



Ongoing Pediatric Health Care for the Child Who Has Been Maltreated

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Pediatricians provide continuous medical care and anticipatory guidance for children who have been reported to state child protection agencies, including tribal child protection agencies, because of suspected child maltreatment. Because families may continue their relationships with their pediatricians after these reports, these primary care providers are in a unique position to recognize and manage the physical, developmental, academic, and emotional consequences of maltreatment and exposure to childhood adversity. Substantial information is available to optimize follow-up medical care of maltreated children. This new clinical report will provide guidance to pediatricians about how they can best oversee and foster the optimal physical health, growth, and development of children who have been maltreated and remain in the care of their biological family or are returned to their care by Child Protective Services agencies. The report describes the pediatrician's role in helping to strengthen families' and caregivers' capabilities and competencies and in promoting and maximizing high-quality services for their families in their community. Pediatricians should refer to other reports and policies from the American Academy of Pediatrics for more information about the emotional and behavioral consequences of child maltreatment and the treatment of these consequences.

Pediatricians provide medical care and anticipatory guidance for children who have been maltreated. Because as many as 25% of the child population has experienced some form of maltreatment, medical encounters in a pediatric practice with maltreated children are not uncommon.¹⁻³ Although only a small proportion of children who have been maltreated are investigated by Child Protective Services (CPS), each year, state CPS agencies determine that approximately 700 000 children have been victims of child maltreatment.⁴ Approximately 75% of these children are neglected, and about 17% are physically abused; many children suffer multiple forms of maltreatment. In the United States, an estimated 1700 children die each year as a result of abuse and neglect. Child maltreatment has many long-term health, developmental, and

abstract

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emotional consequences for the children who survive.

Two-thirds of children who have been determined by CPS to have been maltreated will remain in the care of their families while receiving supportive and therapeutic services.⁴ Even when children are placed in out-of-home care, approximately half will be returned to their families within days to months. The median length of stay in foster care for children who are later reunified with their family of origin is 8 months.⁵

Because families may continue their relationships with pediatricians despite the other disruptions and challenges they have experienced, pediatricians are ideally positioned to recognize and manage the physical, developmental, and emotional consequences of the maltreatment and to provide support and direction to the families of the children.⁶ In this report, we will provide guidance to pediatricians and other primary care clinicians about the service and care for these children's physical, developmental, and cognitive needs. Pediatricians should refer to the reports from the American Academy of Pediatrics (AAP), "Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment"⁷ and the forthcoming "Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication,"⁸ for information about the emotional and behavioral consequences of maltreatment and the treatment of these consequences. Previous reports have described the care of children entering foster care.^{9,10} Providing care for the child remaining with the family and/or after his or her return to the family is the focus of this report. Besides the clinical care of the child, the pediatrician has a role in monitoring and supporting the family, working with the community, and advocating for appropriate interventions and services to help

ensure that children grow up in safe, stable, nurturing environments.

FOLLOW-UP CARE OF THE CHILD

Children who have been maltreated need to be evaluated more frequently by the primary care clinician than other children of the same age. Certain ages and developmental stages will merit more thorough evaluations and more frequent follow-up. The clinician can follow the recommendations for youth entering foster care: 3 visits in 3 months after CPS involvement or leaving foster care and every 6 months after that.^{9,11} Although much of the medical care for these children will follow along standard paths (eg, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*¹²) certain areas deserve a more-thorough evaluation in children who have been maltreated. Typically, the child may be seen within the first week after return to his or her family, at 1 month, and again at 3 months after the transition.

The initial history should include the reason for CPS intervention, the outcome of the investigation, and any services recommended, if this information is available. Pediatricians may be aware that a patient has been reported to CPS. In some cases, the pediatrician will have been the initial reporter, and other times, a parent will have told the pediatrician about the report or subsequent investigation, possibly asking for the pediatrician's support or assistance. CPS investigators may have contacted the pediatrician during their investigation into an allegation of possible child maltreatment. When speaking to CPS, it is helpful for the pediatrician to document the name and contact information of the CPS investigator.

Pediatricians, however, report that they are not always informed of the outcome of the investigation.¹³ Although in some states CPS may

notify the initial reporter about the outcome of the investigation (whether it has been substantiated or unfounded), the pediatrician may not be informed of the outcome of the investigation or told about any services or interventions provided to the family. Sharing information between medical and child protection professionals can be challenging but is vital because the pediatrician can play an important role in supporting the family, ensuring that the family continues to participate in indicated services, monitoring the family for recurrent maltreatment, and preventing further maltreatment. If the CPS investigator refuses to provide information, the pediatrician can obtain parental consent and ask CPS for a multidisciplinary team meeting to discuss how he or she can best assist the family. Another strategy is to ask to speak to the investigator's supervisor or the director and explain how knowledge of the investigation and recommended services may help protect the child and assist the family with parenting. Some jurisdictions have medical directors who may be able to assist. Pennsylvania passed legislation in 2014 (Act 176) that enabled 2-way communication between CPS and the primary care physician.¹⁴

The pediatrician may want to ask the family if the child was placed in a cultural environment different from the family. For example, the family may speak a different language than that spoken by the family with whom the child was placed. In addition, because of the relative lack of approved American Indian foster homes, American Indian children may have been placed in non-American Indian foster homes, despite passage of the Indian Child Welfare Act (Pub L No. 95-608 [1978]).^{15,16} Cultural displacement can occur when any child is placed out of his or her distinctive ethnic, linguistic, spiritual, or cultural community with any foster

family who the child may view as “other.”¹⁷ American Indian children placed in white foster homes report feeling that they do not belong in either an American Indian community or in white society.¹⁸

If the child was placed outside the home, the pediatrician may ask about any medical problems, hospitalizations, immunizations, and other health care, including mental health care, that the child received during this placement. The parent can also be asked about referrals to subspecialists and whether their child was seen for those appointments. Although it may be challenging to obtain the medical records, the pediatrician will find it helpful to have access to the records of any medical care and mental health care provided. The parents may assist in obtaining these records if they understand the importance for both the parent and pediatrician to have this information.

The pediatrician can ask the parent about any behavioral changes or adjustment difficulties. The AAP report “Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment” discusses possible behavioral and emotional responses of a child who has been previously maltreated.⁶ The pediatrician may be able to interview, separately from the parents, those children who are verbal and ask about their adjustment to the changes in their life and their return home. If the family has information about the placement home, the pediatrician can assess for possible exposures, such as lead in preschool children, secondhand tobacco smoke, and other hazards.

During adolescence, a psychosocial interview focusing on home environment, education and employment, eating, peer-related activities, drugs, sexuality, suicide or depression, and safety from injury and violence (HEEADSSS) can be

conducted.¹⁹ Using the HEADSSS method of interviewing will help to assess the adolescent’s adaptation and elicit risky health behaviors. Adolescents who have been maltreated may engage in risky behaviors, such as smoking, drug use, regular alcohol consumption, and binge drinking, which are behaviors with short- and long-term health consequences for the adolescent.^{1,20,21} A history of sexual abuse during childhood is associated with risky sexual behaviors and early pregnancy.^{22,23} Consider the administration of the human papillomavirus (HPV) vaccination, which can be administered as early as 9 years of age, in this high-risk population.²⁴

Assessing Development, Cognition, and Academic Performance

Child maltreatment and other childhood adversities may affect brain development. Severe ongoing stress or “toxic stress” affects brain anatomy and function.^{25,26} Early adverse experiences may affect the structure, organization, and activity of the brain because of the brain’s plasticity.²⁷ Maltreatment may alter the hypothalamic-pituitary-adrenal (HPA) axis and autonomic nervous system function.²⁸ Exposure to adversity and early life stress, if not mitigated, may result in epigenetic changes.^{29–31} Therefore, pediatricians may want to monitor developmental and social-emotional milestones, cognition, and the academic performance of the child.

Although pediatricians generally check developmental milestones in all children, children who have been neglected or have suffered abusive head trauma (AHT) will particularly benefit from having their milestones closely monitored. The etiology of both atypical developmental and behavioral delays is multifactorial.^{32,33} Because drug and alcohol abuse are risk factors for child maltreatment, the risk of prenatal

drug and alcohol exposure effects is increased in children who have been maltreated.³⁴ Therefore, the clinician may find signs of fetal alcohol spectrum disorders or behavioral issues related to other drug exposures.^{35,36}

Early intervention services are often indicated to help speed up the child’s acquisition of new skills. Repeated and regular surveillance and screening to assess and identify children who may be at risk for developmental delay is recommended. The AAP does not recommend or endorse 1 particular standardized screening tool. Guidance is available in the AAP policy,³⁷ and training and resources are available on the AAP Screening in Practices Web site, at www.aap.org/screening.

Child maltreatment is associated with an increased chance of impaired cognition and academic functioning; maltreated children are more likely to have lower grades and lower standardized test scores and IQ scores.^{38–40} Academic difficulty associated with maltreatment may manifest as early as kindergarten.⁴¹ Early maltreatment causes problems for adolescents because they may miss more days of school and complete fewer years of school compared with adolescents who were not maltreated.^{38,40} Adolescents are at risk for impairment in cognitive flexibility, the ability to switch between thinking about 2 different concepts.^{42–44} Cognitive flexibility is a measure of executive function. In addition to untoward changes in academic performance or school attendance, affected children may have difficulties interacting with peers. Extreme shyness, aggressive behavior, social isolation from peer groups, unstable moods, eccentric choice of clothing, or frequent use of school health services may suggest acute or unresolved victimization.^{38,45} Some of these factors are also linked to the

increased risk of more severe psychiatric illness.

Special attention should be given to the child's academic achievement because low school achievement is associated with low reading skills and overall educational outcome.⁴⁰ Lower academic achievement in parents may confer a higher risk of learning struggles in these children, and higher rates of family dysfunction contribute to delayed acquisition of preacademic and self-regulation skills.⁴⁶ Pediatricians can ask about school attendance because regular attendance appears to serve as a protective factor.⁴⁷

Review of Systems

In addition to a general review of all systems, the family should be asked about the circumstances of any injuries occurring before and since the child was initially reported to CPS. Careful documentation of the circumstances of such injuries is essential.

Physical Examination

The physical examination should be guided by any current concerns or complaints, the type of maltreatment that occurred previously, and the age of the child. At each visit, the examination should include a complete head-to-toe inspection.

Growth parameters should be measured and compared with previous patterns of growth. Child maltreatment may be associated with nutritional disorders, including both growth failure and obesity.^{48,49} Nutritional neglect may manifest as malnutrition.⁵⁰ The severity of the growth delay can have a long-term or permanent effect on the growth and cognitive development of the child. A child with marked malnutrition needs careful monitoring of his or her head circumference until 2 or 3 years of age as well as developmental status because severely malnourished children may never reach their full cognitive potential. All growth

parameters should be followed until the pediatrician is confident that the child is on a healthy growth trajectory. Most children who have been malnourished will need to be followed more frequently than the standard health supervision schedule.¹²

Maltreatment can also be associated with obesity and eating disorders.^{1,48} Childhood obesity is a concern for all children, but children subjected to maltreatment have higher rates of obesity.^{48,49,51} The prevalence of obesity can persist and increase into adulthood. The British Birth Cohort, one of the largest studies to follow the effects of child maltreatment on BMI into adulthood, followed 15 000 subjects.⁵¹ Children were not found to have increased BMI initially, but through adolescence and adulthood, BMI increased compared with those who were not maltreated. Physical abuse was associated with an odds ratio 1.67 (95% confidence interval: 1.25–2.24) gain in BMI by age 50 years. Sexual abuse and neglect are also associated with obesity.^{51,52} The pediatrician may carefully follow the weight of children who were maltreated because early counseling and treatment may help to alter this trajectory.

Children who have been maltreated are also at risk for other eating disorders, such as anorexia nervosa and bulimia nervosa.⁵³ In particular, children who experienced physical neglect or sexual abuse are at risk for eating disorders in adolescence.⁵³ Maladaptive paternal behavior, described as low paternal communication with the child and low paternal time spent with the child, is also associated with eating disorders.⁵³

An unclothed physical examination may reveal evidence of malnutrition or other signs of neglect and identify skin findings or other injuries suspicious for abuse. Bruises and other soft tissue injuries are the most

common injury caused by child abuse.^{54,55} If an infant who is not yet cruising has a bruise, the pediatrician may consider that the child may have been abused.⁵⁶ Patterned bruises and bruises on the face, ears, neck, trunk, and upper arm may also raise suspicion of abuse.^{57,58} Bruises and scars resulting from previous injuries, including physical abuse, should be documented. The pediatrician should also document any new injuries. Attempts should be made to ensure that these lesions have been recognized and investigated by CPS.

An oral examination should be performed on children who have experienced maltreatment because children who have been neglected are more likely to have unmet oral health needs, and about half of children evaluated before entering foster care needed dental care.^{59,60} A dental evaluation should be performed by a trained oral pediatric health care provider on all children 12 months or older.¹¹ It is likely that children who are reported to CPS and remain in their home have similar dental needs. Because frenulum tears in infants can be caused by child abuse, the pediatrician should also check the frenulum when performing the oral examination.^{60,61}

The child's stage of sexual development is generally assessed and documented at each visit. Physicians should be sensitive to any previous trauma, particularly sexual trauma, when performing this assessment and examination. The onset of puberty in girls may be affected by abuse. Because the HPA axis is affected by child maltreatment and other adverse childhood experiences, alterations in onset of puberty can be found in children after maltreatment.^{62–65} The type of abuse affects the timing of onset of puberty; a history of child sexual abuse may be associated with precocious puberty and earlier onset of puberty, and a history of severe child physical abuse is associated with both early

puberty and delayed onset of puberty.⁶⁵⁻⁶⁸

Children and adolescents who have been sexually abused or assaulted will likely need follow-up testing for sexually transmitted infections.⁶⁹ The HPV vaccine is recommended at 9 years of age in children who have been sexually abused because these children are at high risk for HPV.^{24,70} Children who are victims of sexual trauma have a greater risk of early initiation of sexual activity and pregnancy and should be counseled and tested accordingly.⁷⁰

AHT

AHT is discussed separately in this report because it has specific physical and developmental consequences for the children who have been subjected to this form of abuse. Outcomes of AHT are related to the severity and location of the head injury or injuries. Children who are unresponsive when they first present for medical attention, those who suffer hypoxic ischemic injury, and those who present with a low Glasgow Coma Scale score tend to have the worst outcomes.⁷¹⁻⁷³ Approximately 20% of children who have suffered AHT will die as a result of their head trauma, and 60% to 80% will suffer some neurologic impairment ranging from mild to severe.^{72,74-76} Children with AHT are slower to recover from their brain injury than children with similar injuries that are not the result of abuse.⁷⁷

Children who suffered from AHT are at risk for microcephaly (from cerebral atrophy) or macrocephaly (from hydrocephalus).⁷⁸ Cerebral injury can result in a number of consequences. Cerebral palsy may evolve, often beginning with central hypotonia and a delay in motor milestones, followed by other signs, such as spasticity. Hemiparesis may lead to poor growth of 1 side of the body, causing an asymmetric body structure.⁷² Cranial nerve abnormalities may also occur. Seizure

disorders are a common sequela.^{32,72,79} About 25% to 40% of children suffering AHT will experience visual impairment related to cortical or retinal injury.⁷² Many children will also have speech and language delays. Attention-deficit disorders, self-injurious behavior, and developmental delays have all been described in children who suffered brain injury.^{72,80} Global cognitive deficits, including problems in motor control, visual processing, and receptive and expressive language, have also been described.⁷³ Some of the cognitive, neuromotor, and behavioral sequelae may not be apparent for months or years after the injury, when a child is expected to perform higher-level cognitive activities.^{81,82} Parents report particular difficulty in managing the behavior of children who suffered frontal lobe injuries caused by AHT.⁷²

Autism spectrum disorder has been described in children who have suffered AHT.⁷² Autism screening should follow the recommendation for pediatric well-child visits.^{37,83}

Endocrine Consequences of AHT

Traumatic brain injury (TBI), including AHT, has been associated with endocrine consequences.^{79,84,85} More data are available about adults who have suffered TBI, but in emerging data in children, endocrine dysregulation is reported in 5% to 90% of children after TBI.^{79,85} Endocrine dysfunction is not a static situation and can evolve over time. Thus, it is important to continue to monitor a child's endocrinologic status after AHT.

Initially, TBI disrupts the HPA axis, resulting in antidiuretic hormone production and release.⁸⁵ Central diabetes insipidus is also observed at a higher rate in the short-term after an injury and is also associated with higher mortality rates. Central diabetes insipidus can occur in up to 30% of patients.⁷⁹ Both diabetes insipidus and cortical metabolism

defects typically improve over the first year after injury; however, even 5 years later, approximately 30% of children who suffered mild to severe TBI will suffer from altered pituitary hormone secretion.

Growth hormone deficiency and disturbances in puberty are the most common endocrine problems that occur after TBI.⁸⁵ It is important to monitor growth over time in children who have experienced TBI by measuring height, weight, growth velocity, and pubertal staging.^{79,86-88} Also, because other endocrine abnormalities can change over time, survivors of AHT should have careful growth and pubertal examinations every 6 to 12 months after the injury and then yearly, once stable. A pediatric endocrinologist will be able to recognize subtle hormone deficiencies and help guide the appropriate workup and follow-up.⁸⁵

Adolescents Transitioning to Adult Health Care

For adolescents who may be transitioning to adult health care, it is important to connect them with providers for both their physical and mental health needs. Approximately 30% to 40% of the adolescents who have experienced child maltreatment are coping with mental health problems, and about one-third have a chronic illness or disability.⁸⁹⁻⁹¹ The clinician can teach adolescents the skills they will need to navigate the adult health care system.⁹² Preparation for transitioning should start early: depending on their cognitive abilities, children 14 years or younger can be prepared and taught to manage their own care. Youth with special health care needs may require a longer transition process because issues such as guardianship and transfer of specialty care must be addressed.^{89,92} Pediatricians can identify physicians in their community who are interested in working with adults with health care and mental health

challenges.⁹² In some communities, however, it may be challenging to identify such physicians.

Resiliency

Children who have experienced childhood adversities, including child maltreatment, do not demonstrate a uniform response to these “childhood traumas.”⁹³ Certain protective factors appear to buffer the child’s response to these childhood adversities, including the child’s temperament, personality, cognitive ability, and coping strategies and demographic variables, such as male sex, older age, and greater amount of education.⁹⁴

The pediatrician can help build the child’s resiliency. Children who have a caring and supportive adult in their life are more resilient.⁹⁵ This adult can be a parent, friend, relative, or teacher. The pediatrician can encourage the child to form relationships with supportive adults. A pediatrician who is a caring and constant individual in the child’s life may help to promote the child’s resiliency.⁹⁶

Resiliency is also bolstered by a supportive family environment.^{97,98} Pediatricians can help parents and caregivers be supportive and therapeutic by helping them understand the behaviors of children exposed to maltreatment.

A positive school experience may improve the child’s sense of self-worth.⁹⁹ Extracurricular activities may also help to improve a child’s self-esteem. In 1 study of children who had experienced violence in childhood, higher resilience was associated with greater spirituality, emotional intelligence, and support from friends.⁹⁶

PEDIATRICIAN’S ROLE WITH PARENTS, FAMILY, AND OTHER CAREGIVERS

The pediatrician may use health care visits to determine how the child, parent(s), and other siblings are

copied after a report and investigation by CPS. If the child or children were placed outside the home, the clinician may ask the parent how they are managing after the child’s or children’s return home. Parents are more satisfied with the child’s primary care provider when stress is discussed during the visit.¹⁰⁰ Observing the parent-child interaction can also provide information about how they are coping. Parents generally respond positively to pediatricians when they are asked about the services or interventions they are receiving because of CPS intervention, especially if the pediatrician is open and nonjudgmental and expresses a desire to help the caregiver successfully parent their children.^{101,102}

Families may perceive the CPS investigation as hostile or adversarial, and therefore they may not cooperate with CPS recommendations for services. In one study, no significant change in social support, family function, poverty, maternal education, or child behavior problems was found in households after CPS had investigated suspected maltreatment because either referrals were not made or families did not participate in the CPS-recommended services.¹⁰³ Because families may have a trusting relationship with their pediatricians, the family may respond to recommendations made by the pediatrician.

Pediatricians can better help families not only if they understand the reason for the initial report and the risk factors that may exist but also if they understand the family’s response to the investigation and any services provided. Although some caregivers report that they are no better off as a result of an investigation, many caregivers report positive changes occurred as a result of CPS intervention and describe how they recognize their own role in the maltreatment reported.¹⁰² Some parents change or reform high-risk parenting behaviors as a result of the report. Parents have

demonstrated that they can learn to use the parenting techniques they learned in parenting classes.¹⁰² Some parents identify new strengths in themselves or develop more confidence in their parenting abilities as a result of CPS intervention.¹⁰²

If the child was placed outside the home during the CPS intervention, the pediatrician should ask the family if the child has developed new or concerning behaviors since living in other home(s). Children who return home after placement in foster care may bring with them new problem behaviors, which can add to the stress of a household.¹⁰⁴

Poverty places additional stress on a family and may lead to food insecurity; therefore, the pediatrician should assess for this and other measures of poverty.^{105,106} Food insecurity is not uncommon, and food insecurity is associated with both malnutrition and obesity. To assess for food insecurity, the AAP recommends the pediatrician ask the family to reply to 2 statements: (1) “Within the past 12 months, we worried whether our food would run out before we got money to buy more” (yes, no) and (2) “Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more” (yes, no).¹⁰⁵ This screen has been found to have high sensitivity and good specificity.¹⁰⁶ Pediatricians can learn about the resources available in their community, such as the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children; summer food programs; and child and adult food programs, and make referrals when food insecurity is identified. Pediatricians can also advocate for adequate funding of community programs.

Recidivism: Identification and Prevention

Pediatricians should be aware that although CPS intervention may have

interrupted the maltreatment, families continue to live in the same environment and may face the same challenges, such as poverty, food insecurity, interpersonal violence, substance abuse, and mental illness, as before the report to CPS. The family may have also experienced new and additional stressors, such as loss of financial support, loss of transportation, and other hurdles because of the CPS report. In addition, because CPS is still involved with the family, the CPS intervention may be an additional source of stress. The pediatrician can help the family by identifying and addressing these old and new stresses and by making referrals for appropriate services in the community, if indicated.

Most importantly, child maltreatment may recur.¹⁰⁷ Many factors are associated with higher rates of recurrence. Neglect is not only the most common type of child maltreatment, but it is also linked to higher rates of recurrence.^{108,109} In addition, children who have suffered more than 1 type of maltreatment (eg, both physical abuse and neglect) are more likely to be maltreated again.¹¹⁰ Many of the factors known to place a child at risk for maltreatment, such as poverty; poor parent-child relationships; younger children in the family; a greater number of children in the family; children with disabilities; families with low levels of family or social support; a single-parent household; caregiver mental health problems, particularly depression; and caregiver substance abuse, also are associated with higher rates of recurrence.^{108,111-113} Caregivers of children with behavior problems and caregivers who were themselves abused as children are more likely to reabuse a child when the child remains in the home after a CPS report.¹¹⁴

Rates of recurrence range from approximately 1% to 2% for families considered at low risk for recurrence to greater than 65% for families at

high risk.^{115,116} In 1 large study of children who remained at home after child maltreatment, more than 60% were rereported within 5 years.¹¹⁷ Families are at greatest risk to be rereported to CPS during the first 6 months after a case disposition.¹¹¹ Clinicians should encourage families to participate in and complete all services recommended by CPS because families who have accepted and actively engaged in services are more likely to be successful at preventing any recurrence.¹¹⁸

The pediatrician should remain alert to signs of recurrence and also understand that children who have suffered 1 type of maltreatment may suffer other types of maltreatment in the future.¹¹⁰ At each visit, the pediatrician should inquire about the factors that initially placed the child at risk for maltreatment, the child's and family's adjustment, and any new stresses in the family. The family's failure to attend medical appointments may be another sign of abuse or neglect.

Families should be asked about the child's behavior and how they discipline or respond to negative behavior. The family should be counseled about appropriate discipline, and any use of corporal punishment should be discouraged. The pediatrician should discuss alternative forms of discipline appropriate to the age and development of the child. The parent should be encouraged to recognize and respond to positive behaviors in the child as a means of reinforcing these behaviors. For more guidance, refer to the AAP policy statement "Effective Discipline to Raise Healthy Resilient Children."¹¹⁹

Maternal depression is common in families involved with CPS.¹²⁰⁻¹²² Maternal depression is associated with harsh parenting, physical abuse, and increased psychological aggression.¹²⁰ Depression in fathers in the postnatal period is also

associated with psychiatric disorders in their children and with family dysfunction.^{123,124} Therefore, it is important to assess for depression and other signs of mental illness and to make appropriate referrals for treatment.^{125,126} The Edinburgh Postnatal Depression Scale is a standardized tool to assess for maternal depression in the postpartum period, but other tools may be more appropriate to assess and identify depression in mothers and fathers of older children.¹²⁷ Pediatricians who suspect a recurrence of child maltreatment must report these suspicions to CPS, as mandated by state laws.¹²⁸ Some pediatricians are reluctant to report because they believe that they can help the family better than CPS can or because they are not certain that the child has been maltreated.¹²⁹ Some physicians fear that they will lose the family as patients if they report, but most families return for care after primary care physicians have reported them to CPS, according to 1 national study.¹³⁰ The CPS case worker, a child abuse pediatrician, or the local hospital child abuse team can serve as a resource for pediatricians when they are uncertain about their decision to report or the next steps they should take. Rather than viewing reporting as a punitive action, the pediatrician should recognize that a report to CPS may help to keep the child safe and may help the family obtain important services. In most cases, it is best for the pediatrician to tell the family that he or she plans to make a report to CPS and why the report is being made. Continuing an open and honest rapport with the family may help to maintain the family's trust.

Supporting Families

The pediatrician can ask caregivers and the children if they have friends or family members who provide emotional support. To help determine whether support is available, the pediatrician may ask whom the

parents or caregivers would ask for help with the child or children if they suddenly became ill or had to be hospitalized. Likewise, the pediatrician can ask children to whom they would talk if they had problems they did not wish to discuss with their parent or caregiver. The primary care clinician can also provide emotional support by asking the caregiver and verbal children in the family about how they are feeling and coping. Caregivers found it helpful when others offered support that made them feel more secure or self-sufficient, rather than offering prescriptive interventions.¹⁰² Supporting the family will increase the caregivers' abilities to buffer the stress for their child or children.¹³¹

ADVOCACY AND COLLABORATION WITH THE COMMUNITY

Communities often have resources that will help to support and strengthen families. Pediatricians should familiarize themselves with the resources available in their communities and advocate for the additional resources that are needed.

Community programs have proved to be successful in promoting parent-child interaction and helping the child's cognitive development and ultimate success. Children who have been neglected, particularly, may benefit from these programs. Reach Out and Read is a program already adopted by many pediatric practices in the country, which encourages parents to read aloud to their children from a young age.¹³² Pediatricians give age-appropriate books to parents at each visit from 6 months to 5 years of age, encouraging the parents to read to their children. Reading aloud has been shown to increase the child's vocabulary and contributes to the child's subsequent reading ability. Pediatricians can help parents to understand the importance of talking to their children and reading aloud to

their children beginning in infancy and how this interaction helps their child's development.

Significant disparities exist in children's early language environments, including differences in the quantity and the complexity of sentences that they hear.¹³³ These disparities are linked to the child's cognitive development and ultimate success in school.¹³⁴ The pediatrician can encourage and model for parents how, even from birth, they can talk to their child throughout the day.

Other resources that have been shown to be effective are home visiting programs and early childhood education programs. In home visiting programs, trained professionals visit parents and children in their home and provide support, education, and information that can help to improve parent caregiving abilities. Home visiting programs vary in form and quality.¹³⁵ The US Department of Health and Human services provides a current review of different home visiting program models and the evidence for their effectiveness.¹²⁹

The Nurse-Family Partnership has been demonstrated to be effective in reducing risk factors for child maltreatment, but the program is only for first-time pregnancies.¹³⁶ The program begins in pregnancy and continues until the child is 2 years old. A number of randomized controlled studies have demonstrated that the program produced significant effects on women's timing and likelihood of subsequent pregnancies and number of subsequent births. In addition, these programs have increased the stability of the mothers' relationships with their partners; improved the mother-child responsive interaction; and improved the emotional development, language, mental development, and academic achievement of children born to mothers with low psychological resources.¹³⁷⁻¹³⁹ There is also

evidence that home visiting reduces the risk of child abuse and unintentional injury.¹¹⁶

Early Head Start programs have been shown to improve the child's cognitive abilities, language, attention, and health as well as decrease behavior problems.¹⁴⁰ Early childhood education programs can promote school readiness.¹⁴¹ In addition, mothers also demonstrated improved parenting, better mental health, and more employment when their children participated in early childhood programs.¹⁴² For school-aged children, some schools offer skilled and comprehensive support services, including assessment, counseling, mentoring, and tutoring. Primary care pediatricians should consider coordinating information, resources, and intervention with school personnel to support at-risk children and families. Other resources for the pediatrician are listed in Table 1. Pediatricians can learn more about the resources in their communities from their local CPS agencies and from social workers, child abuse teams, and child abuse pediatricians in their communities.

Parents need access to quality child care and education systems. Neighborhoods with more child care spaces relative to child care needs have demonstrated lower rates of child maltreatment.¹⁴³

Parent training programs are designed to improve parents' child-rearing skills, increase the parents' knowledge of child development, and encourage positive child management skills. Pediatricians should determine which parent training programs are available in their communities. Rather than focusing on the children, Shonkoff, from the Center for the Developing Child, and Fisher¹⁴⁴ advocate focusing more resources on the adults who care for young children by strengthening their capabilities and improving the health and well-being of the parents and

TABLE 1 Resources for the Pediatrician

Resources
AAP <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> provides pediatricians with guidelines for each health supervision visit. The tool and resource kit contains assessments and tools that the pediatrician can use to identify psychosocial issues, including suggestions for open-ended questions that can assess for family stress. Available at: https://brightfutures.aap.org <i>Connected Kids</i> addresses violence prevention for children of different ages. Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx <i>The Resilience Project</i> provides education and resources to more effectively identify and care for children and adolescents who have been exposed to violence. Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/About-the-Project.aspx <i>Screening in Practices</i> initiative provides training and resources to improve early childhood screening, referral, and follow-up for developmental milestones, maternal depression, and social determinants of health. Available at: www.aap.org/screening <i>Helping Foster and Adoptive Parents Cope with Trauma</i> provides materials for pediatricians on how to support adoptive and foster families. Available at: http://www.aap.org/traumaguide Council on Child Abuse and Neglect. Available at: www.aap.org/council/childabuse AAP Policy Statement. "Abusive Head Trauma in Infants and Children." Available at: http://pediatrics.aappublications.org/content/123/5/1409 AAP Clinical Report. "The Evaluation of Children in the Primary Care Setting When Sexual Abuse is Suspected." Available at: http://pediatrics.aappublications.org/content/132/2/e558 AAP Policy Statement. "The Pediatrician's Role in Family Support and Family Support Programs." Available at: http://pediatrics.aappublications.org/content/128/6/e1680 AAP Clinical Report. "The Pediatrician's Role in Child Maltreatment Prevention." Available at: http://pediatrics.aappublications.org/content/126/4/833 AAP Clinical Report. "Evaluation for Bleeding Disorders in Suspected Child Abuse." Available at: http://pediatrics.aappublications.org/content/131/4/e1314 AAP Clinical Report. "Caregiver-Fabricated Illness in a Child: A Manifestation of Child Maltreatment." Available at: http://pediatrics.aappublications.org/content/132/3/590 AAP Clinical Report. "Evaluating Children With Fractures for Child Physical Abuse." Available at: http://pediatrics.aappublications.org/content/133/2/e477 AAP Clinical Report. "The Evaluation of Suspected Child Physical Abuse." Available at: http://pediatrics.aappublications.org/content/135/5/e1337 Center for the Study of Social Policy. Available at: https://www.cssp.org/ Centers for Disease Control and Prevention Essentials for Childhood Framework. Available at: http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots. Available at: http://www.cdc.gov/violenceprevention/pdf/strategic_vision.pdf Stop SV: A Technical Package to Prevent Sexual Violence. Available at: https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities. Available at: https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf Pinterest board for Positive Parenting. Available at: https://www.pinterest.com/cdcgov/cdc-positive-parenting/ Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Available at: https://www.cdc.gov/violenceprevention/pub/connecting_dots.html Violence Education Tools Online (VetoViolence). Available at: http://vetoviolence.cdc.gov Harvard University Center on the Developing Child. The Science of Early Childhood Series. Available at: https://developingchild.harvard.edu/resources/inbrief-science-of-ecd/ National Survey of Children's Exposure to Violence Bulletins. Available at: http://www.ojdp.gov/publications/PubResults.asp?sei=94&PreviousPage=PubResults&strSortby=date&p= Talk, Read, and Sing Together Every Day. Available at: https://www.ed.gov/early-learning/talk-read-sing Too Small to Fail. Available at: http://toosmall.org/ Resilience: The Biology of Stress and the Science of Hope. Available at: http://kpfjfilms.co/resilience/

other caregivers to support the child's optimal development. They also advocate for the development of a better linkage between the services provided to the child and to the adult, what they call "two-generational programs."¹⁴⁴

The Triple P (Positive Parenting Program) is a public health population-based intervention program designed to provide parenting and family support.¹⁴⁵⁻¹⁴⁷ The program includes different intervention levels of increasing intensity. The program has shown

positive effects on maltreatment and associated outcomes.¹⁴⁸

Behavioral parent training programs, such as Parent-Child Interaction Therapy, The Incredible Years, and SafeCare, have been found to increase positive parenting behaviors, decrease problem behaviors in children, reduce abuse and neglect risk factors, and reduce recidivism in families involved in the child welfare system.¹⁴⁹ Attachment and Behavioral Catch-up therapy (10 sessions with child and mother) has been found to be effective in treating

disorganized attachment, frightening parental behavior, and other atypical behavior associated with disorganized attachment.¹⁵⁰ More information is available in "Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment."⁷

GUIDANCE FOR PEDIATRICIANS

In summary, pediatricians can play an important role in helping children who have suffered previous maltreatment to grow and develop optimally. They can work with

families to identify their strengths and stresses and develop priorities and goals that will assist families to provide a safe, nurturing environment. Pediatricians can advocate for community-based services that facilitate optimal growth and development of children.

Child

- Identify children in the practice who have been reported to CPS because of maltreatment. Using appropriate *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* codes will help to track these at-risk children.
- Obtain records of any medical or mental health care provided.
- In the history, during the initial visit, include the reason for the CPS intervention, the outcome of the investigation, and any services recommended.
- Ask about any injuries occurring before and since the report to CPS.
- Assess whether cultural displacement occurred: ask if the child was placed in a cultural environment different from the family.
- Screen for possible hazardous environmental exposures, such as lead, drugs of abuse, and secondhand smoke.
- Monitor the child's growth and assess for growth failure, obesity, and eating disorders.
- Monitor the child or adolescent's development, academic progress, and emotional health.
- Monitor the child's adjustment in the home and at school.
- Be alert to signs of recurrence. The greatest risk for recurrence is during the first 6 months after a case disposition.
- Physical examination: Monitor growth parameters, look for signs of malnutrition, examine the skin for signs of previous injury or physical abuse, perform a dental

evaluation on all children 12 months and older, and document the stage of sexual development at each visit.

- Help build resiliency by encouraging the child to form relationships with supportive adults.
- Children will need more frequent visits: 3 visits in 3 months and every 6 months after the maltreatment occurred and after returning home from foster care.
- AHT: If a child has suffered head trauma, follow the head circumference closely until 2 or 3 years of age, in addition to other growth parameters. Monitor development and academic performance and make appropriate referrals for intervention. Be aware that survivors of AHT may suffer from altered pituitary hormone secretion, which may persist. Carefully monitor growth and pubertal examination 6 and 12 months after the injury and annually once stable. Consider a consultation with a pediatric endocrinologist who can help guide the workup and follow-up.
- Adolescents: Assess for concerns with returning home and for risky behaviors. The HEEDSSS assessment may be used. Consider administering the HPV vaccine, which can be given as early as 9 years of age. Prepare adolescents for transition to adult providers by teaching them skills they need to navigate the adult health system.
- Children and adolescents who have been sexually abused or assaulted and who are examined soon after the assault will need follow-up testing for sexually transmitted infections.

Parent and Caregiver

- Encourage and enable family to follow through with recommendations and services provided by CPS. Focus on

improving the capabilities and competencies of the child's caregivers. Identify other services that may be needed and make appropriate referrals for treatment programs for modifiable stresses, such as alcohol and drug abuse and parental depression.

- Assess how the parent(s) and other siblings are adjusting after a report to and investigation by CPS.
- Understand the family and child stresses, triggers, and dysfunction that led to the maltreatment. Provide families with the knowledge, skills, and support to raise their children. Help parents and caregivers to understand the behaviors of children associated with toxic stress. As needed, refer families to programs and resources that will help to improve their knowledge and skills and provide them with the support they need to raise their children.
- Encourage parents to talk to their children and read aloud to their children. Educate families about resources that may assist them in caring for their child, such as parental coaching programs. Recommend that preschool-aged children enroll in Head Start or other early childhood programs.
- Coordinate with school personnel to support at-risk children and families.
- Assess for food insecurity. Be aware of services such as the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children; summer food programs; and adult and child food programs.
- Assess caregivers for depression and refer them for treatment if depression is identified.
- Assess families for their method of discipline. Any use of corporal punishment should be discouraged.
- Assess whether the parent(s) and child have friends and/or family

who provide them with emotional support.

- Work with the family to build resiliency. Fostering a positive, caring relationship between child and parent is a way to enhance resiliency.

Community and Advocacy

- To demonstrate the need for more community services, educate the community about the effects of toxic stress and adverse childhood experiences.
- Educate the community about child factors, family factors, and community factors that are protective and help to build resiliency.
- Collaborate with the community to identify vulnerabilities and effective services. Be knowledgeable about community resources for at-risk children and families. Advocate for high-quality, evidence-based services and programs, including early childhood and K-12 programs, that reduce toxic stress and mitigate the negative effects of toxic stress on the health and development of children to ensure that the services are equipped to properly address children with a history of trauma in a manner that is not punitive. Advocate for the funding of home visiting programs.
- Promote healthy community environments. Advocate for

physically safe and hazard-free out-of-home placements for maltreated children. Advocate for foster placements in culturally similar environments.

- Join with the AAP chapter to work for better CPS-pediatrician communication. Join with the AAP chapter to advocate for better funding for CPS and to provide input into local and state services for children who are maltreated.
- Support policies and programs that strengthen economic supports to families and improve quality of child care and education.
- Advocate for more research to determine which strategies best help to reduce all forms of violence and how these strategies can be enhanced and translated into action in all communities.
- Consider serving on the local child protection team or other child abuse prevention programs in your local area as a consultant or advisor.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
AHT: abusive head trauma
CPS: Child Protective Services
HEEADSSS: home environment, education and employment, eating, peer-related activities, drugs, sexuality, suicide or depression, and safety from injury and violence
HPA: hypothalamic-pituitary-adrenal
HPV: human papillomavirus
TBI: traumatic brain injury

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