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CHILDHOOD SEXUAL ABUSE SCREENING AND PREVENTION IN THE
PRIMARY CARE SETTING:
A SURVEY OF PEDIATRIC HEALTHCARE PROVIDERS IN THE STATE OF
VERMONT

A Thesis Presented

by

Kelley E. Groll

to

The Faculty of the Graduate College

of

The University of Vermont

In Partial Fulfillment of the Requirements
for the Degree of Master of Science
Specializing in Nursing

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ABSTRACT

Background. Childhood sexual abuse (CSA) is a silent, but pervasive concern across the United States, the prevalence of which is often vastly underestimated. Some research indicates that as many as one in four girls and one in six boys become victims of CSA. CSA is classified as an adverse childhood experience (ACE), which has been shown to have serious longstanding negative physical, emotional, and mental health impacts. The pediatric primary healthcare provider is well posed to intervene to detect and prevent the occurrence of CSA.

Objective. The overall goal of this study is to gain an understanding of the current state of sexual abuse screening and prevention in pediatric primary care settings in the state of Vermont.

Method. An anonymous, 20-item survey was distributed to Vermont pediatric primary care providers via the electronic mailing lists of three Vermont-based professional organizations for healthcare providers. The online survey was conducted with the Limesurvey software through the secure University of Vermont server. The survey remained active for three weeks, and potential participants received three weekly reminder emails inviting them to complete the survey. As an incentive for volunteer participation in the study, all participants received a list of the available local, statewide, and national resources available to them to assist in sexual abuse detection and prevention following survey completion.

Results. There were 37 participants who completed the survey. The groups were divided based on professional title, patient population, years of experience in practice, geographic location, and access to a social worker. Each of these groups was analyzed against the survey data to determine any underlying trends that existed.

Conclusions. Nurse practitioners were found to be more likely than physicians to routinely screen every child and their caregivers during health supervision visits. NPs were also more likely to report that the electronic health record prompted these screenings. A positive correlation was found between the likelihood of routinely screening children and increased provider confidence with screening. However, no differences were found between NPs and physicians in confidence with screening, nor were there differences in perceived educational sufficiency between the two groups.

Across all professional titles, pediatric providers reported greater confidence in their ability to detect risk factors and red flags than family practice providers. A greater perceived sufficiency of education was positively correlated with provider confidence and comfort with screening. Educational sufficiency was also positively correlated with the perception that area resources are highly available and are effectively used in practice.

Time was reported as the greatest barrier to screening and prevention by those who have the highest perceptions of their ability to make an impact on prevention. Also, those who felt that there were highly available and accessible resources at their disposal also reported time as their greatest barrier. Additionally, those who reported greater than 20 years of experience in practice were significantly less likely to view access to the patient as the greatest barrier that providers face in their efforts to detect and prevent sexual abuse. Further study is indicated to confirm these findings.

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CHAPTER 1: INTRODUCTION

1.1 Overview of the Research Problem

In pediatric healthcare settings, providers commonly use annual “well-child checks,” otherwise known as health supervision visits, to evaluate a child’s safety and health status. Based on the data gathered in these assessments, health care providers will often provide tailored education and anticipatory guidance to the child and his or her caregiver. With seemingly healthy children, safety assessments involve screening questions about seat belts, smoke detectors, helmets, gun safety, sunscreen, adequate nutrition and exercise. One of the most important assessments of a child’s safety, however, is his or her level of risk for sexual abuse. Identifying and educating children (and their care givers) who are at risk for abuse is an important responsibility of the pediatric or family practice provider. The manner in which this delicate topic is addressed, or conversely, its neglect by a provider, can greatly influence the trajectory of a child’s health, happiness, and his or her lifetime interaction with the healthcare system. Numerous studies have demonstrated that adverse experiences in childhood, including sexual abuse, have long-term negative impacts on mental, emotional and physical development.

1.1.2 Definitions.

By definition, childhood sexual abuse (CSA) is a category of child maltreatment. For this purposes of this research, child maltreatment is perceived as the overarching term used to encompass the neglect or abuse of a person under the age of 18. Neglect is defined as the failure to provide a child with adequate food, clothing, shelter or healthcare. Abuse is further differentiated into three categories: physical, emotional and sexual abuse. Physical abuse is defined as death, permanent or temporary disfigurement, or the

impairment of any bodily organ or function other than by accidental means. Emotional abuse is a pattern of malicious behavior, which results in impaired psychological growth and development. Child sexual abuse (CSA), the third category of abuse, is defined by this research as any act or acts by any person involving sexual molestation or exploitation of a person under the age of 18. According to Vermont state law, this includes but is not limited to, “incest, prostitution, rape, sodomy, or any lewd and lascivious conduct involving a child. Sexual abuse also includes the aiding, abetting, counseling, hiring or procuring of a child to perform or participate in any photograph, motion picture, exhibition, show, representation or other presentation which, in whole or in part, depicts sexual conduct, sexual excitement or sadomasochistic abuse involving a child.” (33 VSA § 4912). This research will specifically examine CSA as an important and often overlooked form of child maltreatment.

1.1.3 Significance.

Every year in the United States, thousands of children become victims of sexual abuse or violence. In an effort to understand the patterns and incidence of child maltreatment, the United States Department of Health and Human Services (USDHHS) periodically conducts a congressionally mandated research study known as the National Incidence Study (NIS-4) of Child Abuse and Neglect. According to the “Endangerment Standard” (the more inclusive of two definitional standards utilized in the NIS-4), an estimated 180,500 children experience CSA each year (Sedlak et al., 2010). This data is collected based on the number of cases identified and investigated by child protective services (CPS) agencies.

Other sources indicate that this number is under-representative of the actual prevalence due to significant under-identification and under-reporting. One study found that 2.2% (99 out of 4500) of children younger than age 18 surveyed had experienced a sexual assault in just the last year. Sexual assault in this case was defined as the equivalent of contact sexual abuse or an attempted or completed rape (Finkelhor, Turner, Shattuck & Hamby, 2013). This did not include the other elements of CSA, such as the sexual exploitation of a child, meaning that the true estimation of CSA prevalence is likely an even greater percentage of the population. Based on responses found in a study by Dube et al. (2005), some have estimated that as many as one in four girls and one in six boys will be sexually abused before the age of 18. A mutual consensus of these studies, however, is the finding that girls are significantly more likely to be sexually abused than boys (Finkelhor, Turner, Shattuck & Hamby, 2013; Dube et al., 2005).

As of 2013, the United States Preventive Services Task Force (USPSTF), an agency tasked with providing evidence-based, national recommendations for health screening measures, gave universal screening of children for maltreatment a grade I recommendation (Moyer, 2013). This rating indicates that there is currently insufficient research evidence to argue for or against this practice in children who do not display any signs or symptoms of maltreatment. One of the greatest challenges in the recognition of victimization, however, is the vast variety in these presenting signs and symptoms (Kellogg, 2009).

Some victims of sexual abuse demonstrate the expected red flags, such as sexual knowledge or behaviors that exceed what is expected for their age range or developmental stage, or sudden changes in personality or behavior. Other signs can be much more subtle, possibly leading to under-identification. These signs may include disturbed sleeping

patterns, clinginess, social avoidance, abdominal pain or enuresis, to name only a few potential signs or behaviors (Kellogg, 2009). Typical developmental changes can be difficult to distinguish from potential warning signs of victimization.

Although some professional organizations take the same stance as the USPSTF on routine screening of maltreatment such as the American Academy of Family Physicians (2013), others, such as the American Academy of Pediatrics (AAP) and the American Medical Association (AMA), feel that the inquiry related to CSA and other forms of maltreatment for all children as part of a typical health supervision visit qualifies as appropriate and thorough care (AMA, 2007; Flaherty & Stirling, 2010). The National Association of Pediatric Nurse Practitioners (NAPNAP) supports “the implementation and development of protocols for screening, evaluation, treatment, and referral of child maltreatment” (“NAPNAP position statement on child maltreatment, 2011). Despite these endorsements for screening, there is no recommended standardized screening tool for CSA provided by these organizations. Additionally, routine screening tools are scarce in the literature to date. The few available are targeted towards primarily identifying risk factors in the parents, such as the Parent Screening Questionnaire (Appendix A).

Despite the varied recommendations for screening by the various professional organizations, Vermont’s state law is very clear. All healthcare workers are mandated reporters of child abuse and neglect, even if there is merely a suspicion of this accusation (33 V.S.A. § 4911-4923). As a result, the child’s healthcare provider has an obligation, not only to the child, but also to the state to routinely screen all children for maltreatment. Given the severe consequences of under or unidentified child abuse, a child’s healthcare provider should be vigilant for any risk factors or red flags that may warrant further

investigation. Some barriers to screening that may exist include the lack of standardized screening tools, conflicting recommendations, and deficiencies in provider training. There is currently a lack of evidence describing the current screening practices in healthcare settings. In Vermont, in particular, information of this nature has not been collected to date.

1.2 Purpose

The purpose of this study is to gain an understanding of the current state of sexual abuse screening and prevention in pediatric primary care settings in the state of Vermont. This data was based upon a survey of providers in pediatric and family practices across the state. The providers addressed in the survey include advanced practice registered nurses (APRNs) [nurse practitioners (NPs)], medical doctors (MDs), and any other certified professional who may be practicing as a pediatric primary care provider (such as a physician assistant (PA) or a doctor of osteopathy (DO)). As the recommendations about routine screening are varied, it is expected that individual practices will have varying methods for addressing this pertinent issue.

1.2.1. Aim 1.

The first major objective of this research was to investigate the attitudes and experiences of Vermont's pediatric healthcare providers with sexual abuse screening and prevention. Specifically, the research asked about what prompting is currently available in their chosen electronic health record and how frequently these screening questions are asked of children and their caregivers. The research also explored provider attitudes about the necessity for a standardized routine screening for maltreatment in pediatric care and their individual reasoning for or against this practice. The results were intended to help identify any discrepancies in responses that may exist, based upon educational background

of the provider, geographical location in Vermont, experience, and available support systems.

1.2.2. Aim 2.

The second major aim was to explore the element of provider confidence and preparation for the primary prevention of child abuse and also in identifying cases of suspected child abuse. The elements of a provider's practice that may influence his or her confidence in ability to prevent CSA or comfort level with screening was explored. For example, might the type of educational preparation that the provider received have a significant impact on their levels of competence? Perhaps a greater influence is years of experience? The intention of this questioning was to identify what preparatory factors may enhance a provider's confidence in his or her competence and ability to address CSA in the primary care setting. Also, what barriers might they identify in their practice or training that may impede their ability to successfully detect and prevent abuse, and does this perception change with increased comfort and confidence with screening?

1.2.3. Aim 3.

A secondary aim of this research was to provide educational materials to participating providers about CSA and maltreatment. Following the survey, participants were provided with current resources, both nationally and locally, through which they will have the opportunity to further educate themselves. Resources included the most current information about childhood maltreatment, as well as known risk factors and potential red flags for sexual abuse. The resources outlined successfully implemented models [such as the Safe Environment for Every Kid (SEEK) model], as well as other readily accessible organizations for providers to learn about and become more involved in preventative

efforts and screening. The dissemination of this information was intended to increase provider awareness of and access to resources and heighten vigilance for child maltreatment, including sexual abuse.

1.3 Conceptual Framework

The conceptual framework behind this research was the Health Belief Model (HBM). This theory of health behavior, developed in the 1950s by U.S. public health officials, was initially created to facilitate an understanding of the underutilization of available preventive health services by the general public. The HBM hypothesized that there are six main constructs that determine a person's likelihood to take action to prevent, screen for, and control illness. These six constructs include perceived susceptibility to the condition, perceived severity of the condition, perceived benefits of taking preventative action or screening, perceived barriers to taking action, exposure to factors that may prompt action (such as a reminder phone call or mailing) and the person's self-efficacy, or confidence, in their ability to successfully perform an action. (Butts & Rich, 2011).

For purposes of this research, it is assumed that children have no power over whether they are susceptible to CSA. There are select populations of children that are at greater risk for CSA (as discussed in section 2.3.1), and it is the responsibility of the provider (rather than the patient themselves) to evaluate this risk and work to prevent its occurrence. Pediatric providers meeting these six constructs would encourage the screening of all children. First, the provider must feel as though the child is susceptible to abuse. Due to the dependent and vulnerable nature of childhood, it can be generally assumed that any child is at increased risk for maltreatment.

Understanding the lifelong impact of maltreatment on psychological, physical, and emotional health can help providers to perceive the importance of preventive screening. When the evidence of the impact that screening and prevention can have in a primary care setting is demonstrated to providers, they may be more likely to feel as though they can make a positive impact on a child's life thereby increasing their own self efficacy. This research also assessed for perceived barriers to screening that may exist in the primary care setting. Finally, it is anticipated that the provision of resources, research and prevalence statistics will act as a reminder to providers about the importance of screening and prompt the initiation of routine screening for CSA, as well as other forms of maltreatment, during all health supervision visits.

1.4 Implications for APRN Practice

This study was guided overall by the competencies identified and developed by the National Organization of Nurse Practitioner Faculties (NONPF) in 2012. These competencies represent the essential behaviors of all NPs to be demonstrated upon graduation from an educational program. This study addressed and illustrated a number of these competencies, including practice inquiry, quality, ethics and leadership.

Firstly, the NONPF population focused task force states that the competent NP “leads practice inquiry, individually or in partnership with others” and “disseminates evidence from inquiry to diverse audiences using multiple modalities” (NONPF, 2012). In partnership with various organizations inclusive of pediatric primary care providers, this research performed anonymous practice inquiries. Ideally, participation in this study was impetus for some of these providers to further educate themselves with the various resources supplied at the end of the survey. The results of this study will be disseminated

to the Vermont Department of Health, the Vermont Chapters of the AAP, Academy of Family Physicians (VTAFP) and the Vermont Nurse Practitioners Association (VNPA), well as to the University of Vermont community, so that the findings may be useful in informing and improving pediatric primary care practice in the state of Vermont.

The quality competency was also demonstrated by this study, as the background research, study tools, and analysis were examined and thoroughly reviewed by peers numerous times throughout the course of its development. According to NONPF (2012), the competent NP “applies skills in peer review to promote a culture of excellence.” On a broader scale, this study also helped to highlight any potential deficits in practice quality that may exist. With the distribution of this information to NPs and other providers across the state of Vermont, these deficits can be addressed. NPs utilize the “best available evidence to continuously improve quality of clinical practice” (NONPF, 2012).

NONPF explains that as part of the ethics competency, the NP “integrates ethical principles into decision making” (2012). The topic of CSA is very sensitive, and its victims are a highly vulnerable population. A significant effort was made in this study to protect this population, including the avoidance of direct questioning about specific cases, the anonymous nature of the survey, and obtaining prior approval by the University of Vermont Institutional Review Board (IRB).

In effort to improve sexual abuse screening and prevention practices, leadership is crucial. The results of this study demonstrate that, in Vermont, NPs are commonly involved in this screening process and thus are integral components of this movement. The leadership competency explains that NPs provide “leadership to foster collaboration with multiple stakeholders (e.g. patients, community, integrated health care teams, and policy

makers) to improve health care” (NONPF, 2012). Often times, the identification of a victim of CSA (as well as the prevention of CSA) requires a team, including the NP or other healthcare provider, family members, social workers, teachers, and the department for children and families (DCF). Also, involvement in professional organizations that advocate for the protection of these individuals, such as the VNPA, demonstrates this leadership competency as well.

CHAPTER 2: LITERATURE REVIEW

2.1 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) have been steadily gaining recognition throughout the medical community as significant predictors of future adverse health outcomes. The three categories of ACEs include abuse (sexual, physical and emotional), neglect (emotional and physical), and household dysfunction (which includes exposure to situations such as parental incarceration and/or separation, domestic violence, household mental illness and substance abuse). The current theory supporting this connection is that ACEs exude a profound amount of unhealthy, or “toxic” stress on the developing brain of a child, disrupting the proper development of the nervous and immune systems (National Scientific Council on the Developing Child, 2014).

Research postulates that the excessive stress placed on developing neurons leads to anatomic and physiologic disruptions in the circuitry of the brain. The specific areas that are thought to be affected are the hippocampus, amygdala, and the prefrontal cortex (PFC). “exposure to stressful experiences has been shown to alter the size and neuronal architecture of these areas as well as lead to functional differences in learning, memory and aspects of executive functioning” (Shonkoff, Garner, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics, 2012). Hyper-activation of the amygdala can lead to exaggerated anxiety responses, PFC atrophy impairs judgement and decision making, and hippocampal changes can impair memory and dysregulate mood and emotional responses, as seen in post-traumatic stress disorder (Shonkoff et al., 2012).

2.1.1. Long-Term Effects.

An ongoing landmark study conducted by the Centers for Disease Control and Prevention (CDC) through Kaiser Permanente is presently evaluating the long-term emotional, mental and physical health outcomes of those exposed to ACEs during childhood. With greater than 17,000 participants, this study began in 1995 and subsequently has gathered roughly 20 years of prospective evidence demonstrating the lasting impact of childhood trauma and stress (Felitti et al., 1998). Findings to date have helped link ACEs with many adverse health condition including mental illness, substance abuse and addiction, eating disorders, suicide, chronic diseases and risky sexual behavior. In regards to sexual health, children who have experienced ACEs have proven to be more likely to initiate sexual behavior early, contract sexually transmitted infections, experience intimate partner violence and have unintended pregnancies (Felitti et al., 1998; Brown et al., 2009; Anda et al., 2006).

One study by Dube et al. (2005) analyzed the data gleaned from the ACEs study to investigate the relationship between gender and CSA. The definition of CSA utilized in this questionnaire was the following:

During the first 18 years of life, did an adult, relative, family friend, or stranger ever (1) touch or fondle your body in a sexual way, (2) have you touch their body in a sexual way, (3) attempt to have any type of sexual intercourse with you (oral, anal, or vaginal), or (4) actually have any type of sexual intercourse with you (oral, anal, or vaginal)? (Dube et al., 2005, p. 432)

Of the 17,000 participants, 16% of males and 25% of females responded “yes” to at least one of these four questions, qualifying them as victims of CSA. Amongst both genders, those who had experienced CSA were at similarly increased risk for the drug and alcohol use, depression and marital and familial problems. Some of the most striking data included the finding that those who reported CSA were twice as likely to attempt suicide when compared to those who had denied CSA (amongst both men and women). Also, both genders were found to be 40% more likely to have married an alcoholic if they had been victims of CSA (Dube et al., 2005).

2.2 Vermont

2.2.1 Vermont Statistics.

There is limited data available to demonstrate the prevalence of CSA in Vermont. However, in 2010, the Vermont Adult Behavioral Risk Factor Surveillance System questioned adult Vermonters about their exposure to ACEs during childhood, including witnessing or experiencing sexual abuse, physical abuse and emotional abuse. It was found that 57% of participants reported experiencing at least one ACE. Even more shockingly, 13% of Vermont adults reported exposure to four or more of these adverse experiences (though the data does not specify which four ACEs were most commonly reported). This data does demonstrate, however, that those who had exposure to four or more ACEs in childhood were significantly more likely to suffer from obesity, depression and one or more chronic diseases than the average adult Vermonter. Also significant was the finding that those with four or more ACEs were significantly more likely to smoke cigarettes and to have smoked marijuana within the last 30 days than those who experienced fewer than four ACEs (Vermont Adult Behavioral Risk Factor Survey, 2012).

Early sexual behavior problems, such as sexually aggressive behaviors, excessive masturbation, or behaviors that begin at a much earlier age than would be developmentally expected, have been strongly associated with CSA (Friedrich et al., 2001; Silovsky & Niec, 2002). In Vermont, according to the 2013 Youth Risk Behavior Survey (YRBS), 42% of high-schoolers report ever having sexual intercourse, and 4% of high school aged students reported having had intercourse before the age of 13. Furthermore, 9% of students reported ever being physically hurt by someone they were dating, and 6% were physically forced to have sex. Boys were significantly more likely to report sexual intercourse before the age of 13 (VT YRBS, 2013). In Vermont, if any child younger than the age of 13 reports sexual contact, DCF involvement is required to identify if the perpetrator is of the same age, developmental level, and size of the child, whether there was any coercion or violence involved and what the relationship of the perpetrator is with the child. The YRBS does not ask about this information, and therefore this data is limited in helping to determine how much of this early sexual behavior may have been the result, or even the act, of sexual abuse.

2.2.2. Vermont Legislative Action.

In recent years, Vermont's state legislation has acknowledged the shocking prevalence of sexual violence in children, and significant steps have been made to help combat CSA in the communities and schools. In March of 2009, the S.13 bill or "Act 1" was signed into law in Vermont, which called for a multifaceted approach to improving Vermont's sexual abuse response system. The intent of this legislation was "to increase child sexual abuse prevention efforts" as well as to further enhance Vermont's ability to identify, prosecute and supervise child sexual abuse offenders (16 V.S.A. § 1-51). The

multi-pronged approach to prevention that was provided intended to encourage collaboration and communication between all persons associated with the welfare of Vermont children and therefore maximize their individual efforts. Included in this legislation was the mandate that all Vermont schools were to incorporate sexual violence education into their health education curriculums by July 1, 2011.

More recently, the deaths of two Vermont toddlers at the hands of their caregivers during the summer of 2014 lead to the creation of the Child Protection Bill, otherwise known as S.9. The families of both of these young children had already been under investigation by DCF, indicating a significant deficiency in Vermont's Child Protection System. The overarching goal of this new legislation was to enhance protection for children who are vulnerable to abuse and neglect. It was intended to foster closer collaboration and information sharing between DCF and Special Investigation Units in the cases of physical and sexual abuse. It also created a Joint Legislative Child Protection Oversight Committee in order to provide ongoing review of the Child Protection System and help to identify and discuss solutions for any further areas in which the system is deficient. Vermont Governor Peter Shumlin signed this bill into law on June 15, 2015 and it took effect on July 1, 2015 (13 V.S.A. § 1304).

2.3 Primary Care Prevention and Screening

Act 1 was monumental in helping to improve school and community-based sexual violence prevention and education, but it did very little to influence another major source of health education for both children and parents; the child's primary health care provider. Despite clinically insufficient evidence for universal screening of all children for sexual

abuse (per the USPSTF recommendation), providers can have an enormous impact on maltreatment detection and prevention via child and parental educational efforts.

2.3.1. Known Risk Factors and Red Flags.

In 2010, the American Academy of Pediatrics (AAP) published specific guidance to the pediatric providers about their role in preventing childhood maltreatment, as well as tips to help aid in its identification. As shown in Table 1 (Flaherty & Stirling, 2010), this guideline helped to classify some of the most prominent risk factors in children or their environment that might predispose them to these experiencing adverse events.

Table 1: Factors and Characteristics that Place a Child at Risk for Child Maltreatment (Flaherty & Stirling, 2010)

Child	Parent	Environment (Community and Society)
<ul style="list-style-type: none"> • Emotional/behavioral difficulties • Chronic illness • Physical disabilities • Developmental disabilities • Preterm Birth • Unwanted • Unplanned 	<ul style="list-style-type: none"> • Low self-esteem • Poor impulse control • Substance abuse/alcohol abuse • Young maternal or parental age • Abused as a child • Depression or other mental illness • Poor knowledge of child development or unrealistic expectations for child • Negative perception of normal child behavior 	<ul style="list-style-type: none"> • Social isolation • Poverty • Low educational achievement • Single-parent home • Non-biologically related male living in home • Family or intimate partner violence

Screening for these various risk factors is one way in which a provider might objectively classify a child's risk, and therefore tailor any anticipatory guidance and education for his or her unique situation. It is important for pediatric providers to provide appropriate education and guidance to all families in anticipation of projected developmental challenges, including personal safety. Talking to children and their caregivers about what behavior from an adult or peer is appropriate and what to do if they ever feel as though their safety is in jeopardy is important anticipatory guidance that should be discussed at each visit. In order to help providers conceptualize the specific guidance required for various age ranges, the AAP published a guide, known as Bright Futures (Hagan, Shaw & Duncan, 2008), which is now in its third edition with the fourth edition in process. This resource is intended as a guide for providers to help prioritize topics of interest during health supervision visits for all age ranges. It also provides a wide variety of validated screening tools for practices to utilize. One of the tools included is a Parent Screening Questionnaire (PSQ). This tool is intended to assist providers in identification of risk factors for child maltreatment, specifically maternal depression, substance abuse in the family and intimate partner violence (Appendix A). This questionnaire is also utilized in the SEEK Model (see Section 2.3.2 for more details).

Another important role of the provider is to help differentiate typical sexual behavior from behavior that is more concerning. In toddlers, for example, a parent may be concerned that their child occasionally tries to view them while they are in the shower. As shown in Table 2 (AAP, 2015), this would be classified as a normal behavior for a child of this age. The provider should conduct a thorough history of this behavior, however, and use clinical reasoning in order to rule out any more concerning signs or symptoms. Lack

of comfort in the topic, minimal training, and lack of confidence in one's ability to differentiate between normal and abnormal sexual behaviors may hinder a provider's ability to properly screen for and prevent any potential sexual abuse.

Table 2: Examples of Sexual Behaviors in Children Aged 2 to 6 Years (AAP, 2015)

Normal, common behaviors	Less common normal behaviors^a	Uncommon behaviors in normal children^b	Rarely normal^c
<ul style="list-style-type: none"> • Touching/masturbating genitals in public/private • Viewing/touching peer of new sibling genitals • Showing genitals to peers • Standing/sitting too close • Tries to view peer/adult nudity • Behaviors are transient, few, and distractible 	<ul style="list-style-type: none"> • Rubbing body against others • Trying to insert tongue in mouth while kissing • Touching pees/adult genitals • Crude mimic of movements associated with sexual acts • Sexual behaviors that are occasionally, but persistently, disruptive to others • Behaviors are transient and moderately responsive to distraction 	<ul style="list-style-type: none"> • Asking peer/adult to engage in specific sexual act(s) • Inserting objects into genitals • Explicit imitation of intercourse • Touching animal genitals • Sexual behaviors that are frequently disruptive to others • Behaviors that are persistent and resistant to parental distraction 	<ul style="list-style-type: none"> • Any sexual behavior involving children who are 4 or more years apart • A variety of sexual behaviors displayed on a daily basis • Sexual behavior that results in emotional distress or physical pain • Sexual behaviors associated with other physically aggressive behavior • Sexual behaviors that involve coercion • Behaviors that are consistent and child becomes angry if distracted

^aAssessment of situational factors (e.g., family nudity, day care, new sibling) contributing to behavior recommended.

^bAssessment of situational factors, family characteristics (e.g., violence, abuse neglect) recommended.

^cAssessment of all family and environmental factors and report to child protective services recommended.

2.3.2. Safe Environment for Every Kid (SEEK) Model.

The SEEK model, first introduced and published by Dubowitz, Feigelman, Lane & Kim in 2009, is a model of enhanced primary care to identify and support providers in screening for and preventing childhood maltreatment. There are four components of this intervention. The first is the universal employment of a standardized and validated screening tool, the Parent Screening Questionnaire (PSQ), that asks specifically about various concerning factors that may put the child at greater risk for harm (Appendix A). The second element is provider training. In the intervention, the providers were trained over two half days about the recognition of maltreatment risk factors and red flags and how to briefly and effectively assess and address these potential problems. Every six months, the providers were supplied with a “booster” training session to continue developing their skills and knowledge. Thirdly, these providers were supplied with a handout with the most practical information for quick reference, as well as a listing of local resources that were available to them and their patients. The fourth element of the SEEK model is the inclusion of a social worker in the practice. The need to use this resource was determined by the patient or the provider, and the individual in this role helped to provide “guidance and support in the clinic and referrals to community agencies” (Dubowitz et al., 2009).

Implementation of the SEEK model has been shown to decrease child abuse and neglect in comparison to practices without this established framework. This has been demonstrated via numerous measures. In one study of an inner-city resident-run clinic where the SEEK model was implemented, there were one-third fewer reports made to Child Protective Services (CPS) than in those clinics who did not receive this intervention. Based on the child’s medical record, there were also fewer delayed immunizations and non-

adherence to prescribed medical care. The researchers interpreted this data to demonstrate a decrease in parental neglect of the child's healthcare needs. According to parental self-report, there also were fewer instances of harsh punishment of the child (Dubowitz et al., 2009). This model has been implemented and evaluated in both high-risk and low-risk populations. Even in the low-risk population studied (middle-income, mostly white families), the SEEK model was still found to be impactful in reducing maltreatment. The statistical significance of the impact, however, was found to be much less than in the high-risk group (urban, low income, mostly African American families). In the low risk group, the SEEK model was associated with a reduction in psychological aggression by the mother and in minor physical assaults to the child. Although these offenses are not typically CPS reportable, they can have a lasting negative psychological impact of the child. Therefore, the researchers postulated that the SEEK model is impactful and influential in the lives of children at all levels of risk for maltreatment (Dubowitz, Lane, Semiatin, & Magder, 2012).

The SEEK model has demonstrated a positive impact on providers. In a study that assigned 18 different practices to either this intervention or routine practice, the providers in the SEEK model intervention group demonstrated improved levels of comfort and perceived confidence in their abilities to effectively screen for and address issues of maltreatment. Furthermore, in regards to practice behavior, the SEEK providers were found to screen for targeted problems significantly more often than those in the control group (Dubowitz et al., 2011).

Currently, with the increasing emphasis on the importance of primary care and the trend towards the development of patient centered medical homes, widespread implementation of the SEEK model in practice is becoming increasingly feasible. Often,

in patient-centered medical homes, social workers are very easily accessible, commonly working alongside health care providers to provide ease of access to care and improved care coordination. Another element of the SEEK model, the PSQ, is freely available from the AAP online for all to access. Increased provider training and provision of appropriate and available resources are the only two missing links to providing universal access to an enhanced system of pediatric primary care via the SEEK model.

2.3.3. Connected Kids: Safe, Strong, Secure.

In recognition of the gap in provider training and available resources, the AAP developed the Connected Kids program. Originally known as the Violence Intervention and Prevention Program (VIPPP), this free online resource offers a “comprehensive, logical approach for health care providers to integrate violence prevention into their practice. “Connected Kids takes an asset-based approach to anticipatory guidance, focusing on helping parents and families raise resilient children” (Levin-Goodman, 2009, p.1). This is conducted through the use of age-appropriate anticipatory guidance and counseling, informed by an extensive clinical guide, numerous parent and teen handouts, and a Power Point lecture series aimed towards providers.

The AAP implemented the use of this resource into eight pediatric practices and published a report of the findings in 2009. Each of the diverse pediatric practices was allowed the freedom to implement as much or as little of the program as they felt appropriate. Some immediately integrated it into practice and made changes along the way, whereas others took a more preparatory approach. The age ranges for which these resources were used also greatly varied between the practices. Providers who participated in this study found that the resources improved their skills in counseling by “addressing families’

needs more specifically instead of only generally, addressing topics that were previously addressed only superficially or not addressed at all, and discussing topics in a more open-ended and non-judgmental way” (Levin-Goodman, 2009, p.7). Providers also reported feeling more confident in their ability to discuss violence-related subjects, a greater awareness of the impact and prevalence of concerns in the community, improved relationships with patients, increased community connectedness and greater levels of patient and staff satisfaction (Levin-Goodman, 2009). Additional research is needed to formally evaluate the effectiveness of this tool in practice. However, these preliminary findings indicate that this program is feasible, appealing to providers and sustainable (Flaherty, & Stirling, 2010).

These models have demonstrated the recent efforts to establish a more competent and confident primary care workforce, and therefore to make screening and prevention of sexual abuse a routine component of each health supervision visit. However, they continue to be in their initial stages of development and implementation. Very little is currently known about how the practice is routinely conducted in pediatric offices in the state of Vermont, how providers feel about their ability to do so, and what other barriers may impede its incorporation into every-day, routine visits. It is anticipated that the data provided by this research will help to fill this gap in understanding, and deliver the most appropriate and available resources to the providers who wish to seek further training on the subject of screening and prevention efforts of CSA.

CHAPTER 3: METHODS

3.1 Participants

All voluntary participants in this study were healthcare professionals who are currently practicing as primary care providers (PCPs) in the state of Vermont. It was a requirement of study inclusion that they see pediatric patients in their practice, as indicated by the initial mailing that called for the attention of all pediatric primary care providers. Providers could practice in either a pediatric-specific setting or in a family practice setting, with care of children integrated into the practice. These eligibility requirements were outlined in the initial recruitment electronic mailings (Appendix B). Furthermore, the providers surveyed were intended to be of various educational and philosophical backgrounds, including family and pediatric nurse practitioners, pediatricians and family practice medical physicians. As a result, it was anticipated that the findings would be representative of the natural variety of screening and prevention experienced by Vermont's children who seek primary care services. Therefore, the results of this survey would ideally be representative of patients with various levels of education, socioeconomic status, and risk for child maltreatment.

3.2 Recruitment

All recruitment for this study was conducted via electronic mailings through mailing lists of Vermont-based health care professional organizations. The three organizations that agreed to distribute this survey included the Vermont Chapter of the AAP, the Vermont Nurse Practitioners Association (VNPA), and the Vermont Academy of Family Physicians (VTAFP). The recruitment mailings included a brief description of the study and its purpose, the benefits of participating, and the assurance of participant

anonymity (Appendix B). The initial mailings also clearly stated the number of questions in the survey and the anticipated time commitment. The estimated number of addresses that the survey was distributed to is roughly 1,000. However, it would be expected that some participants were members of multiple organizations. In these cases, participants might have received the request to participate from various sources. The recruitment mailings informed its recipients of this possibility and asked that participants only respond once. The risks and benefits of participating in this study were also explicitly stated in this initial mailing.

3.3 Procedures

As this research involved human subjects, it was subject to critique and approval from the University of Vermont Institutional Review Board (IRB). Due to the anonymous nature of the electronic survey responses, the research was deemed exempt from full IRB review under Exemption Category 2, as shown in Appendix E.

The research was conducted in the format of a 20-item online survey (Appendix C). This survey was self-developed by the researcher, but loosely modeled after the SEEK Health Professional Questionnaire (Dubowitz et al., 2011). The content of the survey was vetted by the leaders of the three professional organizations that agreed to distribute the survey to its members, as well as peer reviewed. Following this process, the survey was translated into digital formatting via the survey building program, Limesurvey, on a secure server through the University of Vermont. The initial distribution of the recruitment mailing and this survey was executed on the first of June of 2015. The survey remained open and available for response for three full weeks. At the beginning of each of the three weeks, the recruitment mailing and survey were redistributed as a reminder to those who

wished to participate. One week following the third and final reminder, the link to the survey was disabled. Following all responses to the survey, the participants received information about how they can further their education in the subject matter. They were provided with a number of online, local, and national resources that are readily available to provide further training in abuse prevention and detection (Appendix D).

3.4 Data Analysis

Following data collection, the overall data was placed in a Microsoft Excel spreadsheet and examined for overall trends. The statistical analysis software program SPSS was then used to determine significant relationships between the data, with all significance set at $p < 0.05$. Responses to each of the multiple choice format questions were initially coded for ease of calculations. For example, for questions that were dichotomous, the “No” responses were coded into “0” and “Yes” responses were changed to “1”.

Initially, the demographic data (professional title, years in practice, patient population, practice location, and access to a social worker) was categorized and utilized as independent variables from which to compare responses. For example, the respondents were split into comparative groups such as those who practiced as physicians and those who practiced as NPs. Relationships between the dichotomous (yes or no) responses and professional title, geographical location, years of experience, overall patient population and ease of access to a social worker were explored in depth using a chi square analyses. For questions in which the responses could fall on a spectrum of one to ten (the scaled responses), the average responses per demographic group were calculated and compared using independent sample *t*-tests.

Next, the responses to question twenty, the open-ended question (regarding the greatest barrier faced in practice) were examined for overall trends. There were five salient themes identified; time, access, knowledge, resources and resistance. The time category encompassed all responses that explicitly voiced time constraints or competing priorities in visits. Access referred to physically getting the child into the clinic or having an opportunity to talk with the child alone. Knowledge referred to any response that mentioned a lack of training, inexperience or difficulty with recognition of CSA. Three participants felt that lack of resource availability was the greatest concern, including a lack of validated screening tools, lack of family and child supports and poor state engagement and follow up. The final theme, resistance, encompassed the responses that conveyed fear of disrupting the therapeutic relationship between the provider and the family, and, in the case of the abused child, fear of the exposure that comes with disclosure, a lack of trust in the provider and discomfort. These responses were then compared to the demographic data and the other binary data using Pearson's correlations.

Finally, one of the questions lent itself to a scaled analysis known as the one-way analysis of variance (ANOVA). Question number 16 asked about sufficiency of preparation in education, and allowed for a yes, somewhat, and no response. Using the ANOVA test, the results of this question were compared to those of the 10-point scale questions (question numbers 13, 14, 15, 18 and 19). A post hoc analysis was then performed in order to do a pairwise comparison of the responses.

3.4.1. Discarded Questions

For a few of the survey questions, response rate was poor or responses very unclear. These questions were unable to be utilized in analysis, and therefore discarded. Question

number five asked; “How many pediatric patients are you personally responsible for the care of in your practice?” (Appendix C). Some participants chose not to answer this question, some gave vague ranges or percentages, and others chose to respond with written responses such as ‘hundreds.’ Analysis and comparison of these responses proved not to be feasible. Also discarded were questions seven and eight, which asked about yearly experience with maltreatment and the percentage of these cases in which CSA is involved. These two questions were originally intended to be analyzed in tandem to determine the perceived prevalence of CSA in childhood maltreatment cases. Unfortunately, only sixteen participants, 43% of respondents, chose to respond to the latter of the two questions, rendering both relatively useless for the purposes of this study.

Other questions were not used in the analysis because the responses were so overwhelmingly one-sided. All but four respondents answered “yes” to question twelve, which asked; “in your opinion, is routine screening for maltreatment appropriate for all children, including those considered low-risk?” Also, all but one participant responded “yes” or “maybe” to question seventeen: would you be interested in receiving supplemental training regarding child sexual abuse prevention, screening and detection? Although these are both significant findings, these questions were able to be utilized in the statistical analysis, as they would not demonstrate any significant trends. If this survey is to be utilized in future research, this should be taken into consideration, as it may be an indication to remove these items from this tool.

CHAPTER 4: RESULTS

4.1 Demographics

Overall, there were 37 complete responses to the survey. In regards to professional title, the question allowed for multiple responses [if, for example, an individual was certified as both a pediatric nurse practitioner (PNP) and a family nurse practitioner (FNP)]. However, there were no participants who chose more than one option. There were also no PAs who responded to the survey. One DO did respond, and was initially classified as “other” (Table 3). For the purposes of comparison and analysis, the participants were divided into two groups: physicians versus NPs. The DO respondent was classified under the title of “physician”.

Table 3. Professional Title Distribution of Participants

Professional Title	MD	PNP	FNP	Other
Number of Participants	26	3	7	1

Participants were also asked about the geographical location of their workplace. This, too, allowed for multiple responses, as many positions may include some amount of travel across the state of Vermont. Two participants selected multiple counties in which they practiced. Again, for the purposes of analysis and comparison, the counties were split into “Northern Vermont” (Caledonia, Essex, Franklin, Grand Isle, Lamoille, Orleans and Washington Counties), “Southern Vermont” (Addison, Bennington, Orange, Rutland, Windham, and Windsor Counties and Chittenden County as a standalone. The two participants who had identified more than one county were both exclusively practicing in the counties identified as “Southern Vermont” and therefore each of their replies was

quantified as a single response (Table 4). Geographic location, however, proved not to be significantly correlated with any of the other variables studied in this research.

Table 4. Geographical Distribution of Participants' Practice

Location	Northern Vermont	Southern Vermont	Chittenden County
Number of Participants	9	14	14

The remainder of the demographic questions were also dichotomized. Family practice versus exclusively pediatric practice lent itself to this separation very easily (Table 5). Access to a social worker was split between “No” and “Yes” responses. The “sometimes” responses were grouped together with the “yes” responses, as only three participants chose this response (Table 5). Finally, the years of experience in practice were divided as evenly as possible based on the responses, which resulted in a split between those with more than 20 years of practice and those who have been practicing for 20 years or less (Table 5).

Table 5: Demographic Data Distributions

	Years of Experience		Family vs Pediatric Practice		Access to a Social Worker	
	0-20	>20	Family	Pedi	Yes/ Sometimes	No
Number of Participants	22	15	19	18	23	14
Total Participants (N)	37		37		37	

Following thorough analysis of the data, access to a social worker also proved to have no significant relationships with any of the other findings.

4.2 Professional Title

The greatest number of significant differences between all of the groups studied was found in the comparison between physicians and NPs. The first major difference was found in current screening practices. Only 48% of physician respondents reported that they routinely screen all children for maltreatment during health supervision visits, whereas 100% of the NP respondents reported this current practice ($p=0.003$). Similarly, only 33% of physician participants reported routinely screening the parents for maltreatment risk factors (i.e. domestic violence, mental health disorders, substance abuse, etc.) during health supervision visits. One hundred percent of the NP respondents reported this as a routine practice ($p<0.001$). Finally, the NP respondents were significantly more likely than physicians to report that the EHR used in their practice automatically prompts providers to ask maltreatment screening questions ($p=0.022$).

Another difference between the professional titles, though only marginally statistically significant (or $p<0.10$) was found in provider self-perceptions in their screening and prevention abilities. The average NP scores of comfort level in screening for sexual abuse red flags and risk factors, on a one to ten scale, was 6.50, whereas the average physician score was 4.89, which was found to be significant through t -test ($p=0.082$). Also, the NPs' perceptions of their impact on prevention as a child's PCP were greater than those of the physician respondents, with NPs averaging a score of 6.80 versus the average physician score of 5.44 ($p=0.078$).

The final noteworthy difference between these two groups was found in regards to the perception of barriers to screening in primary care. The physician group was more

likely to mention time as a major barrier to screening, though only marginally significant ($p=0.054$). For more results regarding barriers, see section 4.7.

4.3 Patient Population

Another statistical difference that was identified occurred between those who work exclusively in pediatrics and those who see entire families. The value that was found to be significantly different between these two groups was their confidence in their ability to detect the risk factors and red flags of sexual abuse. Those who worked in pediatrics exclusively reported an overall average confidence score of 6.56, whereas those in family practice reported an average confidence score of 4.47 ($p=0.002$).

Again of note, though not statistically significant, the average pediatric-specific provider's comfort level in screening for sexual abuse and perceived impact on prevention as a child's PCP were greater than those of the family practice respondents ($p= 0.107$ and $p= 0.105$, respectively).

4.4 Experience in Practice

It was also discovered that years of experience had a significant association with the perceptions of barriers to screening facing primary care providers. Providers who reported more than 20 years of practice were found to be significantly less likely to mention access to the child as a barrier to screening and prevention. Only 6.7% of those with more than 20 years reported this barrier, whereas 36.4% of providers with 20 years or less experience voiced this opinion ($p=0.039$).

Another finding, though again only marginally significant, was that providers with more than 20 years of experience were more likely to report routine screening of all children during health supervision visits. Eighty percent of providers with more than 20

years of experience reported this, as compared to only 50% of those with 20 years or less experience ($p=0.065$).

4.5 Confidence, Competence, and Perceived Impact

Likelihood of routine screening also appeared to be positively correlated with a provider's self-perceptions of confidence and comfort with screening and detection of CSA. As shown in Table 6, both those who had greater levels of comfort with sexual abuse screening and those who felt more confident in their abilities to detect sexual abuse were significantly more likely to screen all children for signs of maltreatment ($p=0.009$ and $p=0.003$, respectively).

Table 6: Pearson Correlations of Routine Screening vs Provider Self-Perceptions

		Comfort level in screening for sexual abuse	Confidence in ability to detect sexual abuse	Impact I have in sexual abuse prevention
Routine screening of all children during health supervision visits	Pearson Correlation	0.424	0.473	0.224
	Sig. (2- tailed)	0.009	0.003	0.183
	N	37	37	37

4.6 Resource Availability and Utilization

Provider comfort with sexual abuse screening, confidence in ability to identify red flags and risk factors and perceived impact on prevention were also compared to the provider's feelings regarding the accessibility of local and state child advocacy and sexual abuse prevention resources and the efficacy with which they feel their current practice utilizes these resources. Every one of these relationships was found to be statistically

significant (Table 7). The strongest correlation in magnitude is 0.7, which represents the relationship between practice utilization of resources and confident in ability to detect sexual abuse.

Table 7: Pearson Correlations of Resource Perceptions vs Provider Self-Perceptions

		Comfort level in screening for sexual abuse	Confidence in ability to detect sexual abuse	Impact I have in sexual abuse prevention
Availability of Resources	Pearson Correlation	0.377	0.474	0.348
	Sig. (2- tailed)	0.021	0.003	0.035
	N	37	37	37
Practice Utilization of Resources	Pearson Correlation	0.474	0.735	0.421
	Sig. (2- tailed)	0.003	0.000	0.009
	N	37	37	37

4.7 Barriers to Screening

The most commonly mentioned barrier to screening was time and other competing priorities in the health supervision visit, with fourteen mentions. Lack of knowledge was a close second, with ten mentions. Lack of access and lack of follow up was the third most popular response, with seven mentions. Resistance to screening and discomfort had five mentions, and lack of resources was mentioned three times.

Perception of the various barriers to screening in primary care also appeared to be significantly impacted by a provider's feelings regarding his or her ability to be impactful. Correlational data showed that those providers who perceived their impact on sexual abuse prevention to be greater were found to be significantly more likely to mention time as the greatest barrier to screening that they face in the primary care setting ($p=0.002$).

Furthermore, perception of prevention resource availability was also found to be positively correlated with mentioning time as a barrier to screening ($p=0.013$).

Although not statistically significant, a positive relationship was also found between those who have greater levels of comfort and confidence and the mention of time as the greatest barrier to screening ($p=0.101$ and $p=0.084$, respectively). Another marginally significant finding was that provider comfort level was negatively associated with the mention of knowledge as the greatest barrier ($p=0.066$) (Table 8).

Table 8: Pearson Correlations of Barriers to Screening vs Provider Self-Perceptions

		Comfort level in screening for sexual abuse	Confidence in ability to detect sexual abuse	Impact I have in sexual abuse prevention
Time	Correlation	0.274	0.288	0.503
	Sig (2-tailed)	0.101	0.084	0.002
	N	37	37	37
Knowledge	Correlation	-0.305	-0.160	-0.243
	Sig (2-tailed)	0.066	0.343	0.148
	N	37	37	37
Resources	Correlation	0.163	-0.022	0.027
	Sig (2-tailed)	0.334	0.899	0.874
	N	37	37	37
Access	Correlation	0.028	-0.011	-0.130
	Sig (2-tailed)	0.870	0.947	0.442
	N	37	37	37
Resistance	Correlation	0.012	-0.054	-0.116
	Sig (2-tailed)	0.943	0.751	0.493
	N	37	37	37

4.8 Sufficiency of Educational Preparation

The final noteworthy findings resulted when the providers' scaled perceptions of the adequacy of their educational training (sufficient, somewhat sufficient, and not

sufficient) was examined against all of the 10-point scale questions (comfort, confidence, prevention impact and accessibility and current utilization of resources). The one-way ANOVA test (Table 9) demonstrated that all of these factors, except for perceived impact on prevention, were positively and significantly associated with the perceptions of the sufficiency of training.

Table 9: One way ANOVA of Educational Training Sufficiency

		Sum of squares	df	Mean Square	F	Sig
Accessibility of resources	Between groups	31.939	2	15.969	3.278	0.050
	Within groups	165.629	34	4.871		
	Total	197.568	36			
Utilization of resources	Between groups	89.769	2	44.884	12.157	0.000
	Within groups	125.529	34	3.692		
	Total	215.297	36			
Comfort in screening	Between groups	70.701	2	35.350	8.045	0.001
	Within groups	149.407	34	4.394		
	Total	220.108	36			
Confidence in screening	Between groups	67.836	2	33.918	12.087	0.000
	Within groups	95.407	34	2.806		
	Total	163.243	36			
Impact on prevention	Between groups	8.269	2	4.134	0.928	0.405
	Within groups	151.407	34	4.453		
	Total	159.676	36			

Following the ANOVA testing, a post hoc analysis of the scale variables was performed against the sufficiency variable in order to determine which pair-wise comparisons were significantly different (Table 10). This follow-up testing demonstrated that the “yes” and “somewhat” responses were not significantly different from each other when it came to questions about resources. In regards to questions about comfort and confidence with screening, the “yes,” “no” and “somewhat” responses were each found to be significantly different from one another. This indicates that those who reported high levels of comfort and confidence with screening also reported receiving an adequate amount of training in their education. Likewise those who reported low levels of comfort and confidence reported insufficient training, and those in the middle felt their preparation was mediocre.

Table 10: Post Hoc Comparison of Scale Variables vs Educational Sufficiency

Dependent Variable	Sufficiently prepared to identify issues	Sufficiently prepared to identify issues	Mean difference	Std. error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Accessibility of resources	No	Yes	-2.714	1.088	0.018	-4.92	-0.50
		Somewhat	-2.014	0.969	0.045	-3.98	-0.04
	Yes	No	2.714	1.088	0.018	0.50	4.92
		Somewhat	0.700	0.855	0.419	-1.04	2.44
	Somewhat	No	2.014	0.969	0.045	0.04	3.98
		Yes	-0.700	0.855	0.419	-2.44	1.04
Utilization of resources	No	Yes	-4.586	0.947	0.000	-6.51	-2.66
		Somewhat	-3.286	0.844	0.000	-5.00	-1.57
	Yes	No	4.586	0.947	0.000	2.66	6.51
		Somewhat	1.300	0.744	0.090	-0.21	2.81
	Somewhat	No	3.286	0.844	0.000	1.57	5.00
		Yes	-1.300	0.744	0.090	-2.81	0.21
Comfort in screening	No	Yes	-4.143	1.033	0.000	-6.24	6.24
		Somewhat	-2.493	0.921	0.011	-4.36	3.30
	Yes	No	4.143	1.033	0.000	2.04	6.24
		Somewhat	1.650	0.812	0.050	0.00	3.30
	Somewhat	No	2.493	0.921	0.011	0.62	4.36
		Yes	-1.650	0.812	0.050	-3.30	0.00
Confidence in screening	No	Yes	-4.057	0.826	0.000	-5.73	-2.38
		Somewhat	-2.307	0.736	0.004	-3.80	-0.81
	Yes	No	4.057	0.826	0.000	2.38	5.73
		Somewhat	1.750	0.649	0.011	0.43	3.07
	Somewhat	No	2.307	0.736	0.004	0.81	3.80
		Yes	-1.750	0.649	0.011	-3.07	-0.43
Impact on prevention	No	Yes	-1.343	1.040	0.205	-3.46	0.77
		Somewhat	-1.093	0.927	0.246	-2.98	0.79
	Yes	No	1.343	1.040	0.205	-0.77	3.46
		Somewhat	0.250	0.817	0.762	-1.41	1.91
	Somewhat	No	1.093	0.927	0.246	-0.79	2.98
		Yes	-0.250	0.817	0.762	-1.91	1.41

CHAPTER 5: DISCUSSION

5.1 Implications

NPs who were practicing as primary care providers in both pediatric and family practice settings reported a significantly more routine practice of universal screenings of both children and parents than physicians. The EHRs used by NPs were also more likely to prompt these screening questions. This finding is consistent with the data available about routine screening for other subtle conditions as prompted by the EHR. The Modified Checklist for Autism in Toddlers (M-CHAT) screening tool for autism, for example, when incorporated into the EHR was found to reduce false screenings, both of those labeled at-risk and not-at-risk (Harrington, Bai, & Perkins, 2013). The researchers hypothesized that this reduction in false classification was likely due to the follow-up questions that are required when trying to identify or rule out autism, as is also the case with screening for sexual abuse.

The data also demonstrated that overall, greater levels of confidence in detection was significantly associated with the routine screening of all children. There was, however, no difference between NPs and physicians in regards to confidence. As previously noted, there was only a marginally significant difference noted in comfort with screening and perceived impact on prevention, with NPs reporting a greater average score in both measures. However, there was no statistically significant difference found between the physician and NP group and their perception of the sufficiency of their educational training on this topic.

Pediatric providers were also significantly more likely than family practice providers to report greater levels of confidence in their ability to detect risk factors and red

flags. One hypothesized reason for this relationship is that family practice providers see pediatric patients less frequently. As a result, pediatric providers have theoretically more overall exposure to CSA and may have greater confidence in their ability to detect it as a result. Also the educational training of the pediatric provider may have focused more on this topic than the family practice provider, as discovered in a study by Starling, Heisler, Paulson and Youmans in 2009. In their nationwide survey of physicians in various settings, they came to the conclusion that “pediatric programs provide far more training and resources for child abuse education than emergency medicine and family medicine programs.”

Both geographical location and access to a social worker were found to have no significant relationships with the data. The lack of relationship found between social worker access and resource availability and utilization was particularly unexpected. Historically, social workers are the initial resource that primary care providers refer to in suspected cases of CSA. Newton and Vendeven (2010) strongly suggested that, “medical providers consult with a hospital-based child protection team or social worker to assist in triage and management of cases of sexual abuse.” The necessity for involvement of social work from a prevention standpoint is much less clear. Of note, in regards to the accessibility of prevention resources, the average scores of those with and without access to a social worker were 6.17 and 6.00, respectively. This may indicate that even those without access to social work feel well connected to local and state resources.

Both availability of resources and effective practice utilization of these resources had a very large impact on providers’ self-perceptions. This may indicate that prevention resources are evenly distributed throughout the state, and those who are efficiently linked

to these resources become subsequently more comfortable and confident with screenings, and also have a greater perceived impact on CSA prevention. It may also imply that those who have an intrinsically greater self-perception are more connected to the community resources and therefore efficiently utilize them in their own practice.

Pertaining to reported barriers, there were a number of significant findings. Time was mentioned as the greatest barrier by those who felt that resources were readily available and by those who felt that they could have a significant impact on the prevention of CSA. One hypothesis for why this relationship might exist is that those who feel they have the experience, knowledge, skills and appropriate support only feel limited by factors more beyond their control, such as the limited time slots allotted by their practice. Also, those with greater than 20 years of experience were significantly less likely to mention access to CSA victims as a barrier to screening. Although the reasoning behind this finding is unclear, one theory is that those with more experience may feel more connected to the community and have established trusting relationships with their patients. Also, though not significant, the negative correlation between knowledge and comfort implies that a provider would be uncomfortable performing a sexual abuse screening if he or she was unsure of what qualifies as an abnormal finding.

5.2 Limitations

There are a number of limitations to this study that must be acknowledged. Firstly, all of the relationships noted in the results of this study are correlational. As this is not a randomized controlled trial, there is no ability to draw definite conclusions about causation from the data. Further study is required to identify the origin of the significant differences observed in these results.

Other limitations include the fact that the survey utilized was developed entirely by the researcher. It has not been scientifically validated as a research tool. Also, for reasons unknown, the Limesurvey software allowed for some questions labeled as “mandatory” by the researcher to be skipped by the participants. Therefore, there were some responses that were incomplete. Some questions, such as question number eight (Appendix C) were answered by fewer than half of the participants and therefore were discarded, as previously discussed (section 3.4.1).

There was also a poor response rate, making the data difficult to generalize to larger populations. It was estimated that the mailing would reach roughly one thousand email addresses, according to estimates provided by the leaders of each of the three professional organizations. The VPNA estimated that there were over 500 recipients on their mailing list. However, this list encompasses NPs in all different clinical settings, and only a small fraction of these NPs currently work with pediatrics in the primary care setting. The Vermont Academy of Family Physicians estimated that their mailings would reach 350 providers, and the Vermont chapter of the AAP estimated 200. As mentioned in the recruitment mailing, there was an anticipated overlap in involvement in these professional organizations. This leads to under-representation of distribution numbers and an underestimation of response rate. Also, the responses were unevenly split between groups. For example, the physician group contained 27 participants, whereas the NP group contained only 10. However, had the initial aim of this study been to only compare NPs and physicians, then participants would have been selected based strictly on this factor.

Furthermore, the small sample size ($N = 37$) is a significant limitation to this study. As a result of this small sample size, the statistical power of the study was diminished. It

is difficult to infer truly significant differences between the results with a sample of this size.

Another possible limitation to this study is the way in which the “access to a social worker” data was categorized. There were a very small number of respondents ($N = 3$) who selected with the “sometimes” option in this question. This number was too few to derive any statistical power from, and therefore these participants were grouped with the “yes” respondents. The researchers assumed that a “sometimes” and “yes” response both implied that social work is at least established as a collaborating partner in the practice, without indication of whether that service is available on a full-time basis. However, it is possible that there was a significant difference between these two responses that collapsing them both into one category confounded the data.

5.3 Directions of Further Research

Following survey completion, the study participants were provided information about the various online, local, state and federal resources available to assist providers in the prevention and detection of maltreatment and the subsequent sequelae. Unfortunately, as the survey was anonymous, there was no means of tracking who accessed these resources to improve their skills, or which resources providers found to be most helpful. An interesting direction of further study might be a follow-up survey of these same participants to determine how much of an impact the self-study resources supplied had on the items measured.

5.4 Conclusions

Despite the limitations of this study, a number of the findings and lessons learned can be utilized as an impetus for practice change. Firstly, the finding that members of the

NP group were significantly more likely to report that the EHR prompted maltreatment screening questions, and that all of the members of this same group reported screening children on a routine basis is noteworthy. This indicates that there may be a connection between the prompting of the EHR and the likelihood of routinely screening all children. The addition of screening questions into the EHRs used in pediatric primary care is a minor change in practice that can be easily implemented across various settings and will increase the likelihood of prevention, screening and detection of CSA.

Another lesson gleaned from this data was that the vast majority of providers reported believing that routine screening for maltreatment is appropriate for all children, including those considered low-risk. Despite this pervasive agreement, many did not report screening of the child and/or the caregiver for maltreatment as routine practice during health supervision visits. The most commonly reported barriers were time as well as a lack of knowledge on the subject. Also, nearly every participant voiced interest in receiving supplemental training regarding child sexual abuse prevention, screening and detection. These findings indicate that providers are welcoming of further education on this sensitive subject, and are willing to implement routine screenings. Also, allotting longer time slots for these health supervision visits would be a logical first step in helping to hurdle the barrier of limited time.

Recognition of child sexual abuse has steadily progressed in the past 30 years. Now, as the healthcare system becomes more focused on “well-care” versus “sick-care”, pediatric primary care providers are perfectly posed to intervene in the lives of at-risk children early on. In doing so, they can help to prevent the vast number of possible negative health sequela that accompany this adverse experience. The findings and

recommendations of this study are intended to help make CSA screening just as common as the screening for other safety measures, such as fire safety and the use of car seats. Further research and provider education is needed to help accomplish this goal.

APPENDIX A:

Parent Screening Questionnaire

A Safe Environment for Every Kid (SEEK)

Dear parent or caregiver: Being a parent is not easy. We want to help families have a safe environment for kids. We are asking everyone these questions. Please answer the questions about your child being seen today for a check-up. They are about issues that affect many families. If there's a problem, we'll try to help.

Today's Date: _____/_____/20____
Child's Date of Birth: _____/_____/_____
Sex of Child: ☐ Male ☐ Female

PLEASE CHECK

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you need the telephone number for Poison Control? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you need a smoke alarm for your home? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does anyone smoke tobacco at home? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there a gun in your home? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In the last year, did you worry that your food would run out before you got money or food stamps to buy more? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you worry that your child may have been physically abused? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you worry that your child may have been sexually abused? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Lately, do you often feel down, depressed, or hopeless? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you often feel lonely? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | During the past month, have you felt little interest or pleasure in the things you used to enjoy? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you often feel your child is difficult to take care of? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you wish you had more help with your child? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you feel so stressed you can't take another day? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you sometimes find you need to hit/spank your child? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In the past year, have you or your partner had a problem with drugs or alcohol? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In the past year, have you or your partner felt the need to cut back on alcohol? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been in a relationship in which you were physically hurt or threatened by a partner? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In the past year, have you been afraid of a partner? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In the past year, have you thought of getting a court order for protection? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are there any problems you'd like help with today? |

Please give this form to the doctor or nurse you're seeing today. Thank you.

Appendix B: Recruitment Mailing

Attention all Vermont Pediatric Primary Care Providers.

Are you interested in learning more about how you can screen for and prevent sexual abuse in your pediatric patients?

If so, please take the next five minutes to complete the following **anonymous**, 20-item survey.

Following the survey, you will be provided with a variety of carefully selected national and local resources in this subject matter that are readily available to you.

[CLICK HERE TO COMPLETE THE SURVEY!](#)

By completing this survey you will be:

- Participating in a research project conducted by a University of Vermont Masters of Nursing Student
- Contributing to the knowledge about current practice and attitudes regarding abuse screening and prevention
- Provided with the means to further educate yourself on how to screen for and prevent child sexual abuse in your pediatric patients

Please note: This survey was distributed with permission from three distinct professional organizations of primary care providers in the state of Vermont. Our apologies if you received this email more than once due to dual enrollment in these organizations. Please only complete the survey once.

APPENDIX C: Survey

Childhood Sexual Abuse Screening and Prevention Survey

Glossary of Terms Used:

- Child Maltreatment: The overarching term used to encompass the abuse and/or neglect of a person under 18 years of age
 - a. Abuse:
 - i. Child Sexual Abuse: Any act of acts be any person involving sexual molestation or exploitation of a person under the age of 18
 - ii. Physical Abuse: Death, permanent or temporary disfigurement, or impairment of any bodily organ or function other than by accidental means
 - iii. Emotional Abuse: A pattern of malicious behavior, which results in impaired psychological growth and development
 - b. Neglect: Failure to supply a child with adequate food, clothing, shelter, or health care

Demographic Questions

1) What is your professional title? (select all that apply)

MD
FNP
PNP
DNP
PA

Other:

2) How many years have you been in practice?

<5 years
5-10 years
11-15 years
16-20 years
>20 years

3) In which VT County do you currently practice? (select all that apply)

‘
Addison County
Bennington County
Caledonia County
Chittenden County
Essex County
Franklin County

Grand Isle County
Lamoille County
Orange County
Orleans County
Rutland County
Washington County
Windham County
Windsor County

4) Which population do you see in this practice?

Pediatrics exclusively

Families of all ages, including pediatrics

5) Roughly how many pediatric patients are you personally responsible for the care of in your practice?

6) Do you have direct access to a collaborating social worker in your practice?

Yes

No

Sometimes

Prevalence Questions

7) How frequently, on average, do you encounter suspected cases of child maltreatment (abuse and/or neglect)? In other words, how many times in one year do you make contact with the Department of Children and Families (DCF)?

#_____ case(s) per year

8) In what percent of these maltreatment cases would you estimate that sexual abuse is involved?

<5%

5-10%

11-15%

16-20%

21-25%

26-30%

31-35%

>35%

Screening Questions

MALTREATMENT: GENERAL SCREENINGS

9) In your practice, do you routinely screen all **children** for maltreatment during well child checks?

Yes
No

10) In your practice, do you routinely screen all **parents** for maltreatment risk factors (i.e. domestic violence, mental health disorders, substance abuse, etc.) during well child checks?

Yes
No

11) Does the electronic health record used by your practice automatically prompt screening questions about maltreatment during well child checks?

Yes
No

12) In your opinion, is routine screening for maltreatment appropriate for all children, including those considered low-risk?

Yes
No

SEXUAL ABUSE: SPECIFIC SCREENING

13) On a scale of 1 to 10, how **comfortable** are you in screening for child sexual abuse (1 = least comfortable, 10=most comfortable)

1 2 3 4 5 6 7 8 9 10

14) On a scale of 1 to 10, how **confident** are you in your ability to identify and detect child sexual abuse **red flags and risk factors**?

(1 = least confident, 10=most confident)

1 2 3 4 5 6 7 8 9 10

Prevention Questions

15) On a scale of 1 to 10, how much of an impact do you feel you can have in sexual abuse prevention as a primary care provider? (1 = no impact, 10 = significant impact)

1 2 3 4 5 6 7 8 9 10

16) Do you feel as though your educational training on this subject matter has sufficiently prepared you to identify and address these issues in practice?

Yes
No
Somewhat

17) Would you be interested in receiving supplemental training regarding child sexual abuse prevention, screening and detection?

Yes
No
Maybe

Resources Questions

18) On a scale of 1 to 10, how accessible do you feel your local and state child advocacy and sexual abuse prevention resources are to you and your practice? (1= not at all accessible and 10 = readily accessible)

1 2 3 4 5 6 7 8 9 10

19) On a scale of 1 to 10, how well do you feel your practice utilizes these available community and national resources? (1= poorly, 10 = to the fullest extent possible)

1 2 3 4 5 6 7 8 9 10

Barriers Question

20) In your opinion, what is the greatest barrier that pediatric primary care providers face in screening for child abuse and neglect?

Appendix D: Resource List

Available National Resources

National Sexual Violence Resource Center: www.nsvrc.org

The NSVRC has a unique online library collection that provides access to a comprehensive selection of relevant and timely resources on sexual violence, prevention, and related topics to assist advocates and others interested in understanding and eliminating sexual violence.

Stop It Now!: www.stopitnow.org

Since 1992 Stop It Now!® has been preventing the sexual abuse of children by helping adults, families and communities take actions that keep kids safe - especially before they are ever harmed. Stop it Now! also offers a wealth of information about children with sexually harmful behaviors. Hotline: 1-888-PREVENT.

American Academy of Pediatrics Resources:

- A parent/caregiver screening tool for maltreatment risk factors
http://brightfutures.aap.org/pdfs/Other%203/PSQ_screen.pdf
- The American Academy of Pediatrics Connected Kids: Safe, Strong, Secure
Website: <http://www2.aap.org/connectedkids/>
Clinical Guide: <http://www2.aap.org/connectedkids/ClinicalGuide.pdf>
- An online training for health providers regarding sexual behavior and sexual violence
<http://www2.aap.org/pubserv/psvpreview/pages/whatissv.html>

Futures Without Violence: <http://www.futureswithoutviolence.org/>

Striving to reach new audiences and transform social norms, we train professionals such as doctors, nurses, judges, and athletic coaches on improving responses to violence and abuse. We also work with advocates, policy makers, and others to build sustainable community leadership and educate people everywhere about the importance of respect and healthy relationships. Our vision is a future without violence that provides education, safety, justice, and hope.

Available Statewide Resources

Agency of Human Services, State of Vermont

The Agency of Human Services (AHS) has the widest reach in state government and a critical mission: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

WHAT WE CAN OFFER:

- 1) **The Vermont Center for the Prevention and Treatment of Sexual Abuse:** The Center is mandated by Vermont law to coordinate and oversee the state's systematic response to sexual assault and child sexual abuse. It is jointly administered by the Department of Corrections and the Department for Children and Families. humanservices.vermont.gov/center-for-prevention-and-treatment-of-sexual-abuse
- 2) **Commit to Kids:** The Vermont Edition of the Canadian Center for Child Protection's *Commit to Kids* program is available on DVD. This program helps child-serving organizations create safe environments for children. The DVD includes a workbook, training video and reproducible forms. Chapter 2 of the workbook, along with the training video, provides a detailed orientation to child sexual abuse, while chapters 3 through 8 will help schools move beyond awareness to organizational change that helps keep children safe. Chapter 7 includes information about reporting child abuse in Vermont. This information should be included in all employee orientations. For the Vermont edition of the DVD contact Priscilla White (see contact information below).
 - a. Canadian Center for Child Protection: protectchildren.ca/app/en/overview_commit2kids
- 3) **Step Up: Protect Kids from Child Sexual Abuse:** Learn what you can do to prevent, recognize, and react responsibly to child sexual abuse. dcf.vermont.gov/stepup
- 4) **Guidance on mandated reporting:** dcf.vermont.gov/fsd/reporting_child_abuse/mandated_reporters
- 5) **Child Abuse & Neglect Reporting Line:** 24/7 phone line to report suspected child abuse and neglect: 1-800-649-5285

CONTACT:

Child Victim Treatment Director

Phone: (802) 769-6329

Email: priscilla.white@state.vt.us

WEBSITE: humanservices.vermont.gov/center-for-prevention-and-treatment-of-sexual-abuse

Green Mountain Self-Advocates

The purpose of Green Mountain Self-Advocates (GMSA) is for people with developmental disabilities to educate peers to take control over their own lives, make decisions, solve problems, and speak for themselves.

WHAT WE CAN OFFER:

- 1) **Self-Advocacy** and **Self-Determination** workshops taught by and for youth and adults with developmental disabilities.
- 2) **Disability awareness workshops and trainings** for Vermont schools, businesses, universities, and other community groups.
- 3) Training on **recognition and prevention** of domestic violence and sexual assault.
- 4) Training on **rights and responsibilities** for people to **express their sexuality**.
- 5) The *7 Habits of Highly Effective Teens* which provides building blocks to teach students real steps to take charge of their lives and to develop leadership skills.
- 6) **Options counseling** and **person-centered futures planning** for youth with disabilities.
- 7) Training on **strategies for effective communication** with people with developmental disabilities.
- 8) Supporting Vermonters with disabilities to **share their powerful stories**.
- 9) Hosting and participating in **youth leadership events**.

CONTACT:

Outreach Director

Toll FREE: 1-800-564-9990

Phone: 1-802-229-2600

Email: info@gmsavt.org

WEBSITE: www.gmsavt.org

Outright Vermont

Outright is a queer youth center and statewide advocacy organization. The mission of Outright Vermont is to build safe, healthy, and supportive environments for gay, lesbian, bisexual, transgender, queer, and questioning youth ages 13-22. Since 1989, in addition to providing safety and support for queer youth, Outright Vermont has helped make schools more inclusive, and focuses on youth empowerment, leadership, and advocacy. Youth serve as board members, interns, panelists, spokespersons, and program coordinators. Outright works to advocate with and on behalf of queer youth both statewide and nationally.

WHAT WE CAN OFFER:

- 1) **Technical Assistance:** Outright visits middle schools, high schools, colleges, and agencies statewide delivering Anti-Harassment, Ally Development, Queer and Trans* 101, Supporting Queer Youth Survivors, and other workshops tailored to meet the needs

of students, faculty, and staff. Outright helps start and support Queer/Straight Alliance (QSA) groups and works collaboratively with schools and agencies to ensure they are meeting the needs of queer students.

- 2) **Advocacy and support for queer youth:** Outright provides Friday Night Group, our signature social and support group, in several regions in Vermont. Outright also offers youth drop-in space in Burlington, the SASS Academy (an HIV prevention and sexual health workshop), free anonymous HIV testing, after-school programming and various events statewide. Outright works in collaboration with Common Ground Center to offer Camp Outright, a traditional, residential, summer camp experience for queer and allied youth.

CONTACT:

Director of Advocacy

Phone: (802) 865-9677

Email: advocacy@outrightvt.org

WEBSITE: www.outright.org

Prevent Child Abuse Vermont

Prevent Child Abuse Vermont (PCAV) promotes and supports healthy relationships within families, schools and communities to eliminate child abuse. PCAV offers parenting education and support, shaken baby syndrome prevention programs, and child sexual abuse prevention programs.

WHAT WE CAN OFFER:

- 1) **Parents' Helpline:** The Parents' Helpline provides support, information and referrals on such topics as parenting, understanding children's sexual behaviors, alternative forms of discipline, making reports of suspected abuse and neglect and more. 1-800-CHILDREN, Monday-Friday, 9:00 a.m.-5:00 p.m.
- 2) **Child sexual abuse prevention trainings:** Professionals who work in early care and education receive professional development hours by attending 2-3 hour workshops. Workshops are also available to professionals working with children at-risk, including foster parents, mentors, mental health staff, and others.
- 3) **School-based sexual violence prevention programs:** The Healthy Relationships Project encompasses all three of PCAV's school-based sexual abuse prevention programs. In addition to the curriculum delivered in the classroom with students, all programs include home sheets for parents, opportunities for parents to meet with PCAV staff, and training for all school staff in child sexual abuse and its prevention. Additionally, educators teaching the curricula in their classrooms are trained on trauma-informed practice and other important elements of effective sexual violence prevention.
 - a. **Care for Kids:** (Preschool, Kindergarten, grades 1-2)
 - b. **We Care Elementary:** (Grades 3-6)

c. **The Sexual Abuse Free Environment for Teens (SAFE-T) Program:** (Grades 7-8)

CONTACT:

Healthy Relationships Project Coordinator

Toll FREE: 1-800- CHILDREN / 1-800-244-5373

Phone: (802) 229-5724

Email: pcavt@pcavt.org

WEBSITE: www.pcavt.org

Vermont Network Against Domestic and Sexual Violence

The Vermont Network is a statewide resource on domestic and sexual violence. Network staff provide technical assistance and training to member programs and statewide partners, inform public policy, and coordinate statewide projects and conferences. The Network has 14 member programs providing direct domestic and sexual violence crisis support, shelter, legal advocacy and other support services to Vermonters around the state.

WHAT WE CAN OFFER:

- 1) **24-hour hotlines** and support for people experiencing domestic, dating or sexual violence and stalking:

Domestic Violence/ Stalking: 1-800-228-7395

Sexual Abuse or Assault: 1-800-489-7273

Or call your local program directly by finding them on the web:
www.vtnetwork.org/get-help/member-programs

When you call the hotline, you will connect to your nearest member program. You do not have to be in immediate crisis to call, you can call to find out more information to help a friend or family member or for yourself. You do not have to give your name.

- 2) **Community-Based Educators:** Each of the Vermont Network member programs can provide education to students and teachers in your area. They will work with your school to identify your educational needs.
- 3) **Access to statewide prevention resources:**
- a) ***WholeSomeBodies***~ A curriculum for adults who have children and youth in their lives-such as parents, teachers, coaches, and mentors. Curriculum increases knowledge of healthy sexuality and skills and motivation to model and teach healthy sexuality to the youth and children in their lives.
 - b) ***Vermont Consent Campaign***~ Classroom teaching tools, planning information, and resource lists for middle and high school educators teaching about consent and sexual violence prevention.

- c) ***The Relationship Status booklet***~ This free resource is available in hard or electronic copy. The booklets provide information for middle and high school youth around what supportive relationships look like and warning signs of controlling behavior.

CONTACT:

Community Change Coordinator

Phone: (802) 223-1302

Email: prevent@network.org

WEBSITE: www.vtnetwork.org


Appendix E: IRB Exemption Certification



**The
UNIVERSITY
of VERMONT**
Committees on Human Subjects
Serving the University of Vermont
and the UVM Medical Center

RESEARCH PROTECTIONS OFFICE
213 Waterman Building
85 South Prospect Street
Burlington, Vermont 05405
(802)656-5040 ph
www.uvm.edu/irb/

Protocol Exemption Certification

TO: Kelley Groll
FROM: Donna Silver, Assistant Director 
DATE OF CERTIFICATION: 08-May-2015
SUBJECT: CHRMS: 15-549
Childhood Sexual Abuse Screening and Prevention in the Primary Care Setting: A Survey of Pediatric Healthcare Providers in the State of Vermont

Following IRB review of your project, it has been determined that it qualifies for exemption, as indicated below.

Exemption Category: 2

Federal Exemption: "Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior, unless: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation."

This exemption is effective for the duration of the project UNLESS modifications are made that affect the original determination of exemption.

cc: Carol Buck-Rolland

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