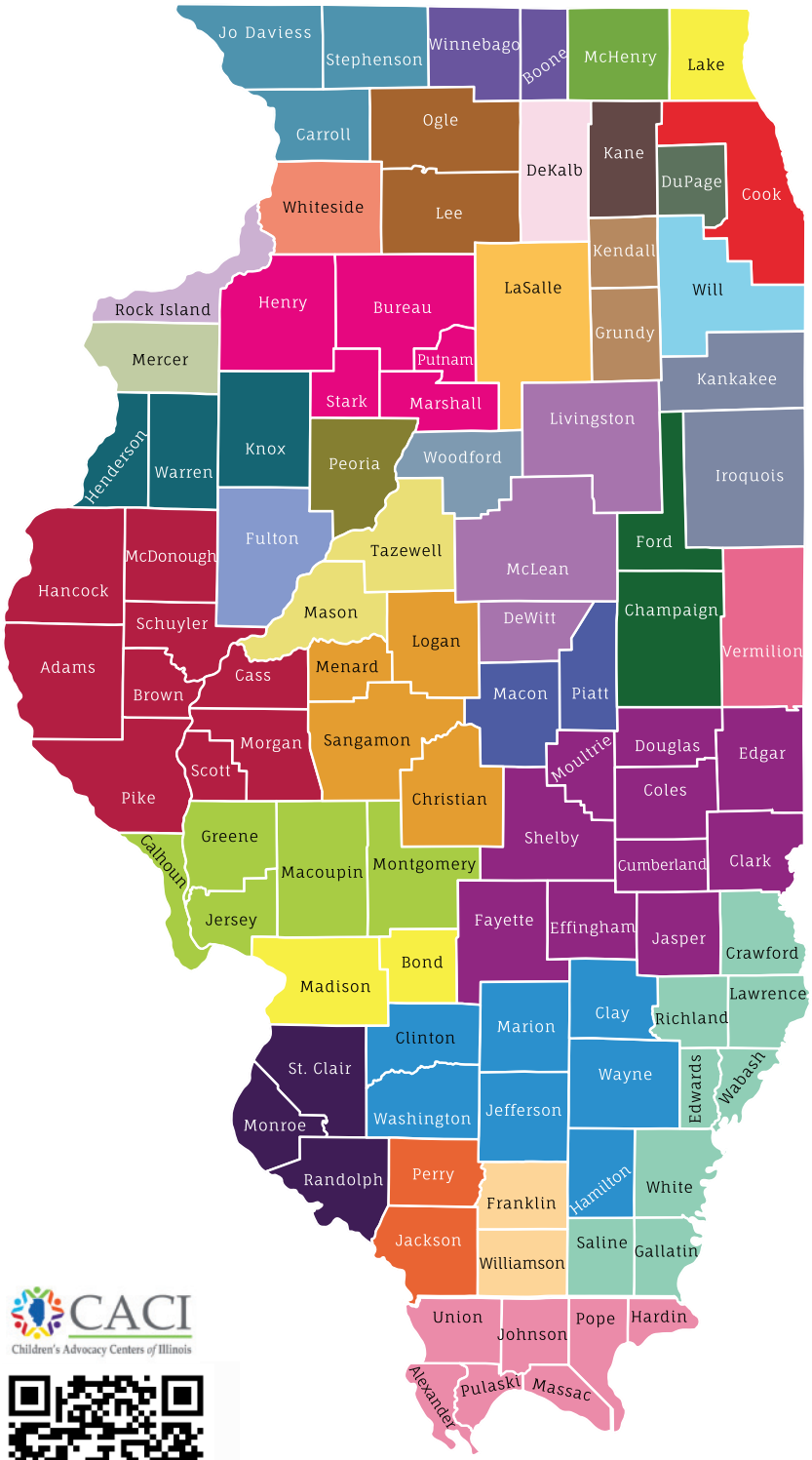
Answering questions and concerns

You will be provided with many opportunities throughout your entire CAC visit to ask questions and share any concerns that you may have. As always, the CAC is here to help keep your child safe and healthy. After your visit to the CAC, your advocate will follow up with you to check in on how you and your child are doing. You'll have an opportunity to ask additional questions and discuss any needed support that is available to you and your child.

Find your local Illinois Children's Advocacy Center here:

SCAN ME

IL CAC Map with QR Code



CACI
Children's Advocacy Centers of Illinois

Scan QR code to find your local CAC and their contact information.

SCAN TO SEE CAC LOCATIONS IN ILLINOIS

Northern Region

April House
Braveheart Children's Advocacy Center
Carrie Lynn Children's Center
Child Advocacy Center of McHenry County
Child Network
Dani-Brandon Center for Children
Family Service Agency
Kane County Child Advocacy Center
Kendall County Children's Advocacy Center
Lake County Children's Advocacy Center
Mercer County Children's Advocacy Center
Rock Island County Children's Advocacy Center
Shining Star Children's Center
Tyler's Justice Center for Children
Will County Children's Advocacy Center

Cook County Region

All Our Children's Advocacy Center
Chicago Children's Advocacy Center
Children's Advocacy Center N & NW Cook County
LaRabida Children's Advocacy Center
Proviso Children's Advocacy Center

Central Region

Advocacy Network for Children
Champaign County Children's Advocacy Center
Children's Advocacy Center of McLean County
Children's Advocacy Center of E Central Illinois
Fulton-Mason Crisis Service
Peoria County Children's Advocacy Center
Sangamon County Child Advocacy Center
Tazewell County Children's Advocacy Center
The Child 1st Center
Turning Point Child Advocacy Center
Unified Child's Advocacy Network Center
Vermilion County Children's Advocacy Center

Southern Region

Amy Schulz Child Advocacy Center
Franklin-Williamson Child Advocacy Center
Madison County Child Advocacy Center
Perry-Jackson Child Advocacy Center
St. Clair County Child Advocacy Center
The Guardian Center, Inc.
Two Rivers Child Advocacy Center

Child Maltreatment Weblinks

Non-exclusive list of resources that may be useful to ED multidisciplinary teams including first line responders.

Academy of Forensic Nursing (AFN)
This website provides access to membership to the AFN where members can have access to a variety of educational offerings. This site also provides information on AFN certification and has resources to guide forensic nursing practice.
https://www.goafn.org/

American Academy of Pediatrics (AAP)
This website offers access to membership to the academy, as well as offers education opportunities and current research in pediatrics. This site also contains a child-abuse-specific area where a member can access AAP policy statements, clinical practice guidelines and recent CAN reports.
https://www.aap.org/en/patient-care/child-abuse-and-neglect/

American Professional Society on the Abuse of Children (APSAC)
This website offers robust information regarding CAN and the multidiscipline process to its members. It provides educational training(s), continuing education and resources to the most up-to-date research in all areas of child maltreatment. May also access their document describing best practices related to pediatric forensic interviews, which is meant to be a guiding framework used in conjunction with the APSAC Handbook on Child Maltreatment.
https://www.apsac.org/
www.apsac.org/_files/ugd/4700a8_06b064b4cc304ccc97be55a945acd90d.pdf

Centers for Disease Control and Prevention (CDC)
This website provides information from the CDC, which is the nation's leading science-based, data-driven, service organization that protects the public's health. The CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats and responds when these arise. Such topics that can be searched include the 2021 STIs Guidelines, adverse childhood experiences (ACEs), child abuse and neglect and developmental milestones.
www.cdc.gov
https://www.cdc.gov/violenceprevention/aces/index.html
https://www.cdc.gov/std/treatment-guidelines/sexual-assault.htm
https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html Link: https://www.cdc.gov/ncbddd/actearly/milestones/index.html

Child Trauma Academy
This website is set out to help improve the lives of traumatized and maltreated children — by improving the systems that educate, nurture, protect and enrich these children, focusing its efforts on education, program consultation and research, and disseminating innovations in the field.
www.childtrauma.org

Children's Advocacy Centers of Illinois
This website describes the services available and supported by Children's Advocacy Centers of Illinois (CACI). CACI is dedicated to the multidisciplinary, child advocacy approach and a coordinated, comprehensive response to child abuse. These centers are located throughout the state.
https://www.childrensadvocacycentersofillinois.org

Emergency Medical Services for Children (EMSC) Innovation and Improvement Center
This website offers pediatric education advocacy kits (PEAKS) on the topic of child abuse to disseminate best practice educational resources for families, advocates and stakeholders.
https://emscimprovement.center/

FBI Stop Sextortion
This website aims to provide parents, caregivers and educators with resources to teach students about sextortion. The Stop Sextortion campaign seeks to inform students that sextortion is a crime, so they are less likely to engage in risky situations online and know how to ask for help if they are being victimized. Recourses include tip sheets, classroom posters and informational videos.
www.fbi.gov/news/stories/stop-sextortion-youth-face-risk-online-090319

HEAL
HEAL Trafficking is an integrated national network of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a health perspective. HEAL offers protocols, evidence-based education and trainings, and an opportunity to interact with a community of healthcare workers in the issue of human trafficking.
https://healtrafficking.org

Illinois Department of Children and Family Services (DCFS)
This website link describes the free online course (60–90 minutes) for helping all Illinois mandated reporters learn their critical role in protecting children by recognizing and reporting child abuse.
https://mr.dcfstraining.org/UserQuth/Login!loginPage.action

Illinois Department of Children and Family Services (DCFS)
At this website, the user can access the IL DCFS Manual for Mandated Reports with supporting documents.
https://dcfs.illinois.gov/content/dam/soi/en/web/dcfs/documents/safe-kids/reporting-child-abuse-and-neglect/documents/cfs_1050-21_mandated_reporter_manual.8.0.pdf

International Association of Forensic Nursing (IAFN)
This website provides leadership in forensic nursing practice by developing, promoting and disseminating information internationally about forensic nursing science. The site includes membership access, education for SANE certification and continuing education for SANE providers as well as access to state chapter membership.
https://www.forensicnurses.org

International Association of Forensic Nurses (IAFN) Non-Fatal Strangulation Documentation Toolkit
This Non-Fatal Strangulation Documentation Toolkit provides detailed guidance on assessment techniques, documentation and evidence collection. Recourses include sample documents for discharge instructions and policies/procedures. IAFN aims to improve and standardize the care of patients that have been strangled.
https://www.forensicnurses.org/page/STOverview/ Link: https://www.forensicnurses.org/page/STPreface

Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2023
This journal article is a consensus of professional opinion by leading national child abuse experts on their interpretation of pediatric anogenital findings, which is essential for the provider to know when performing anogenital examinations on children including those where SA is suspected.
https://www.sciencedirect.com/science/article/abs/pii/S0145213423002648

LCAST
This website link allows the user to gain access to the Lurie Children's Child Injury Plausibility Assessment Support Tool (LCAST) for free on their cell phone. See p.51.
https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health- outcomes-research-and-evaluation-center/tricam/lurie-childrens-child-injury-plausibility-assessment-support-tool- lcast/

National Center for Missing and Exploited Children (NCMEC)
This website provides a plethora of resources to prevent child sex trafficking and exploitation, sextortion and abductions, and recover missing children. They receive grant funding from national programs like the Office of Juvenile Justice and Delinquency Prevention, as well as public donations. At this website you can search for missing children, download educational materials and browse their extensive list of publications. Note, the NCMEC has assisted law enforcement, families and child welfare recover more than 400,000 children.
www.missingkids.org

National Child Traumatic Stress Network
This website and network were created to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. They work to provide clinical services, develop and disseminate new interventions and resource materials, offer education and training programs, collaborate with established systems of care, engage in data collection and evaluation, and inform public policy and awareness efforts.
www.nctsn.org

National Human Trafficking Hotline (NHTRC)
This website is a 24/7 resource available to anyone providing immediate support to trafficked individuals or those who might try to assist them. The hotline can take tips or reports, offer advice (even with hypothetical scenarios) and give local resources.
https://humantraffickinghotline.org/en

National Runaway Safeline
This website provides training and services to help those at risk for running away and those who have run away, with goal of ending youth homelessness. A youth can call 1.800.RUNAWAY (1.800.786.2929) 24/7/365 days to speak with a trusted, compassionate person who listens and helps create a plan to address your concerns. Can also access staff via live chat, text, e-mail or forum.
https://www.1800runaway.org/youth-teens

National Sexual Violence Resource Center
This website provides research and tools to advocates working on the front lines to end sexual harassment, assault and abuse with the understanding that ending sexual violence also means ending racism, sexism and all forms of oppression.
www.nsvrc.org

The Vicarious Trauma Toolkit
This national resource can be found on the Office for Victims of Crime website. This toolkit helps organizations mitigate the potentially negative effects of trauma exposure (i.e., vicarious trauma) for staff working with victim services, EMS, fire services and law enforcement. It is relevant to other allied professionals, too (e.g., SANEs, social workers, chaplains, child life specialists, etc.).
https://ovc.ojp.gov/program/vtt/introduction

Period of PURPLE Crying®
A website geared towards recognizing and managing the increased crying period that a baby normally experiences between 2 weeks and 3 to 4 months of age. Provides education, resources and networking for parents and caregivers as well as information for medical professionals. This is a preventative strategy against abusive head trauma since this increased crying phase may cause frustration in parents/caregivers. See p.71.
https://dontshake.org/purple-crying

Polaris
Polaris is the non-profit organization which runs the National Human Trafficking Hotline (NHTH). Polaris compiles data from the hotline and generates reports, offers trainings and creates targeted systems-level strategies to disrupt and prevent human trafficking.
https://polarisproject.org

Prevent Child Abuse America
This website promotes programs and resources informed by science that enable kids, families and entire communities to thrive. Prevent Child Abuse America creates, interprets and distributes innovative research on new and existing child abuse prevention solutions and develops a wide range of valuable tools for parents and caregivers. Further information including free brochures (English and some in Spanish) can be found at the Illinois Prevent Child Abuse America website. A link to a colorful flyer "How you can help prevent child abuse and neglect" is posted below too.
www.preventchildabuse.org
https://www.preventchildabuseillinois.org
https://www.cac-swfl.org/how-you-can-help-prevent-child-abuse-and-neglect/

PublicHealthLearning, University of Illinois
At this website, you will also find the IL EMSC's "Resources, Guidelines and Tools" that can be used by prehospital providers, emergency department staff, hospital leaders/administrators and anyone else interested in providing best pediatric practices to children requiring emergency and critical care. This site also provides access to educational modules that provide free CE credit for prehospital providers, nurses, advanced practice providers and physicians. This free site does require users to register and create a password.
https://www.publichealthlearning.com/

RAINN
RAINN (Rape, Abuse and Incest National Network), according to their website, is the nation's largest anti-sexual violence organization and operates the National SA Hotline (800.656.HOPE). In 29 years, they have helped 4.9 million survivors and their young loved ones. Website offerings include SA statistics, general info like parenting safety tips and comparison of different state laws.
https://rainn.org/

Reclaim13
A website where the user (general public or medical professional) can learn more about this Illinois program whose aim is to helping children survivors and those at risk for human trafficking and exploitation through safe housing, education, counseling and mentoring.
https://www.reclaim13.org

Secure Digital Forensic Imaging (SDFI)-Telemedicine
This free protocol promotes the continued development of the highly specialized skills necessary for an effective evaluation of a person assaulted by strangulation. This Non-Fatal Strangulation Photo Documentation protocol was created for first responders, healthcare providers, attorneys and law enforcement to utilize as an assessment and documentation tool.
www.buysdfi.com/ecommerce/sdfi-pediatric-non-fatal-strangulation-protocol

SOAR
SOAR is a nationally recognized, accredited training program delivered by the National Human Trafficking Training and Technical Assistance Center (NHTTAC) on behalf of the Office on Trafficking in Persons in partnership with the Office on Women's Health at the U.S. Department of Health and Human Services. It offers free trainings, including CE/CME credit, for professionals, organizations and communities that address human trafficking in healthcare, behavioral health, public health and social services settings.
https://nhttac.acf.hhs.gov/soar

Stop It Now!
This website provides information around child abuse prevention focusing on the dissemination about SA, enhancing services to children who are victims of sex abuse, providing specialized treatment programs for people who have committed a sexual offense, offering sexual education and improving our understanding of behaviors that make children vulnerable.
www.stopitnow.org

Training Institute on Strangulation Prevention
The Institute provides training, technical assistance, web-based education programs, a directory of national trainers and experts and research related to DV and SA strangulation crimes. The information for upcoming training(s) or how to schedule a training for your community can be found here.
https://www.strangulationtraininginstitute.com/

U.S. Department of Justice Office on Violence Against Women
This document is the National Protocol for Pediatric Sexual Abuse Medical Forensic Examinations. This guide is meant to be for HCPs who conduct SA medical forensic examinations of prepubescent children, and other professionals and agencies/facilities involved in an initial community response to CSA, in coordinating with HCPs to facilitate medical forensic care
www.justice.gov/ovw/file/846856/download

SASETA Weblinks

These remaining weblinks listed below are focused on the topic of the Illinois Sexual Assault Survivors Emergency Treatment Act (SASETA)

Sexual Assault Survivors Emergency Treatment Act (SASETA)
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1531&ChapterID=35

410 ILSC 70/ Sexual Assault Survivors Emergency Treatment Act (SASETA)
SASETA is an Illinois law that governs the healthcare that an Illinois hospital is required to provide a sexual assault survivor. It also establishes a statewide forensic evidence collection system and creates a reimbursement system to cover the cost of care and evidence collection.
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?actid=1531&chapact=410%C2%A0ilsc%C2%A070/&chapterid=35&chaptername=public+health&actname=sexual+assault+survivors+emergency+treatment+act.

https://www.ilga.gov/commission/jcar/admincode/077/077005450000250R.html

Illinois Coalition Against Sexual Assault (ICASA)
ICASA is a not-for-profit corporation of 30 community-based sexual assault crisis centers working together to end sexual violence. This website provides resources for survivors and hospitals. The website also includes detailed information about SASETA and SASETA compliance.
https://icasa.org
https://icasa.org/legal-issues/health-care/saseta-information-and-resources

Illinois Department of Public Health (IDPH)
This website provides access to information reported to IDPH by Illinois hospitals as required by the Sexual Assault Survivors Emergency Treatment Act (SASETA). The information available includes a listing of SASETA hospital designations as well as data from each hospital with volumes of sexual assault patients (adult and pediatric) presenting, number of evidence collection kits offered/collected/declined.
https://dph.illinois.gov/topics-services/health-care-regulation/hospitals/saseta.html

Illinois State Police
This website provides information about the Illinois State Police Division of Forensics including statistics and data, links to medical forensic forms used by hospitals and the Sexual Assault Tracking Application.
https://isp.illinois.gov/Forensics

Office of the Illinois Attorney General
This website contains information about sexual assault nurse examiners (SANE), upcoming SANE trainings, hospital education opportunities and links to other SANE resources.
- Guide for establishing a Sexual Assault Examiner Program
- Educational materials for hospitals and approved pediatric healthcare facilities
- Educational materials for healthcare providers
- Sample Template: Memorandum of Understanding between Rape Crisis Centers and Hospitals or Approved Pediatric Health Care Facilities
- Photo documentation and sample digital photography policy
- Sample Template: Pediatric Sexual Assault Areawide Treatment Plan
  https://ag.state.il.us/victims/saimplementationtaskforce.html
  https://ag.state.il.us/victims/photo_documentation_and_sample_digital_photography_policy.pdf
  https://www.illinoisattorneygeneral.gov/Safer-Communities/Responding-to-Sexual-Assault/SANE

SASETA Implementation Task Force
The SASETA Implementation Task Force has developed documents and templates to assist Illinois hospitals in becoming compliant with SASETA. The documents can be requested by contacting the Office of the Illinois Attorney General SANE Program at sane@ilag.gov.

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