

## Getting Better at Getting Them Better: Health Outcomes and Evidence-Based Practice Within a System of Care

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Diversity is a hallmark of behavioral health care systems. Many different people, with many different backgrounds and interests, are involved in many different activities through many different human organizations. Given this diversity, it is not surprising that multiple conflicting views emerge about how limited resources should be distributed, who should be served, and what services should be provided. Among this diversity, one common rallying point is the notion that when services are provided, better quality of life should result.

During the past 10 years, public mental health services for children and youths in Hawaii experienced a major system restructuring. The five current goals of the Department of Health Child and Adolescent Mental Health Division (CAMHD) strategic plan are shared ownership, accountable business practices, system of care principles, evidence-based practices, and performance evaluation (Child and Adolescent Mental Health Division, 2003). Before the system reform, child and adolescent mental health services in Hawaii were generally delivered through a direct service model by small teams at regional guidance centers.

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At present, CAMHD orchestrates a public-private collaboration with eight regional public family guidance branches providing care coordination and administrative services and approximately 35 contracted private provider agencies delivering the majority of direct care. The comprehensive system of care framework, which was locally demonstrated through the federally funded Ohana project, is the statewide model for delivery of intensive mental health services, except on the island of Kauai, where an integrated school-based program is used. Elsewhere, educationally supportive, less intensive (e.g., day treatment), and outpatient services are arranged through the school-based behavioral health program of the Department of Education. For the Medicaid-eligible population, less intensive and outpatient services are provided through the state-contracted health plans. This latest reorganization was largely completed in 2002.

A major evidence-based services initiative was implemented following the initial development of the system of care (Table 1; see Chorpita and Donkervoet, 2005). Approximately 5 years into the system of care reform, an evaluation identified marked increases in the number of youths accessing services, as well as the amount, types, and total cost of mental health services. In addition, qualitative analyses identified weaknesses in the provider array in the form of undesirable use of restrictive levels of care (e.g., serving youths with conduct disorders in hospital settings) and use of therapeutic approaches with uncertain efficacy. It was unclear whether this expanded investment was associated with better child and family functioning. To move forward, system leaders initiated quarterly quantitative child status assessments and explored large-scale dissemination of evidence-based services as an initiative

to improve child and family outcomes (Chorpita et al., 2002). A common misperception is that this initiative was mandated as part of a lawsuit; in fact, it was a leadership-initiated quality improvement strategy.

### HAWAII'S EVIDENCE-BASED SERVICES INITIATIVE FOR YOUTHS

Hawaii has implemented a diverse and far-reaching evidence-based services initiative that incorporates a wide variety of quality improvement activities (Daleiden and Chorpita, 2005). The initiative may be broadly characterized as a two-pronged strategy: first, building specific empirically supported programs and second, pursuing incremental improvement of current care toward evidence-based ideals. The former strategy

involves identifying, selecting, and implementing specific evidence-based programs, such as multisystemic therapy (MST; Henggeler et al., 1998) and multidimensional treatment foster care (Chamberlain and Reid, 1991). The latter approach involves defining common components of empirically supported treatments and trying to increase the prevalence of those components in routine care (Chorpita et al., 2005; Daleiden and Chorpita, 2005). The various components of the evidence-based services initiative included (1) preliminary planning of the initiative, consensus building about the definition of evidence, and treatment selection; (2) efforts to increase stakeholders' awareness and enthusiasm for evidence-based services; (3) a program of large-scale training of stakeholders using a variety of models; (4) contractual integration through

**TABLE 1**

Timeline Describing Common Activities and the Evolving Focus of System Evaluations During a Decade of Restructuring of Public Mental Health Services for Children and Youths in Hawaii

Period	Activities	Evaluation Focus
Pre-1994	Provide direct services through regional guidance centers	
1994–1995	Establish leadership structure External technical assistance Regional community planning Ohana project system of care grant	Population
1996–1998	Implement statewide system of care Organizational restructuring of regional centers Service expansion through private provider network Integration of statewide family organization Quality monitoring reviews	Population Fiscal Service access
1999–2001	EBS initiative Review services literature Performance standards and practice guidelines Practice development office begins EBS conferences and trainings Disseminate packaged treatments (e.g., multisystemic therapy, cognitive-behavioral therapy) Quantitative outcome measurement Comanagement model developed with less intensive services provided by school-based behavioral health program or Medicaid health plans	Population Fiscal Service access Service utilization Youth outcomes
2002–2005	Evidence-based decision-making initiative Case-based EBS consultation and mentoring Formation of best practice networks Practice element distillation and literature review Provider practice and progress reporting Integrated population, service, and outcome decision-support systems  Continuous quality improvement	Population Fiscal Service access Service utilization Service coordination Treatment targets  Therapeutic practices Youth outcomes

*Note.* EBS = evidence-based services.

performance standards and practice guidelines; and (5) the integration of information systems, performance measures, and feedback tools for administrative management and clinical supervision.

The initiative began with the formation of a task force charged with planning the initiative, building consensus, and identifying evidence-based interventions (Chorpita et al., 2002). The task force evolved into a standing quality review committee that continues to guide the initiative. The initial efforts to build specific evidence-based service programs targeted dissemination of MST (Henggeler et al., 1998) for externalizing problems through community providers and cognitive-behavioral therapy for internalizing disorders through the University of Hawaii.

Efforts to raise awareness and build enthusiasm for evidence-based services included holding best practice conferences; producing regular, detailed reports summarizing the results of the service research reviews; distributing a one-page "menu" summarizing evidence-based programs; and making numerous presentations to diverse stakeholder groups to address attitudes and concerns about evidence-based services. A statewide training institute was established to coordinate evidence-based service dissemination activities and conduct interagency training in evidence-based practices. Over the years, practice development activities have evolved from relatively large audience, didactic training toward case-based "expert" consultation by practice development specialists and peer-oriented best practice networks among providers facilitated by state-funded practice development specialists.

Another key aspect of the initiative is to integrate evidence-based service information into relevant performance standards, practice guidelines, supervision and training requirements, as well as contracting for services. Specifically, an interagency document describes requirements for each level of care in the public behavioral health service array regarding services offered, admission and discharge criteria, as well as staffing, clinical operation, and documentation requirements (Hawaii Department of Education and Department of Health, 2002). In addition, clear "procedures of choice" are recommended for most of the common problem areas (i.e., attention and hyperactivity, anxiety, pervasive developmental disorders, childhood schizophrenia, disruptive behavior, depression, eating disorders, substance use, bipolar disorder, psychiatric

medication management) through summaries of supported assessment protocols and instruments, common coexisting conditions, and the more effective psychosocial and psychopharmacological interventions. This document is included as an attachment to requests for proposals and service contracts. Not only does this serve an educational function but it also integrates evidence-based services monitoring with funding proposal evaluation and contract monitoring activities.

Daleiden and Chorpita (2005) presented an extended discussion of how evidence-based services have been integrated into information systems, performance measurement, and feedback tools. Some examples include implementing an on-demand clinical reporting system that summarizes children's services and outcomes, quarterly quality reviews of service plans that include evaluation of the extent to which evidence-based services are incorporated into the plans, annual case-based reviews that address use of best practices, and a special study on the incorporation of evidence-based practice recommendations in mental health assessments and treatment plans. A more recent development involved identifying the common practices among empirically supported treatment protocols to create practice profiles for each problem area that describe how frequently each practice appears in supported protocols. For example, 97% of supported protocols for anxiety included the practice of "exposure," whereas this practice does not appear in supported protocols for attention and hyperactivity, disruptive behavior, or depression. Network providers complete monthly progress summaries identifying the specific practices used in each youth's treatment during the month so that local practices benchmark directly with empirically supported practices (see also Daleiden et al., 2004).

## SYSTEM EVALUATION AND OUTCOMES

Procedures for evaluating the Hawaii system of care for youths have evolved over the years, so long-term, well-validated child and system status measures that clearly map the course of the transformation are not available. Nevertheless, progressive information from each of the reform eras can be illuminating. Among the earliest and most enduring evaluation procedures were child and system quality reviews performed by interagency monitoring teams. Trained monitoring teams of parents and representatives from multiple agencies

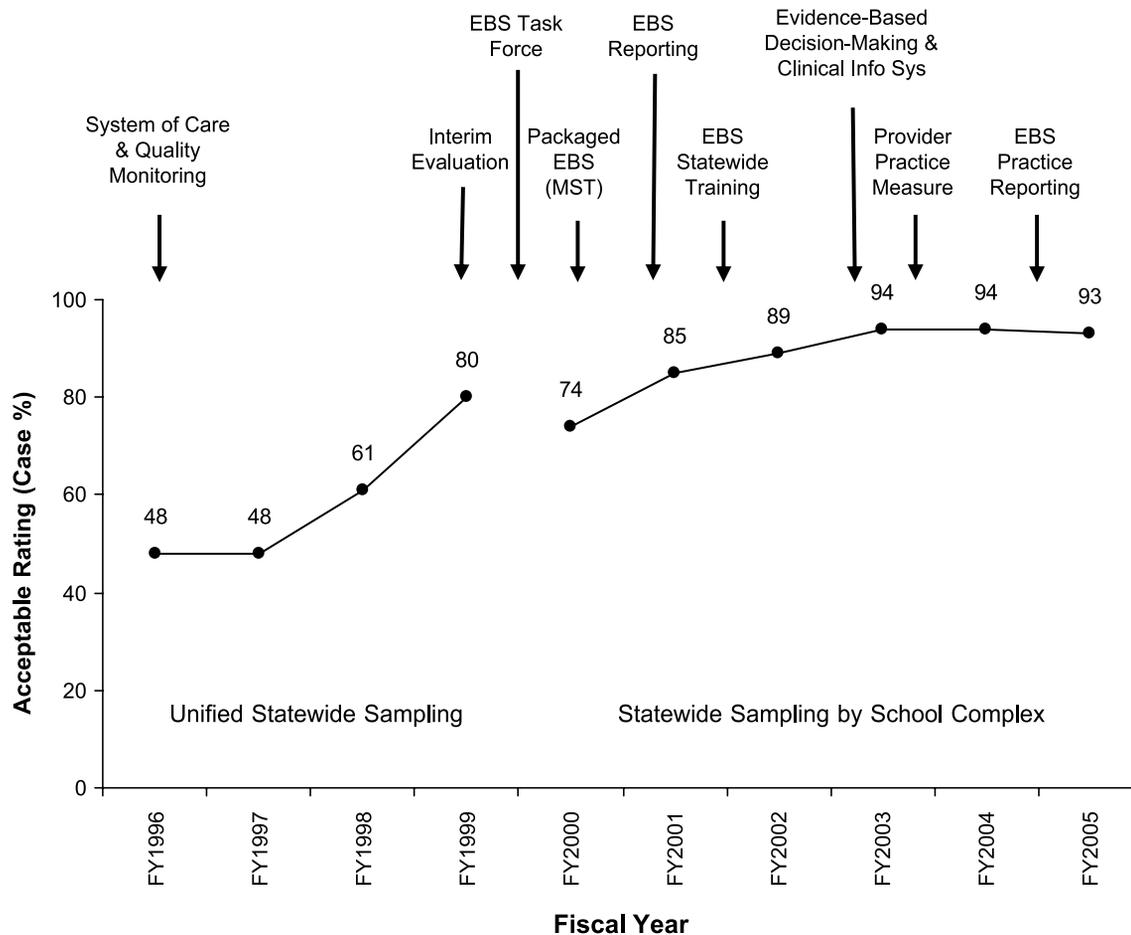
perform the annual reviews. The team reviews records, conducts interviews with family members and service providers, and completes a service-specific structured case review protocol that was developed for Hawaii's service array (Foster and Groves, 1997).

These review protocols require monitoring teams to rate a number of dimensions of child status and system performance. The child status ratings include emotional and behavioral well-being, academic learning progress, personal responsibility, safety and personal well-being, community living, caregiver functioning, and child and family satisfaction. The system performance ratings include use of functional assessment, service planning and implementation, service coordination, caregiver supports, service monitoring, and effective results.

The monitoring protocols present extensive behavioral descriptions along a 6-point scale for each

dimension assessed with rating values of 1 to 3 labeled as unacceptable, whereas rating values of 4 to 6 are labeled as acceptable. These ratings are aggregated into overall child status and system performance indicators of the percentage of cases reviewed that were rated as acceptable in child status and system performance, respectively. The child status indicator is not a youth progress measure, but rather it describes the relative proportion of cases at the time of the review that the teams determined to be acceptable.

For fiscal years 1996–1999, relatively small (<100) samples were randomly selected for these reviews from a statewide sampling frame. After several years of experience and infrastructure development, review procedures were expanded to include larger ( $\approx$ 500) stratified random samples from all school complexes throughout the state during fiscal years 2000–2005.



**Fig. 1** Cases rated as acceptable in child status during interagency case-based quality reviews presented in the context of key evidence-based service (EBS) activities. MST = multisystemic therapy.

These findings present a broad historical overview, but the reliability and validity of the monitoring reviews remain largely unknown.

### YOUTH STATUS AT A POINT IN TIME

Examination of this interagency review-based child status indicator reveals a general pattern of improvement across the 10 years of reform with a slight discontinuity when the sampling procedures changed (Fig. 1). The most rapid improvement occurred during the middle years of the reform, and the ratings have stabilized in recent years at a high level. It is not clear why the change in random sampling procedures resulted in a lower point estimate. It is possible that the stratification and larger samples sizes promoted inclusion of youths with less frequent but more problematic concerns. Nevertheless, within each sampling procedure, a pattern of improvement over time was evident, albeit at different overall levels of child status.

These findings suggest that youths receiving public mental health services today are more likely to function better than the youths receiving services before the reform. The measured improvement became evident after the period of administrative reorganization and capacity expansion, and during the period of expanded care coordination, performance management, and information systems development. The evidence-based services initiative began approximately halfway through the period of improvement. The specific causes and time course of their effects are not testable in this uncontrolled historical analysis. Nevertheless, because the performance improvements preceded the evidence-based services initiative, this initiative was not responsible for initiating change but may have contributed to maintenance of the growth trajectory.

### YOUTH STATUS AT INTAKE AND DISCHARGE

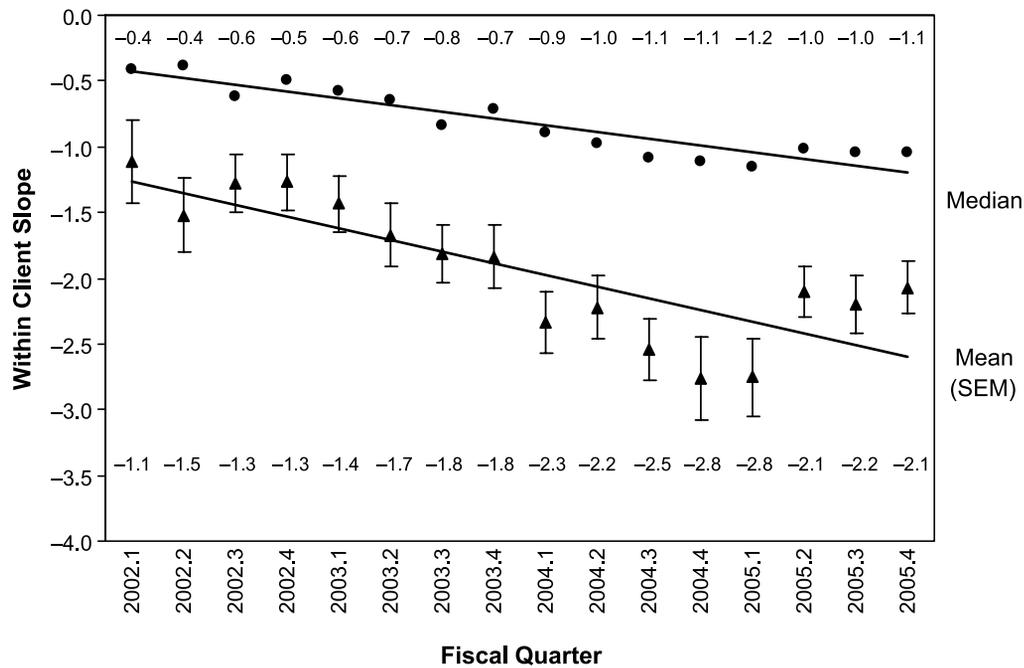
To better understand quantitative outcomes, the CAMHD implemented a policy of quarterly assessment using the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1998), the Child and Adolescent Level of Care Utilization System (CALOCUS; American Academy of Child and Adolescent Psychiatry Work Group on Systems of Care and American Association of Community Psychiatrists, 1999), and the parent, teacher, and youth report forms of the Achenbach System of Empirically Based Assessment

(ASEBA; Achenbach and Rescorla, 2001). Not surprisingly, simply establishing the policy was not sufficient to change practice, and considerable time and effort were invested to achieve acceptable completion rates (e.g., 80%). In fact, high levels of completion on the ASEBA have never been achieved statewide (range of 1%–75% across regional centers).

Publicly funded case managers are responsible for administering these outcome measures, not the private provider network. The strengths of these outcome measurement procedures are structured training and administration, longitudinal measurement of youths over time, and relatively well-known measurement properties (the exception being the psychometric properties for the CALOCUS, but see Daleiden, 2003). The weaknesses of these outcome measurement procedures are imperfect completion rates, incidental sampling of youths enrolled for services, and inclusion of only youths registered with CAMHD rather than the broader statewide interagency service population (e.g., Department of Education).

For more in-depth analysis, the CAFAS findings may serve as a model because of high response rates, broad assessment of child functioning, and completion by professionals certified annually. The CAFAS is a multidimensional clinician rating scale that measures the functional impairment of 5- to 17-year-olds, across the eight domains of school role performance, home role performance, community role performance, behavior toward others, moods and emotions, self-harmful behavior, substance abuse, and thinking (Hodges, 1998). Raters choose from a list of behavioral descriptors for each subscale to yield scores of severe (30), moderate (20), mild (10), and minimal or no impairment (0) for each domain; these subscale scores are aggregated to produce a total functioning score.

Consistent with the quality review results, scores on the total functioning scale of the CAFAS remained relatively stable during the period 2002–2004. This was true for admission, discharge, and average scores during service episodes. Thus, during this period of system stabilization, youths were being admitted at a consistently impaired level of functioning (average CAFAS,  $\approx$ 110), maintained at a moderately impaired degree of functioning (average CAFAS,  $\approx$ 85), and discharged at a level of functioning appropriate for less intensive, outpatient services (average CAFAS,  $\approx$ 60; Daleiden et al., 2004). From this perspective, the service system



**Fig. 2** Rate of change per month on the Child and Adolescent Functional Assessment Scale 8 (CAFAS 8) scale total score during current service episode. Lower scores on the CAFAS indicate better function, so more negative slopes indicate more rapid improvement.

appears to function as its designers intended, but little year-to-year change is apparent that would indicate performance gains resulting from service improvement initiatives (e.g., evidence-based services).

These stable intake and discharge scores do not suggest that improvement initiatives were in vain. On the contrary, once the system is admitting and discharging youths at appropriate levels, the key quality improvement question evolves from whether youths are getting better to how rapidly and efficiently they are getting better. Therefore, in addition to examining the average amount of improvement, the mean and median monthly rate of change during youths' current service episodes was calculated for each fiscal quarter.

### RATE OF CHANGE IN YOUTH STATUS

Findings indicated a pattern of progressive acceleration in the rate at which youths were improving (Fig. 2). Linear trend analysis indicated that the median rate of change was significantly accelerating across quarters,  $t_{14} = -9.65$ ,  $p < .001$ ,  $R^2 = 0.87$ . In other words, the CAMHD system appeared to be getting better at getting youths better. The median rate of improvement nearly tripled during the 4-year period,

whereas the mean rate approximately doubled. Although not depicted here, similar patterns of accelerating improvement were evident on the other adult-reported outcome measures described above (i.e., the total behavior problem scores of the ASEBA parent and teacher checklists and the level of care score from the CALOCUS), supporting the validity of the CAFAS findings.

If youths were improving at a more rapid rate, then the length of service episodes may also be expected to decrease. Indeed, across the 4 years, the average length of service was reduced by 40% to 60%, depending on what factors were statistically controlled. The average length of service reduced most rapidly from 2003 to 2004. For example, at discharge, the average length of services was 866 days in 2002, 748 in 2003, 434 in 2004, and 393 in 2005. Not surprisingly, simple analysis of total service expenditures divided by the average points of improvement on the outcome measures indicated that the average expenditures per point of improvement on outcome measures was reduced by approximately 40% from 2002 to 2005 (e.g., \$1,083 per point of improvement on the CAFAS during 2002 to \$648 in 2005). In sum, during the 4-year period, the admission and discharge characteristics

of the population were relatively stable, the average rate of improvement accelerated, and the average length of service was notably reduced.

Several limitations to these analyses are important to note. First, within-client slopes were analyzed separately from the change in within-client slope across time. This two-step analysis does not completely represent the complex error structure of these nested variables as could be accomplished by hierarchical multilevel modeling. This may lead to misestimating standard errors that could reduce the precision of significance tests. Furthermore, the current analytic model did not control for many potentially confounding client variables (e.g., gender, ethnicity, diagnosis) and organizational level variables (e.g., geographic distribution, level of care). As previously noted, the service system organization was largely stabilizing during the study period, but some changes to the population were evident in terms of younger average age and increasing comorbidity in diagnosis (see, e.g., Daleiden et al., 2004). The outcome analysis also relied on all available data so that a sample of convenience was employed rather than a random sample. This analysis included all youths registered during the quarter, not just youths who were discharged during the quarter. Thus, youths who were not demonstrating improvement were included. When analyses were performed on the smaller sample of discharged youths, the point estimates for rate of change are greater (3.6 CAFAS units per month for discharged youths versus 2.1 for the sample as a whole at the end of fiscal year 2005) because youths showing greater improvement are more likely to be discharged. Nevertheless, despite these limitations, a consistent “signal” emerged through the “noise” across the caretaker- and professional-informant outcome measures.

At the end of the study period, the monthly average rate of change did not show signs of continued improvement. This raises the question of how much gain may be expected before improvement rates level out. To put this into context, the average rate of change per month for specific evidence-based treatment packages may be used as a comparison (Child and Adolescent Mental Health Division, 2004). In fact, the average monthly rate of change varies by type of problem treated and the symptom specificity of the child status measure examined. When effect sizes are used to estimate expected change, treatments for disruptive

behavior and willful misconduct (e.g., parent training and MST) show an average improvement equivalent to roughly 1 to 2 points per month on the ASEBA Total Problems scale. The comparable average rate of improvement in treatments for anxiety and depression was roughly 4 to 7 points per month on more narrow measures of the target symptoms (e.g., ASEBA Internalizing scale). Although these estimates leave a wide range of expected values, they grossly suggest that the monthly average rate of improvement within the CAMHD system may yet increase further.

## CLOSING COMMENTS

A variety of qualitative and quantitative evidence indicates that the Hawaii system of care for youths has improved dramatically during the past decade. Numerous system restructuring and quality improvement activities were implemented during this period. The historical analysis presented here does not allow for attributing the cause of change to any specific initiative. However, these findings are consistent with the conclusion that efforts to implement evidence-based services, to develop care coordination practice, increase information feedback to stakeholders, adopt statewide performance measures, restructure quality improvement and practice-focused performance management processes, and improve utilization management are meeting with success.

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#### **Criminally Prosecuted Cases of Child Starvation** Nancy D. Kellogg, MD, James L. Lukefahr, MD

*Objective:* Here we describe the clinical findings and legal outcomes in 12 prosecuted cases of infant and child starvation. *Methods:* Medical records, investigation records, and transcripts of court testimony were reviewed in the cases of 12 infants and children from locations throughout Texas who had been starved deliberately. The children's ages ranged from 2 months to 13 years. The caretakers of all children received both civil and criminal charges; cases were tried over an 11-year time span. Clinical presentations, examination findings, laboratory findings, symptoms of refeeding syndrome, and legal outcomes were examined. Two illustrative cases are presented in detail here. *Results:* Of the 12 cases reviewed, the median age was 2.7 years, with a range of 2.25 months to 13 years 7 months. Half of the children died shortly before or soon after presentation for medical care or to law enforcement. Survival was more common in older children than in infants. Most of the children were secluded from others, and all had access to food denied or severely restricted. Caretakers claimed few, benign, or no past medical illnesses in the children. Based on weight and height measurements, 10 of the children had severe wasting and stunting, and 2 had mild or moderate wasting. There was a tendency toward more severe wasting in the fatal cases. All children manifested multi organ effects of starvation. All survivors manifested complications with refeeding. Approximately half of the children had past or present injuries or history suggestive of physical or sexual abuse. Parental rights were terminated in all cases. A total of 25 individuals were charged criminally; 23 were found guilty or pled guilty, and trials for 2 individuals were pending at the time of this writing. The types of criminal charges and punishment varied from deferred adjudication to a life sentence. *Conclusions:* Life-threatening criminal starvation of infants and children is a rare and severe form of child maltreatment. In our series, infants were more wasted at the time of presentation and less likely to survive prolonged starvation than were older children. As with other forms of child abuse, caretakers' histories regarding the children's illnesses were inconsistent with the severity and chronicity of the children's degree of wasting. All victims in our series showed multiorgan effects of chronic malnutrition and deprivation, and all survivors developed refeeding complications and required prolonged periods of recovery. *Pediatrics* 2005;116:1309–1316.

#### **Oral and Dental Aspects of Child Abuse and Neglect** Nancy Kellogg, MD, the Committee on Child Abuse and Neglect

*Objective:* In all 50 states, physicians and dentists are required to report suspected cases of abuse and neglect to social service or law enforcement agencies. The purpose of this report is to review the oral and dental aspects of physical and sexual abuse and dental neglect and the role of physicians and dentists in evaluating such conditions. This report addresses the evaluation of bite marks as well as perioral and intraoral injuries, infections, and diseases that may cause suspicion for child abuse or neglect. Physicians receive minimal training in oral health and dental injury and disease and, thus, may not detect dental aspects of abuse or neglect as readily as they do child abuse and neglect involving other areas of the body. Therefore, physicians and dentists are encouraged to collaborate to increase the prevention, detection, and treatment of these conditions. *Pediatrics* 2005;116:1565–1568.