The Pediatric Examiner

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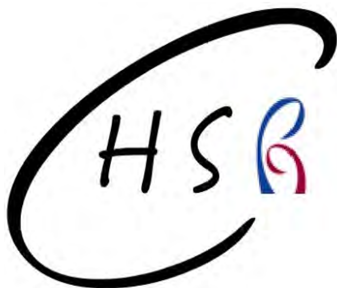
Children's Health Services Research
Department of Pediatrics, Indiana University School of Medicine



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A Systematic Review of School-Based Interventions to Prevent Bullying

By Rachel Vreeman, MD

Although bullying is often dismissed by parents, schools, and even pediatricians as a "normal" part of growing up, bullying can impact children's physical, emotional, and social health into adulthood. As we uncover more and more evidence of the harmful and lasting effects of bullying, educators and researchers have been eager to explore what interventions might prevent or decrease bullying. A growing number of studies examine school-based interventions targeted to reduce bullying, but they leave us wondering what types of interventions actually make a difference.

To answer this question, CHSR fellow, Dr. Rachel Vreeman, and CHSR investigator, Dr. Aaron Carroll, conducted a systematic review of the rigorously evaluated school-based interventions to decrease bullying found in the medical, psychological, and educational literature. The full results of their investigation, entitled "A Systematic Review of School-Based Interventions to Prevent Bullying," were published in the January 2007 issue of Archives of Pediatrics and Adolescent Medicine.

After searching data sources including MEDLINE, PsycINFO, EMBASE, Educational Resources Information Center, Cochrane Collaboration, and

Story continued on page 2

We've moved!

Children's Health Services Research has moved offices to the new HITS Building (Health Information and Translational Sciences).

See *Announcements*, page 8.

A Systematic Review of School-Based Interventions to Prevent Bullying
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Clinical Trials databases, and Sociology: A SAGE Full-Text Collection, Drs. Vreeman and Carroll ultimately uncovered 2090 articles related to bullying. After careful review of the titles, abstracts, and then full-text articles, they narrowed the evidence down to 26 articles that described anti-bullying experimental interventions done in schools with measured outcomes after the intervention.

Five types of interventions were studied in the attempts to decrease bullying: classroom curriculum designed to prevent or reduce bullying; multi-disciplinary/whole-school initiatives that involved both curriculum and school-wide changes; social skills groups for smaller groups of children; mentoring programs; and increased school social worker support. For all of these studies, Drs. Vreeman and Carroll looked at whether the studies measured direct changes in bullying, aggressive behavior, or victimization, as well as indirect changes such as increased self-esteem or and improved sense of school safety.

Many school districts and educators are eager to implement new or revised curriculum targeted at reducing bullying. Although this type of intervention may seem more manageable and less expensive than other options, this review suggests that curriculum interventions are not effective. Of the ten studies that

investigated curriculum interventions, only 4 showed some decrease in bullying, but 3 of those studies also showed no improvement in some populations. The three studies that looked at the impact of social skills groups also showed no clear reduction in bullying.

The interventions that used a whole-school approach involving multiple disciplines and broader changes had somewhat better results. Seven of the ten studies of the whole-school interventions revealed decreased bullying, with fewer positive results for younger children. Only one study looked at a mentoring program, but it resulted in decreased bullying. The one study that looked at increasing the social workers in the school also showed a decrease in bullying.

Drs. Vreeman and Carroll concluded that the interventions that involved multiple disciplines or a whole-school approach have a better chance at reducing bullying than those that merely change curriculum or put children in social skills groups.

Racial Differences in Contextual Mediators of Sexually Transmitted Infections

By Sarah Wiehe, MD

Sexually Transmitted Infections and Topical Microbicides Cooperative Research Centers (STI-TM CRC) Developmental Award, University of Washington Center for AIDS and STD (NIAID) … by Sarah Wiehe, MD

In 2000, approximately 19 million individuals were newly diagnosed with an STI, of which half were aged 15 to 24. Although many individual characteristics, including risky sexual behaviors, have been correlated with an STI diagnosis among young women, two variables which are most consistently associated with STI are race/ethnicity and age. The racial and ethnic differences in STI rates are most dramatic in adolescence and young adulthood. These associations likely represent primarily cultural and behavioral differences rather than biologic ones, although they are not well understood or described.

STIs are distributed geospatially which is attributed to both local sexual networks and risk/protective community characteristics. Most investigations have focused on the association between STI and neighborhood poverty. Some have shown associations with specific contextual characteristics, including concentration of vacant housing, illicit drug use in the community, incarceration rates, and racial segregation. Few have analyzed how specific contextual characteristics are associated with STI risk using indi-

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Exploring New Technologies to Link Newborn Screening Programs and the Medical Home

By Stephen Downs, MD

With the advent of tandem mass spectrometry for newborn screening, the number of conditions that may be detected on a newborn blood spot has increased to over 50. Recent analyses have shown that expanded newborn screening can be cost-effective, perhaps even cost saving. But the analyses assume an effective follow-up system that will identify the child's primary care physician and quickly provide notification of abnormal or inconclusive newborn screens and guidance on how to respond. Guidance is critical because most of these conditions are rare, meaning that most physicians will see only one or two cases in a career.

Information technology is widely touted as the solution to this problem, but there is uncertainty about the correct path to follow. With funding from the Genetic Services Branch, Maternal and Child Health Bureau, HHS, investigators in Children's Health Services Research at Indiana University (CHSR) and the Regenstrief Institute in Indianapolis are working with the Indiana State Department of Health to develop new ways to link newborn screening programs, subspecialists, and the medical home. They are leveraging their experience in two technologies: 1) Regional health information exchange and 2) adaptive turnaround documents.

Indianapolis is the home of the Indiana Network for Patient Care (INPC), a health information exchange that receives health data from 5 hospital systems (over 15

hospitals and affiliated clinics), county and state health departments, pharmacy clearinghouses, Medicaid and other insurers, and others. The exchange has handled nearly a billion results and links health care providers across central Indiana.

Keys to the success of the INPC are the use of standards for communicating and storing data elements between disparate systems and creating a global patient indexing system that identifies the same patients in different systems and links their data under a common global identifier. The INPC relies on the widely accepted communication standard, HL7, and standard clinical vocabularies like LOINC and ICD to keep the data in a consistent format that can be shared among institutions.

With this rich health information infrastructure in place, the CHSR-Regenstrief team wanted to build decision support to link the newborn screening program to the clinicians and families who must respond to positive results. They used a technology they call adaptive turnaround documents (ATD) that they have used in clinic settings for over a decade. An ATD system uses logic rules to examine a clinical database to generate alerts, reminders and other documents that would be useful to the clinician or family. The alerts are put on paper by a printer of fax machine. Clinicians or families can respond to these documents by filling in blanks or checking boxes. When the documents are scanned back into the fax machine, their responses are automatically recorded in the database.

With this technology, they are developing a system that helps identify those clinicians who need to know when newborn screening samples are abnormal, inadequate or missing, and provides "just in time" information to clinicians and families when conditions are detected. Here's how it works…

The INPC receives all newborn screening results from the newborn screening laboratory. It also receives data from healthcare facilities across Central Indiana through the network whenever a child is hospitalized, seen in a clinic or tested in a laboratory. If the ATD system "sees" an abnormal newborn screening result, it generates a notification to the responsible physician that describes the condition and provides information, based on

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Indiana State Child Fatality Review Team

By Toni Laskey, MD

In April of 2006, the Indianapolis Star reported the startling statistic that Indiana leads the nation in child abuse fatalities (Indianapolis Star, 4/6/06). Data released this past spring from the Centers for Disease Control (CDC) showed that Indiana leads the nation in preventable deaths in children less than 1 year of age and we rank third for the age group 0-4 years (WISQARS dataset, http://www.cdc.gov/ncipc/wisqars). Unfortunately, for those who work with children and families in this state, it was not a surprise. Children are harmed every day in Indiana. Some will die, some will be permanently injured, and some will carry the psychological scars for a lifetime. This must change.

Paving the way toward these changes is the Indiana State Child Fatality Review Team (INCFRT). On January 9, Dr. Toni Laskey and the rest of team completed and released their report on reviewed child deaths from SFY2005. The second annual report by INCFRT, a culmination of monthly meetings by the team to review deaths, as well as weeks of authorship and data analysis, calls for better cooperation among public agencies and more consistency in the investigation and tracking of deaths.

Cases were reviewed from the 57 CPS substantiated abuse and neglect deaths for SFY 2005. By definition, these cases had CPS involvement which included an investigation and a finding that by state statute, abuse or neglect had occurred and contributed to the child's death. Only cases that were 1) brought to the attention of CPS and 2) were investigated by CPS and 3) were substantiated were reviewed by this team.

The team reviewed medical records, police and social service records, Coroner's reports, autopsy reports, and other collateral information collected by CPS on these cases. When information from an agency was not included in the CPS records, efforts to gather that information were undertaken. The team discussed each case and tried to determine what prevention lessons could be learned from each death, as well as attempting to learn the outcomes of cases in the criminal justice system.

The results section of the report helped paint a clearer picture of how Indiana children are dying. Demographically, the mean and median ages of the child fatalities were 34 months and 15 months, respectively. As expected, the majority of victims were white. The complete demographic breakdowns are noted in Figures 1 and 2.

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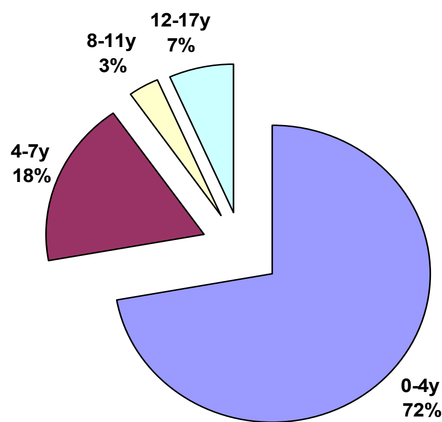

Figure 1: Age distribution of child fatalities

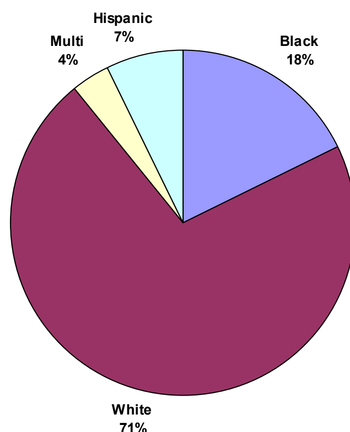

Figure 2: Racial distribution of fatalities

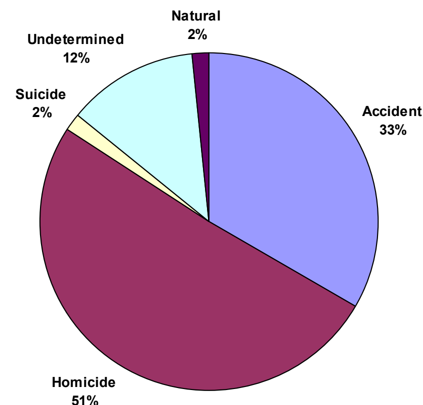

Figure 3: Manner of death

The manners of death among all 57 cases are broken out in Figure 3. Blunt-force head trauma accounted for the majority of abuse deaths in the report -- 17 – while drowning and positional asphyxia accounted for seven deaths each in 2005.

Location of death was also a critical point of analysis. Determining where in the state children are being harmed will be an important piece of information when it comes time to direct prevention efforts.

As represented in the newly-adopted INCFRT logo, prevention can only happen through understanding. To this end, the team listed 27 possible recommendations to help address abuse and neglect deaths, as well as those from preventable accidents. Recommendations were focused on parents/caregivers, medical and other professionals and community leaders. Each recommendation specifically referenced a cause of death for which prevention is possible, including car seat safety, water and fire safety, mandated reporting and training for professionals. Included in the report were resources for individuals interested in learning more about the various hazards for children, as well as local resources to help families deal with the safety issues with which they are faced daily.

INCFRT also published an Executive Summary as a supplement to the full report, which encapsulates the team's findings and recommendations. It is hoped that this brochure will see wide distribution and become a tool for health professionals and lawmakers in their efforts for future prevention. Advice to readers include: "Never shake a baby," "Carseats are the law," and "Sleeping in an adult bed can be deadly for infants." A link to the full report and brochure can also be found at http://www.clarian.org/pdf/2005_childfatalities.pdf. Media coverage in the Indianapolis Star, WIBC and local Evansville television stations will certainly assist in the information dissemination to the most important advocates for the children – their families.

The team has already begun its review of 2006 cases. The success of the SFY2005 report has provided a renewed sense of determination in assisting responsible Hoosiers in the prevention of child deaths. Dr. Laskey and INCFRT have the very important task of giving a voice to children who can no longer speak for themselves. Their SFY2006 promises to be just as comprehensive and will hopefully reference the great strides Indiana takes in response to the recommendations made in this year's report.

Indiana University Family Violence Institute (FVI)

By Toni Laskey, MD

Family violence is a major public health issue in this country. It spans generations and includes child abuse, domestic violence between partners and elder abuse. Statistics are startling; four women are murdered in the U.S. each day by their spouses/boyfriends/partners, and domestic violence is the leading cause of death in the U.S. for women between the ages of 19-45. Both child abuse and domestic violence are severely under-reported throughout the country, and we know even less about the incidence of elder abuse among the growing number of older Americans. Unfortunately, professionals who routinely care for these victims, including medical professionals, social workers, law enforcement officers or judicial officers, are offered little if any training in the issues surrounding interpersonal violence.

Here in Indiana, we have the highest rate of child abuse fatalities per capita in the United States. Everyone is a mandated reporter in this state and yet, there is no existing training to uniformly teach the connotations of mandated reporting, why it is important and how to do it. Adding to the crisis is a paucity of solid research evidence on prevention or management tactics for these various forms of violence. Cross-disciplinary research is even scarcer.

Indiana University has literally dozens of researchers and clinicians who are involved in some aspect of family violence, each working within their sphere to stem the tide. So many different disciplines working on the same topic could mean unnecessary duplication of efforts when dealing with the challenges we all encounter. The research, education and clinical efforts being undertaken would benefit from the collaborative approach found in such consortiums as an academic center.

Rose Fife, MD, MPH, Associate Dean for Research and Toni Laskey, MD, MPH, Assistant Professor of Pediatrics have joined together to develop the Indiana University Family Violence Institute (FVI). The FVI is a novel approach to meshing the spectrum of services with which we all work, as it in-

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Racial Differences in Contextual Mediators of Sexually Transmitted Infections

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vidual-level data. As a result of using aggregate outcomes, their findings are prone to ecological fallacy, in which associations between environmental factors and STI prevalence may not represent an individual's risk of STI. Further analyses using individual-level data would help to identify not only high-risk geographic areas, but high-risk individuals within both high- and low-risk geographic areas, for targeted screening and prevention services. In addition, contextual factors as independent determinants of STI risk may expand our understanding of causal pathways and suggest mechanisms for why and how racial disparities exist. With increased knowledge of contextual correlates, we may develop more sensitive and specific clinical screening tools, effective community interventions and urban neighborhood planning policies.

Rich clinical, laboratory, and contextual data are available for Marion County, Indiana through the Regenstrief Medical Record System or RMRS, the US Census, and Social Assets and Vulnerabilities Indicators or SAVI databases. These data have never been linked and used for this purpose and hold promise to answer specific hypotheses relating to the correlates and mediators of neighborhood poverty influencing risk of STI.

The objective of this study is to evaluate contextual mediators of the association between neighborhood poverty and STI in adolescent and young women in Marion County, Indiana, and to see if this accounts for the racial disparities in STI risk by evaluating whether the association is different for non-Hispanic black, non-Hispanic white and Hispanic individuals.

As such, I aim to:

- Assess whether **STI testing** varies by contextual factors among adolescent and young women.
- Investigate which contextual factors mediate the association between neighborhood poverty and **risk of STI** and **repeat STI** among adolescent and young women.
- Investigate whether associations between contextual factors and risk of STI **vary by race/ethnicity** in adolescent and young women.

Editor's Note: Dr. Sarah Wiehe was one of only fifteen recipients nationwide of the prestigious Robert Wood Johnson Award. Congratulations, Sarah!

Exploring New Technologies to Link Newborn Screening Programs and the Medical Home

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the American College of Medical Genetics "ACTion" sheets, about what to do next. Also generated is a letter for the physician to share with the family, explaining the meaning of the result and what will happen next. These ATDs are sent by fax or secure web connection to the provider.

The documents also include places for the clinician to indicate what action was taken (family notification, referral, testing, baby seen, etc.). The clinician can also indicate if he or she does not know the baby. This will help the newborn screening program track infants with abnormal or inadequate test results.

Dr. Stephen Downs, Director of CHSR and principal investigator of the project, thinks the greatest value of the INPC will be identifying the physician who is responsible for the baby. To do this, the ATD system will monitor all HL7 messages that come into the INPC regarding any patient under a month of age. HL7 messages identify the patient and the institution where the child is being seen. When such a message comes into the INPC, the ATD system will look for a newborn screening result. If the result is abnormal or missing, an ATD message will be sent to the clinician caring for the child. In this way, we can be sure that the clinician who has his or her "hands on the baby" will receive this critical information in time to prevent irreversible consequences.

CHSR and Regenstrief are using a unique environment in Indianapolis to develop these innovative technologies, but Dr. Downs says that similar networks are rapidly developing across the country. Newborn screening programs that adopt the necessary communication and vocabulary standards to link with their regional health information exchanges will be able to utilize similar approaches to insure the effectiveness of the newborn screening system.

PResNet: A Pediatric Research Network

By Eva Schaff, MD

The Department of Pediatrics is pleased to announce a new resource available for the IUSM Community: PResNet, a Pediatric Research Network. PResNet is a practice-based research network organized and supported by Indiana Children's Health Services Research.

PResNet's primary function is to support pediatric clinical research originated by the network's practitioners as well as investigators from outside of the network. The PResNet network includes pediatric practices representing the full socioeconomic and cultural spectrum of Indianapolis, IUMG-PC practices, Methodist Clinics and numerous other practices throughout Indianapolis.

The Challenge

The ability to recruit and study children, both healthy and not, is frequently the rate-limiting component of pediatric health research. Additionally, integration of health research into practice, the principal goal of research, often takes an inordinately long time.

Background

Involving practitioners and the community in the research process is increasingly viewed by the healthcare establishment as a promising response to these challenges. Practice Based Research Networks (PBRNs), which, by their very nature actively engage practitioners in research, may facilitate this process. While several regional and national PBRNs have produced excellent research, a sustainable model of PBRN research operations has yet to be determined.

The Solution

The Department of Pediatrics at IUPUI proposes developing a Pediatric Research Network (PResNet) and associated infrastructure to:

- Facilitate patient recruiting in an outpatient setting
- Facilitate and support a broad range of research initiatives originated by PResNet practitioners and investigators from within and outside the network

The ultimate goal of the network is the effective integration of health research into practice and improvement of patient care. The strategy towards this goal is to draw on practitioners' expertise and to use their "want to know" as the window into the practice- derived research problems as well as to facilitate studies of children in a variety of outpatient settings. PResNet provides the infrastructure and support for a pediatric practitioner who is interested in collaborating on research without having to sacrifice a large amount of time from practice. PResNet functions also as the recruitment vehicle for those researchers who need to study children outside of the hospital setting.

We hope you will take advantage of PResNet's resources in order to pursue a formal investigation of ways to solve problems and improve care in your daily practice.

For more information, please contact the PResNet Executive Director, Cathy Luthman, at cluthman@iupui.edu or phone (317) 278-0552. In addition, PResNet is online at www.medicine.iu.edu/PResNet .

Announcements

In March of 2007, Children's Health Services Research officially relocated to their new offices in the Health Information and Translational Sciences (HITS) Building at Tenth Street on the Canal. This move signals an exciting time of growth for CHSR and we are very pleased to be able to take advantage of the new facilities. Other departments and research centers that occupy the building include Adolescent Medicine, Biostatistics, the Center for Bioethics, the Center for Computational Biology and Bioinformatics, Medical and Molecular Genetics and the Regenstrief Institute.

The official address for Children's Health Services Research is: 410 W. Tenth Street, HS 1020 Indianapolis, IN 46202.

To access our offices from the main IUPUI campus, please use the Clarian People Mover from the IU/Riley station and disembark at the Canal Street station (the first stop). Exit through the Clarian Pathology Buidling and cross 11th Street. Enter HITS through the east entrance facing the canal; proceed to your right from the main lobby and CHSR will be at the end of the hall to your right. If driving, there is a small lot for visitors at the south end of the building, as well as a metered lot west of Senate Avenue on 11th Street.

More detailed directions, as well as a map and additional parking information, can be found on our website: www.ichsr.org .

Upcoming CHSR WIP Presentations

August 28th: Presented by Toni Laskey, MD-Topic to TBA

September 3rd: Labor Day-WIP cancelled

September 10th: Open

September 17th: Presented by Sarah Wiehe, MD-Topic TBA

September 24th: Journal Club-WIP cancelled

CHSR Works in Progress (WIP) Presentations are held on Tuesdays from 11:30AM—1:00 PM in the HITS Building, Room 1130. **As of September, CHSR Works in Progress (WIP) Presentations will be held on Mondays from 11:30AM-1:00 PM in the HITS Building, Legacy Boardroom, 2nd Floor.** If you are interested in presenting or would like to attend, please contact Loyce Stultz at 278-0552 or email lstultz@iupui.edu. Lunch is provided, but please bring your own beverages.

We celebrate the 1st birthday of Demetrius DeVon Dillard, Jr., son of our very dear student employee, Reenika Macon. Reenika has worked with us for over two years now and we're so happy to celebrate little Demetrius' 1st year!

Staff Profile: Jennifer Neumann-Buddenbaum

By Jennifer Buddenbaum

My husband (Tyson Neumann) and I are both originally from St. Charles, Missouri. Although we grew up only 5 miles from each other and even attended the same high school, being two years his senior I had no idea he even existed. Until one afternoon my senior year in college when we were both slated to sell concessions at the Mizzou Football game for the Biochem Club. While Tyson had early on in his college career decided that medicine was his calling, figuring out what I wanted to do with my life wasn't as easy. I had a total of 7 different majors during my undergraduate career and I finally decided to get my BS in Biochemistry only because it meant I could graduate "on time" (i.e., within 4 years).

Following graduation from Mizzou, I had made plans to attend the University of North Carolina at Chapel Hill in order to get my PhD in Epidemiology. But that fateful meeting at the concession stand changed those plans and instead I embarked on a career in bench research. Was that a mistake! I hated the day in day out failure that accompanies bench research and frankly figuring out how urate oxidase functions in the ureide pathway for nitrogen assimilation in tropical legumes just wasn't that sexy. So after a year I decided that it was time for graduate school and in the fall of 1997 I began my studies in Health Administration.

Tyson and I were married in the spring of 1998 and while he prepared to start medical school, I immediately abandoned him for Washington DC where I spent my time interning for Ernst and Young, LLC where I worked in the Center for Business Innovation. I loved my time at Ernst and Young, especially the executive hotel that they put me up in for the summer! In retrospect I wonder if I should have accepted the job offer from them, but at the time I felt I needed more hands on experience in the health care world before taking on a consulting job. Plus I had never been a great fan of air travel. So after graduating with my MHA in May of 1999, I instead took on a fellowship position at Barnes-Jewish Hospital in St. Louis, Missouri. I ended up spending most of my time at BJC as the "Administrator on Duty." For those of you unfamiliar with the term it basically means that any time anyone (patient, visitor, staff or physician) screams that they want to see the "head of the hospital" I was sent out to diffuse the situation and come up with a solution. It was definitely a baptism by fire into the world of health care.

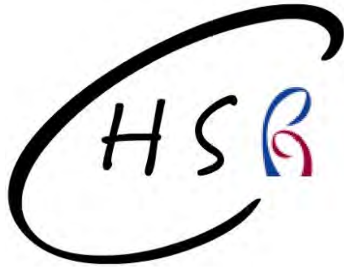
From left to right: Hayden, Tyson, Jen, and the newest addition to the family, Adele Rose.

Once my fellowship was finished I decided that it was time to actually live with my husband for a period of time. So I found a job at University of Missouri Health Care in the Office of Clinical Effectiveness. We were a small shop of all type A women…it was the absolute best! My job included running a physician and nurse executive education program which included teaching the techniques of CQI, facilitating CQI projects, and developing an electronic real-time patient safety reporting system.

In 2002, we moved to Indianapolis so that Tyson could begin his residency in Medicine and Pediatrics. I continued to work for Mizzou until our first child, Hayden, was born in January 2003. After 6 months of being at home with Hayden I decided it was time to go back to school and finally get the PhD that I had always wanted. So I began working on my second Masters degree in Industrial-Organizational Psychology… the plan being that on completion of residency we could move to a city where I could then complete a PhD in either Health Services Research or Industrial-Organizational Psychology. But the great force that is the fellowship match and the draw of EICU at Methodist conspired against me…we would remain here in Indianapolis for the duration of Tyson's fellowship in Pulmonary/Critical Care medicine.

That meant that it was time for me to look for a job. Initially I signed on with the VA Center for Health Services Research, but the prospect of baby number two (Adele, who was born May 2006) led me to look for a job with more flexibility. And that is when I met Aaron Carroll by chance at a mutual acquaintance's birthday party.

I have now been at CHSR since October 2005 and it has really turned out to be the perfect job for me at this point in my life. I have truly enjoyed pulling together grants and proposals as well as drafting manuscripts for publication. At some point down the road though, I am hopeful that the ever elusive PhD will be attainable and I will be able to be a researcher in my own right.



The Pediatric Examiner is a publication of Children's Health Services Research, Department of Pediatrics, Indiana University School of Medicine.

Mission:
We strive to improve the health and healthcare of children by developing and applying the best scientific evidence and methods in health services research and informatics.

Values:
We are guided by compassion for children, partnerships with others, and scientific rigor.

Vision:
We seek to become the nation's preeminent center for children's health services research and informatics. We strive for excellence in research, education and service to children, their families, their communities and the professionals who serve them.

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Indiana University Family Violence Institute (FVI)

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Through the FVI, we will have the opportunity to learn what others are doing, discover unique collaborations, and identify new sources of funding to escalate our efforts to the next level. In January 2007, the FVI was awarded IUPUI Signature Center Status to begin this important process. We are actively pursuing other funding opportunities to fully implement our plans.

The FVI will fill many important roles: provide seed funding for researchers with novel approaches on how to assess, study, prevent, and manage family abuse, conduct local and national research meetings on abuse issues, provide an infrastructure for growing the research base in this subject area and develop new (and expand existing) comprehensive clinical services to victims of family violence, no matter their age.

To accomplish this ambitious plan, dozens of researchers, clinicians and educators from IUPUI and the Indianapolis community have begun convening.

An academic and clinic "inventory" is currently underway to find out what work is currently being done by whom, how they accomplish their work and what funding exists. This group is also beginning to formulate their collective vision for the FVI. Through all of our combined efforts, we will be able to create a truly comprehensive approach aimed at ending family violence at all stages of life.

If you are interested in joining this group (from any area - clinical, research or education), contact Dr. Laskey at alaskey@iupui.edu or Dr. Fife at rfife@iupui.edu.

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Please submit articles, events, updates, corrections, or announcements to: Tricia Aynes
email: taynes@iupui.edu *Thank you!*