Child Maltreatment

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KEYWORDS

- Child maltreatment • Abuse • Neglect • Prevention
- Patient-centered medical home • Racism • Disproportionality

KEY POINTS

- Child maltreatment has serious physical and psychological consequences.
- Racism and bias have resulted in disproportionalities in child maltreatment assessment, reporting, and response, as well as inequities in access to community supports and other protective factors.
- Effective maltreatment prevention is a public health priority. The patient- and family-centered medical home has unique potential as a locus for prevention services.

BACKGROUND

Child maltreatment, which includes physical abuse, sexual abuse, psychological abuse, and neglect, is associated with serious health consequences, many of them long term.[1–5] Although each state has its own legal definition, the federal Child Abuse Prevention and Treatment Act defines child maltreatment as an “act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation,” or an “act or failure to act, which presents an imminent risk of serious harm.”[6]

Young children are at the highest risk for experiencing maltreatment and for suffering significant developmental consequences as a result.[7] In addition to the injuries and posttraumatic stress that can occur as a direct result of abuse and neglect, child maltreatment is associated with poor physical, mental, and emotional health years later in adolescence and adulthood, which may present as symptoms of anxiety

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and depression, problem substance use, and a high prevalence of chronic conditions such as hypertension.[1–5] Child maltreatment is also associated with poor educational outcomes, including high rates of absenteeism, truancy, suspension, expulsion, and dropout, with long-term social and economic consequences and an increased likelihood of involvement with the criminal legal system.[8–11] In addition, although the associations are complex, child maltreatment may be transmitted intergenerationally. Adults who experienced child maltreatment seem to be at higher risk for having children who experience maltreatment as well, particularly in the setting of poor parental mental health and social isolation.[12,13]

PREVALENCE

In 2021, the most recent year for which national child maltreatment data are available, approximately 600,000 children in the United States were determined to be victims of abuse or neglect and 1820 children died as a result of maltreatment.[14] More than 25% of all children who experienced maltreatment were younger than 2 years.[14] Neglect accounted for most maltreatment cases (76% of substantiated cases), followed by physical abuse (16%), sexual abuse (10%), and psychological abuse (6%).[14] Since 1992, the annual rates of substantiated physical and sexual child abuse have declined significantly, dropping by more than 60%, whereas the annual rates of neglect have decreased by a more modest 13% over the same time period.[15]

During the coronavirus disease 2019 (COVID-19) pandemic, children and families experienced multiple stressors, including COVID-related caregiver deaths, financial strain, school closures, and disruptions in social services.[16–19] To date, evaluations of the impact of the COVID-19 pandemic on child maltreatment are mixed, with different studies demonstrating increases, decreases, and no change in prevalence, depending on the outcomes and populations examined.[20,21] Nationally, the number of maltreatment reports to child protective services, substantiated cases of abuse and neglect, and foster care placements have been lower in 2020 and 2021, compared with 2019, but it remains uncertain whether this reflects a true decrease in maltreatment, changes in reporting and investigatory practices, or other factors.[14] Forthcoming data from 2022 and future years will help illuminate maltreatment trends during the acute pandemic and recovery periods.

RACISM, BIAS, AND DISPROPORTIONALITY

There is a history of racism and bias in the assessment, reporting, and response to suspected child maltreatment by both clinicians and governmental agencies, which has especially impacted indigenous and black families in the United States.[22–29] Both interpersonal racism, between individuals, and systemic racism, including historical and present-day policies, practices, and norms that result in inequitable outcomes, contribute to disparities and racial disproportionality in child maltreatment.[22,30]

Racial disproportionality in the child welfare system refers to the overrepresentation or underrepresentation of families of certain races and ethnicities, compared with the proportion of the general population. For example, whereas white children make up the largest total number of children in foster care, indigenous and black children are disproportionally affected by out-of-home placement. In 2021, indigenous children made up only 1% of all children in the United States but were placed in foster care at a rate of 2 times their proportion in the population, whereas black children made up 14% of children in the overall population but 22% of the foster care population (a rate of 1.6 times their proportion in the population).[31] Nationally, compared with white, Latino, and Asian children, indigenous and black children

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have a significantly higher cumulative risk of removal from the home before age 18 years.[25]

With regard to maltreatment assessment and reporting by clinicians, a retrospective study of young children hospitalized with skull or long-bone fractures found that, compared with white children, black and Latino children had more than 8 times the odds of having a skeletal survey performed for further workup of suspected physical abuse, even after controlling for likelihood of maltreatment, appropriateness of the skeletal survey, and insurance status, and had more than 4 times the odds of referral to child protective services, after controlling for likelihood of maltreatment and insurance status.[27] A multisite study of young children hospitalized with head injuries found that, compared with white children, children of other races and ethnicities were significantly more likely to undergo further evaluation for physical abuse and to be reported to child protective services for suspected abusive head injuries.[28] These disparities in evaluation and referral practices varied considerably by clinical site and were most pronounced among children who were determined to be at low risk for abusive injury.[28] Child neglect, which is defined more vaguely than physical abuse, may be even more susceptible to disparate assessment and referral practices.[23]

At the state agency and social service levels, once referred for evaluation of maltreatment, black families are more likely than white families to undergo full investigations for abuse and neglect, have the reports substantiated, and have children placed in foster care but are less likely to receive supportive services.[22–25] Although interpersonal racism and bias can influence decision making at different stages in maltreatment assessment, system-level policies, practices, and norms that drive inequities play a role in these disparities as well.[22,23]

Historically, both indigenous and black families in the United States have been the targets of systemic family separation practices, with children removed from their homes for forced assimilation in the case of residential Indian schools and for profit in the setting of slavery.[22–24] These separations, which often resulted in child death, have left a legacy of intergenerational trauma and loss within communities, which is compounded by present-day inequities. There are multiple examples of laws and policies that have directly contributed to racial disparities in poverty, which is highly correlated with involvement with the child welfare system.[22–24] These examples include the discriminatory housing policies of the Federal Housing Administration in the 1930s, the deliberate exclusion of predominantly black domestic and agricultural workers from social security benefits in the 1930s, and, at the state level, the exclusion of predominantly black single-parent households from Aid to Families with Dependent Children benefits in the 1950s and the 1960s.[22–24] Of these the last one not only exacerbated financial strain in affected families but also led to heightened surveillance of households by the state and increased removal of Black children from their homes.[22–24]

With this legacy of interpersonal and structural discrimination in mind, equity must be a priority at the individual, institutional, and societal levels for maltreatment interventions and initiatives aimed at supporting families and preventing child abuse and neglect. Expert recommendations include training individuals who work with families to recognize and address personal biases and racism and develop cultural humility, disaggregating maltreatment process and outcome data by race and ethnicity to evaluate for disproportionalities and opportunities for intervention, and examining and supporting policy solutions that may narrow, rather than widen, disparities in maltreatment by race and ethnicity, including economic and social supports to families to reduce the risk of poverty.[22,23,26]

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THE ROLE OF THE CLINICIAN AND THE MEDICAL HOME

The patient- and family-centered medical home has unique potential as a locus for supportive child and family services and offers the advantages of longitudinal relationships between clinicians and families, nearly universal access to care, a focus on preventive services, and frequent routine visits during early childhood when children are most at risk for maltreatment. At every clinical encounter, clinicians have the opportunity to connect families to health care services, community resources, and other supports that have been shown to prevent maltreatment. In addition, clinicians should recognize and respond to concerns for maltreatment; provide supportive care and continuity of services to children who have experienced abuse or neglect; support biological, kinship, and foster caregivers in each of their unique roles in caring for children in foster care; and advocate for policies and practices that strengthen all families.

Assessment and Response

Health care workers, including frontline clinicians, are required by law to report suspected child maltreatment to state child protective service agencies or other authorities.[6,32] Research has shown, however, that there are multiple factors that influence clinicians' responses to presentations of potential maltreatment, with marked variability in reporting practices and decisions regarding whether or not to pursue further evaluation.[33–38] In addition to the influence of racism and bias discussed previously, clinicians frequently cite a lack of knowledge about legal mandates and reporting requirements, uncertainty about the likelihood of maltreatment in specific cases, and poor experiences with prior referrals to the child welfare system as major drivers of their clinical decision making.[33–39]

In an effort to improve clinician assessment and referral practices, and decrease both underreporting and overreporting of maltreatment, some health care institutions have introduced the use of clinical guidelines and decision support tools, particularly for the evaluation and workup of child physical injuries.[40] The American Academy of Pediatrics has similarly published policy statements and guidelines for clinicians, including recommendations for the workup of suspected physical abuse,[41,42] as well as the recognition, evaluation, and prevention of abusive head trauma[43] and maltreatment of children with disabilities.[44] Consultation with experienced practitioners, including child abuse pediatricians, social workers, or other members of multidisciplinary child protection teams, may help clinicians more accurately assess risk and guide further workup.

In cases of potential child neglect, clinicians may need support to distinguish between maltreatment by a caregiver and unmet child needs due to poverty or other circumstances.[23] Similar support may be useful when clinicians note general signs that a child is struggling, such as social withdrawal or school failure, and are unclear on whether or how to explore whether there may be a component of maltreatment. Some states have developed systems to help mandatory reporters identify whether or not there are safety concerns that require child welfare involvement, and many child welfare agencies now include an "alternative response" option intended to focus on services for families with unmet needs but low concern for maltreatment.[14] The City of Philadelphia has proposed expanding the free "Philly Families CAN SupportLine" to serve all families with children up to age 17 years in connecting with supportive community services and home visiting programs, without involving child protective services.[45] If successful, the initiative, supported by the Philadelphia Departments of Public Health and Health and Human Services may serve as a model for collaborative family support in other cities.

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Supportive Care

In many cases, the medical home can provide important continuity of care for children impacted by maltreatment. Clinicians should aim to provide trauma-informed care, including establishing a safe and supportive clinical environment, and should recognize the many ways that trauma may present, both in children and their caregivers.[46] In addition to providing routine medical services and supporting child growth and development, clinicians should anticipate the need for collaboration with behavioral health services and increased care coordination, including communication with multiple caregivers and child welfare agencies.[7,47] Children who have experienced complex trauma may require clinician advocacy and guidance to access necessary accommodations and supports at school through individualized educational plans, as well as physical therapy, occupational therapy, and behavioral and emotional supports through programs such as Early Intervention and other publicly-funded services. Trauma-focused cognitive behavioral therapy, and other trauma-specific interventions, may be particularly helpful.

Prevention and Advocacy

Effective maltreatment prevention is a public health priority and should be a focus of clinicians who care for children.[48]s The American Academy of Pediatrics has specifically called on pediatricians to “provide helpful guidance and refer families to programs and other resources with the goal of strengthening families, preventing child maltreatment, and enhancing child development.”[49] Clinicians can engage in prevention-focused work with individual families, within their institutions, and in the broader community through support and advocacy for effective, family-centered policies.

With individual families, clinicians can focus on protective factors associated with maltreatment prevention, including caregiver knowledge of child development and positive parenting practices that support child social and emotional well-being.[50] Clinicians should screen for material needs, such as food and housing insecurity, and help connect families to relevant clinic- and community-based resources that help address identified needs. Given the intricate link between child and caregiver health, clinicians should consider dyadic models of care or close collaboration with adult health care practitioners to ensure family members’ health care needs are being met. In addition to screening for postpartum depression at the recommended 1-, 2-, 4-, and 6-month infant visits, clinicians should routinely ask caregivers about stressors and supports in place, with referrals to clinic- or community-based behavioral health resources as needed.

At the institutional level, clinicians can advocate for colocation of supportive resources, including food pantries and diaper banks, which help families meet their material needs and decrease household stress.[51,52] Cross-sector collaborations that integrate other services into the medical home may effectively address additional social determinants of health. Examples include medical-legal partnerships that facilitate free legal aid for housing and educational advocacy, medical-financial partnerships that help families unlock financial savings and tax credits, and childcare navigation supports.[53–55] Clinicians should examine institutional policies and advocate for changes that center families and decrease the likelihood of unnecessary referrals to child protective services. For instance, automatic maltreatment reporting for all infants with prenatal substance exposure, regardless of the parent’s recovery status or engagement with clinical care, can lead to mistrust and disengagement with health care, further worsening disparities in care and child welfare involvement.[56]

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In the community, there is ample evidence that factors such as access to safe, affordable housing are closely associated with a decreased risk of maltreatment reports.[57,58] Clinicians should advocate for neighborhood- and system-level supports for families and children, including quality housing, safe neighborhoods, healthy food, high-quality affordable childcare, and paid parental leave. There is evidence that systemic initiatives that provide cash payments, including the Earned Income Tax Credit (EITC) and Child Tax Credit may be particularly promising approaches to preventing maltreatment.[59–61] Receipt of state-level refundable EITC is associated with a decrease in hospital admissions for abusive head trauma in young children, and states that provide a higher dollar amount of refundable EITC benefits have fewer state-level reports of child neglect, compared with states with lower benefits.[59,60] As of the beginning of 2023, however, only 31 states and the District of Colombia offer a state EITC. Differences in geographic availability, along with federal and state eligibility restrictions, may widen instead of narrow disparities in maltreatment outcomes and should be examined further.

SUMMARY

Child maltreatment is associated with significant morbidity, and prevention is a public health priority. Given evidence of interpersonal and structural racism in child protective service assessment and response, equity must be prioritized for both acute interventions and preventive initiatives aimed at supporting children and their families. Clinicians who care for children are well-positioned to support families, and the patient-centered medical home, in collaboration with community-based services, has unique potential as a locus for maltreatment prevention services. Clinicians should advocate for policies that support families and decrease the risk of child maltreatment.

CLINICS CARE POINTS

- Clinicians should be familiar with the common presenting signs and symptoms of maltreatment, including injuries that are unusual for a child's age and developmental stage, and should consult practice guidelines and child abuse experts to help assess risk and guide further workup.
- Clinicians should be familiar with trauma-informed approaches to screening for and addressing child maltreatment, as well as community-based resources to support children who have experienced complex trauma.
- Individuals who work with children and families should understand the history of racism in child maltreatment and engage in training to recognize and address personal biases and develop cultural humility.
- Data regarding maltreatment processes and outcomes should be collected and disaggregated by race and ethnicity to evaluate for disproportionalities and identify opportunities for intervention and improvement.
- Prevention of child maltreatment should be a priority. Clinicians should screen for unmet material needs and refer families to resources; connect caregivers with medical care, including behavioral health supports; and advocate for policies like the EITC and Child Tax Credit that support families and children.

DISCLOSURE

The authors have no financial or other conflicts of interest to disclose.

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