Chapter 10
Maltreatment of Children and Youth with Special Healthcare Needs (CSHCN)

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Introduction

Children with special healthcare needs are a readily identified pediatric population with increased risk for child maltreatment (Sullivan and Knutson 1998, 2000; Turner et al. 2011; Child Welfare Information Gateway 2018). The maltreatment of these children and youth is frequently unrecognized and undiagnosed in healthcare settings. Consequently, healthcare providers require education regarding the risk factors associated with maltreatment in children with special healthcare needs. Pediatric providers must be attentive in medical evaluations of children with diagnosed and suspected disabilities. The following chapter provides a review of characteristics related to maltreatment risk factors, perpetrators, and disabilities in children and youth with special healthcare needs. Practical guidelines for pediatricians in identifying maltreatment among children with special healthcare needs are presented along with guidelines for working with families. Case study examples of neglect, physical abuse, medical neglect, and medical abuse of children with special healthcare needs are also given.

The maltreatment of children with special healthcare needs is a significant public health issue. Reduction of childhood maltreatment and maltreatment-related deaths is a leading health indicator in Healthy People 2020. While chil-

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This chapter is dedicated in memory of Dr. Patricia M. Sullivan, a champion for children with special healthcare needs who were at risk for maltreatment.

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dren with special healthcare needs are not specifically referenced in Healthy People 2020 with respect to childhood maltreatment, they are discussed as a pediatric subpopulation requiring access to family-centered, coordinated, and comprehensive health systems. With increased access to such care, the likelihood of detecting maltreatment in special-needs children increases. Children and youth with special healthcare needs are defined by the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and Maternal and Child Health Bureau (MCHB) as:

> …those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (US Department of Health and Human Services 2008)

This definition is broad and inclusive in emphasizing the common characteristics of children with a wide range of medical diagnoses. The National Survey of Children with Special Healthcare Needs (NS-CSHCN) is a compendium of state and national data on the epidemiology of children with special healthcare needs. This survey is sponsored by the MCHB and conducted by the National Center for Health Statistics within the Centers for Disease Control and Prevention. It provides detailed information on prevalence, demographic characteristics, types of medical services needed, as well as access to and satisfaction with the services received. The survey does not gather child maltreatment information. Children are identified by use of publically funded healthcare services. Accordingly, their numbers are defined by socioeconomic parameters that do not include children from all socioeconomic strata. The 2009–2010 survey found that 15% of US children have special healthcare needs and 23% of households with children have at least one child with a special healthcare need. Thus, children with special healthcare needs are a significant group of US children.

Research on Maltreatment of Children with Special Healthcare Needs

There is a growing body of research conducted in medical settings on the maltreatment of children with special healthcare needs. Nearly three decades ago, Sullivan, Brookhouser, Scanlan, Knutson, and Schulte (1991) found that sexual abuse and a combination of sexual and physical abuse perpetrated by family members were the most common forms of maltreatment in a sample of 482 consecutively referred, maltreated children with medical disabilities in a specialty hospital setting. The medical diagnoses included communication disorders, learning disabilities, and cleft lip and/or palate. Males had high rates of sexual abuse, and placement in a residential school was identified as a major risk factor for sexual abuse among deaf and hearing-impaired children.

Researchers in Norway completed a retrospective study of 1293 hospitalized patients, aged from infancy to 16 years, admitted to 26 pediatric hospitals. Mailed questionnaires requested information on the incidence of children receiving medical services for suspected sexual abuse, including demographic characteristics of disability type, age, gender, and determination of the abuse allegations (Kvam 2000). Of the hospitalized children, 6.4% were identified as medically disabled. Diagnoses included intellectual disability, cerebral palsy, physical disability, and deafness. Children with these diagnoses had elevated risk for sexual abuse, and this risk increased with disability severity. The most susceptible children were those with behavior disorders, intellectual disability, and physical disabilities.

In the USA, Giardino, Hudson, and Marsh (2003) conducted an archival study of the medical records of consecutive referrals to a hospital-based healthcare team conducting medical evaluations for suspected child maltreatment in children with special healthcare needs. Sixty records, of children ranging from 3 to 16 years, were examined, and 31% of the children were victims of maltreatment. The recorded special healthcare needs diagnoses included attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorders, blindness, cerebral palsy, developmental delay, hearing impairment, intellectual disability, and speech/language delays.

Sullivan and Knutson (1998) completed a population-based study of maltreatment incidence and characteristics of all children seen at the Boys Town National Research Hospital over a 10-year span. A hospital-wide maltreatment prevalence of 15% was reported, and 6000 maltreatment incidents were recorded. Turner et al. (2011), using the 2008 National Survey of Children's Exposure to Violence, studied a representative national sample of 4046 children aged 2–17 years and examined the associations between several different types of disability and exposure to multiple forms of child victimization. Overall, children with any disability reported significantly higher rates of all forms of victimization, compared to children without disabilities. Children with physical disabilities experienced more maltreatment, sexual abuse, and property crime but were not subjected to increased rates of peer victimization. Results suggested that ADHD elevates the risk for peer victimization (bullying) and property crime, such as personal property theft. Patients with internalizing psychological disorders, such as post-traumatic stress disorder (PTSD), anxiety disorders, and depression, experience substantially higher levels of all four types of victimization, with particular risk for sexual abuse and maltreatment. Of note, mood disorder will often present in children with symptoms of irritability manifesting as tantrums, anger/rage exhibited with violence, or school refusal, instead of depression and withdrawal. Developmental/learning disorders only heighten the risk for property crime. The study did conclude that physical disability did not increase the risk for any type of victimization once confounding factors and co-occurring disabilities were controlled. Interestingly, all four types of victimizations increased with the age of the children but also among respondents whose mother had a psychological or behavioral diagnosis. Male respondents experienced greater odds of peer victimization but lower odds of sexual abuse relative to females. Socioeconomic status (SES) factors such as single-parent families, stepfamilies, and households with nonparent caregivers had increased odds of maltreatment and property crime – 2.3–2.4 times

the odds when compared with two biological parent families. Of note, this study utilized the special-needs children as respondents, so an underrepresented population is those children with more severe disabilities.

With respect to children younger than 2 years, Van Horne et al. (2015) utilized data from state statistics of live births, birth defect surveillance data, and substantiated reports of child maltreatment to examine a cohort of children with three birth defects: Down syndrome, cleft lip with/without cleft palate, and spina bifida. In the Down syndrome group, the prevalence of maltreatment was not statistically different from the prevalence in unaffected children. However, the children with spina bifida and cleft lip with/without palate demonstrated significantly higher prevalence rates than unaffected children. Neglectful supervision was the most common maltreatment form for all children in the study. Compared with unaffected children, the risk of neglectful supervision was similar (Down syndrome) or significantly lower (cleft lip/palate and spina bifida). However, medical neglect risk was 3.6 to 6.2 times higher in the cleft lip with/without palate and spina bifida groups compared with the unaffected group.

Finally, Turner et al. (2011) sought to further understand the connection of specific types of disabilities and the risk for particular types of victimization via an analysis of a nationally representative sample of 4046 children aged 2–17 years from the 2008 National Survey of Children's Exposure to Violence. Findings from this study showed that not all forms of disability were associated with equivalent levels of risk for various forms of victimization and that attention to sociodemographic variables as well as parental characteristics was important for adequate understanding of the risk for child maltreatment (Turner et al. 2011). In the authors' words:

> Findings also point to the importance of accounting for sociodemographic variations across disability groups as well as parent characteristics, such as psychological disorder, that may contribute to some types of child disability as well as some types of child victimization. Simple correlational studies between disability and victimization may overstate the degree of relationship unless these overlapping risk factors are controlled. Findings also suggest that victimization risk associated with one type of disability may often be confounded with other co-occurring types. Thus, controlling for other forms of disability is essential for understanding the types of victimization risks that arise from particular forms of disability. (p. 7)

Table 10.1 provides a summary of characteristics of children with special healthcare needs and the risk of child maltreatment.

In summary, children with disabilities – or more general, those with special healthcare needs – are at risk for various forms of child maltreatment, causing the US Department of Health and Human Services' Children's Bureau to conclude:

> Children with disabilities are at least three times more likely to be abused or neglected than their peers without disabilities (Jones et al. 2012), and they are more likely to be seriously injured or harmed by maltreatment (Sedlak et al. 2010). Even among children with disabilities, the risk of maltreatment varies by disability type (Jones et al. 2012; Lightfoot 2014; Turner et al. 2011). (Child Welfare Information Gateway 2018, p. 1)

Table 10.1 Characteristics of children with special healthcare needs and child maltreatment

Characteristics	Description
Types of maltreatment	Special-needs children are at elevated risk for all forms of maltreatment: physical neglect, medical neglect, physical abuse, sexual victimization, property crime Many special-needs children experience multiple types of maltreatment
Gender of victims	Males have higher odds of peer victimization (Turner) Females have elevated risk of sexual victimization (Turner)
Type of disability/ abuse associations	Children with special healthcare needs overall have higher risk: Maltreated children are 2.2 times more likely to have medical disability (Sullivan) Physical disability – highest risk for maltreatment and property crime (Turner) Developmental/behavioral disorder – most risk for property crime, neglect (Turner) ADHD/ADD – significant risk for peer victimization, maltreatment, property crime (Turner) Internalizing disorders – elevated for all forms of maltreatment, but particularly sexual victimization (Turner) Overall, interpersonal disorders and behavior disorders are mostly strongly associated with victimization risks (Turner)
Age of first maltreatment	>50% of children are abused before age 4 years (Sullivan, Turner)
Severity of maltreatment	Special-needs children experience more severe maltreatment, especially neglect, medical neglect, and sexual victimization (Sullivan)
Duration of maltreatment	Special-needs children experience longer duration of maltreatment, especially sexual, neglect, and medical neglect (Sullivan)
Perpetrators	Special-needs children are most likely to be maltreated by known individuals. Parents account for 95% of neglect perpetrators, 76% of physical abuse perpetrators, and 39% of sexual abuse perpetrators (Sullivan) Young, unmarried, lower educational attainment mothers have a higher risk of maltreating their children (Van Horne) Special-needs children born to pregnant women on Medicaid are at increased risk (Van Horne) Extrafamilial individuals account for 40% of sexual victimization of special-needs children (Sullivan)
Parental chronic illness or disability	~20% of maltreated special-needs children have a parent with chronic illness/disability compared with 10% of parents of nondisabled maltreated children (Sullivan) Maltreatment of special-needs children is significantly greater if the mother has a diagnosis of psychological/behavioral disorder (Turner)
Socioeconomic factors	Significantly more maltreated children with disability live in single-parent, stepparent, or nonparent caregiver households (Turner)

From Turner et al. (2011), Sullivan and Knutson (1998) and Van Horne et al. (2015)

Table 10.2 Significant associations between family socioeconomic stressors and disability group

Disability	Description of family socioeconomic stressors
Behavior/ developmental disabilities	Parental psychological/behavioral diagnosis, difficult parenting due to "unresponsive" children, school difficulties such as bullying, property crime, delinquency, disabled child in family, and child alcohol/drug abuse
Communication disorders	Difficult parenting, inadequate housing, financial problems, pregnancy/ birth of newborn, parental psychological/behavioral diagnosis, social isolation, and fetal alcohol syndrome
Health-related disabilities	Difficult parenting, financial problems, pregnancy/birth of newborn, parent is ill/disabled, parental psychological/behavioral diagnosis, social isolation, disabled child in family, and fetal alcohol syndrome
Mental disabilities	Difficult parenting, financial problems, pregnancy/birth of newborn, parent is ill/disabled, parental psychological/behavioral diagnosis, social isolation, disabled child in family, and fetal alcohol syndrome
Multiple disabilities	Pregnancy/birth of newborn and disabled child in family
Maltreatment type	Description of family socioeconomic stressors
Neglect	Difficult parenting, inadequate housing, financial problems, pregnancy/ birth of newborn, parental psychological/behavioral diagnosis, social isolation, and legal system involvement
Physical abuse	Parental psychological/behavioral diagnosis, parental drug/alcohol abuse, social isolation, and legal system involvement
Emotional abuse	Difficult parenting, inadequate housing, financial problems, pregnancy/ birth of newborn, parental psychological/behavioral diagnosis, parent is ill/disabled, parental drug/alcohol abuse, social isolation, and legal system involvement

Family Socioeconomic Stressors

Family socioeconomic stressors have been associated as correlates in the maltreatment of children with special healthcare needs (Table 10.2). Substantially more familial SES stressors are present in households with maltreated disabled children than in those of maltreated nondisabled children. Significant associations between family SES stressors, maltreatment, and disability have been identified in multiple research studies (Sullivan and Knutson 1998; Turner et al. 2011; Van Horne et al. 2015).

For Pediatric Providers

Hibbard and Desch (2007), in collaboration with the Committee on Child Abuse and Neglect and Council on Children with Disabilities of the American Academy of Pediatrics (AAP), developed guidelines for pediatricians to follow in their evaluations of suspected abuse in children and adolescents with special healthcare needs and disabilities. These are summarized as follows (adapted from Hibbard et al. (2007)):

1. Recognize signs and symptoms of maltreatment in all children and youth, especially those with special healthcare needs and disabilities.
2. Be aware that some disabilities can both mimic abuse and are at increased risk of accidental injury that gives the appearance of abuse.
3. Offer emotional support and referral for resources to the parents and family.
4. Evaluate all maltreated children for the presence of a disability.
5. Advocate for and assist families in acquiring a medical home.
6. Participate in both collaborative team evaluations and treatment plans for children with disabilities.
7. Assess a family's strength and need for resources to help with stress factors faced by the family.
8. Advocate for wraparound services for children with disabilities within the medical home to include identification, intervention, and prevention of maltreatment.
9. Advocate for the use of positive behavioral interventions and the elimination of aversive interventions, including physical restraints in home, school, and institutional settings for children with special healthcare needs.
10. Advocate for comprehensive healthcare coverage from both private and governmental insurers for children with all types of disabilities (see Table 10.3).

The families of children with special healthcare needs are essential partners for professionals in the care and support of these children. Table 10.4 offers suggestions for working in collaboration with those families in a respectful manner that ideally creates a partnership with them.

Case Studies

Case studies are briefly presented to illustrate the neglect and physical abuse of children with special healthcare needs.

Case 1: Physical Abuse

A 33-month-old male with global developmental delay, blindness, and seizures presented with erythema, swelling, desquamation, and blistering of the right hand and forearm. At the proximal forearm was a very distinct demarcation between normal skin and injured skin. His mother indicated that she had placed tube socks around his wrists during the night to keep him from hurting himself. While this boy had documented self-injurious behaviors (i.e., striking his face and eyes and scratching his skin), this injury pattern was consistent with an immersion burn, not a restraint injury (see Photo 10.1).

Table 10.3 Recommended protocol for health providers' evaluation of suspected abuse in children with special healthcare needs

Recommended protocol
1. Conduct a thorough physical examination
2. In so doing, look for signs of maltreatment including neglect and physical and sexual abuse
3. Is there a disclosure of maltreatment? Yes ___ no ___
Does the child's condition fit with the caregiver's explanation?
Does the explanation change or vary over time?
Is the explanation inconsistent with the child's developmental abilities?
Is there a credible disclosure of abuse?
Are there physical or historical findings consistent with abuse?
Is there evidence of poor physical care, inadequate nutrition, emotional neglect, or physical neglect?
Is there failure to follow through on medical recommendations or meet medical appointments?
4. Does the child have a disability or special healthcare need?
5. If yes, how does this disability or medical condition affect this child?
6. Gather collateral information about the child (school, family, and medical history)
7. Are there any conditions or syndromes that could be confused with abuse? (Monteleone 1998)
Mongolian spots
Folk medicine: Vietnamese coining, cao gio, Chinese spooning, Russian cupping, Mexican fallen fontanelle
Easy bruisability: hemophilia, vitamin K deficiency, leukemia, Henoch-Schonlein, erythema multiforme, Ehlers-Danlos syndrome
Burns and burn-like lesions: impetigo, car seat burn, frostbite
Congenital indifference to pain
Osteogenesis imperfecta
Hair tourniquet
Congenital syphilis
Copper, vitamin C or D deficiency
Toddler's fracture or fractures from passive exercise
Self-inflicted injuries, Cornelia de Lange syndrome, Lesch-Nyhan syndrome, headbanging

Case 2: Physical Abuse

A 9-year-old girl with mild intellectual disability was presented with linear bruising and scratches in the middle of her back. She had temporal lobe seizures and was exhibiting aggressive outbursts in school; subsequently her teacher had pushed her to the floor, pulled her arms behind her, and held her down by pushing his shoe in the middle of her back, causing the injuries to her back (see Photo 10.2).

Table 10.4 Suggestions for working with families

Suggestion	Description
Help the parents to	Focus on the child rather than on his/her disability Understand disability facts and issues, in order to work with their child constructively Acknowledge and respond to their feelings regarding the disability Accept the disability without devaluing the child Assist the child in developing individual and family potentials, together and independently Connect with local resources which would benefit the child and family members
Determine what the family knows about	Their child's disability, including his/her medical prognoses Educational implications and programs for their child Assistive devices for their child Available support groups for parents and their child
Enlist the father's participation since it provides	Paternal support, involvement, and commitment to the child, mother, and other family members Gender balance, strengthening the family bond, and lessening the risk of spouse abuse
Doctor-parent communication should be relevant to the parents'	Intellectual ability, language, communication methods, culture, and lifestyle Model effective communication and problem-solving skills Discuss and interpret available information Clarify problems and goals Facilitate problem resolution through collaboration Encourage boundary setting
Abuse prevention	Improve parental awareness and encourage proactive behavior across settings and situations Gain the cooperation and involvement of the parents in abuse prevention Build upon parents' love and commitment to their child Encourage parents to use the effective parenting skills they possess and to develop new skills as needed Provide guidelines to assist parents with selecting safe caregivers using personal references, state license, credential checks, police checks, and unannounced visits to the care center

Adapted from Sullivan (1996)

Case 3: Physical Abuse

A 12-year-old male with Kallmann syndrome (delayed or no puberty, no sense of smell), hearing loss, mutism, severe autism, intellectual disability, failure to thrive, short stature, and gastrostomy tube feeds was presented to the special-needs clinic with human bite marks on multiple parts of his body. Prior to the abusive injuries, the child had been placed in a group home with three other patients. These patients were all grown men with intellectual disability and inability to live independently. The patient visited the clinic that day to meet with his child psychiatrist and adjust his behavior medications. The group home staff member noted the patient had new

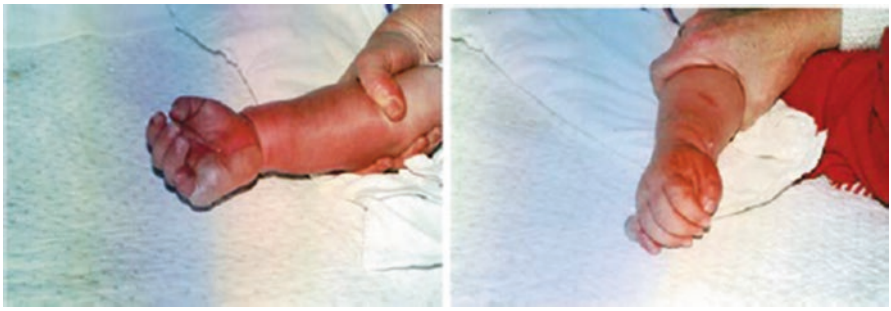

Photo 10.1 Injury consistent with immersion burn

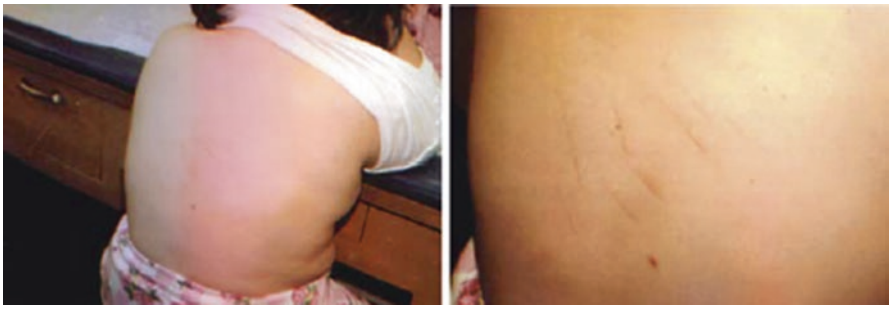

Photo 10.2 Linear bruising and scratches on child's back

"bruises" on his back, legs, and upper posterior thighs. Upon examination, the bruises were determined to be consistent with adult-sized human bite marks and in locations the child would be unable to reach with his own mouth. A full investigation ensued with Child Protective Services (CPS) and Adult Protective Services (APS), but the perpetrator was not discovered and the child returned to the home.

The patient was followed, and it was documented that the bruising from the bite marks had mostly resolved, until return to the clinic 2.5 months later. At this visit, new adult-sized human bite marks were noted on bodily areas the patient would be unable to reach on his own. Referrals were again sent to CPS and APS. The child currently remains in the group home without positive identification of the offender.

Case 4: Physical Abuse

Deep bruising of the upper arm, upper chest, and abdominal wall was found in this adolescent with mental retardation. Bruising of cavitous areas, such as the abdomen, is especially concerning for inflicted trauma (see Photo 10.3).

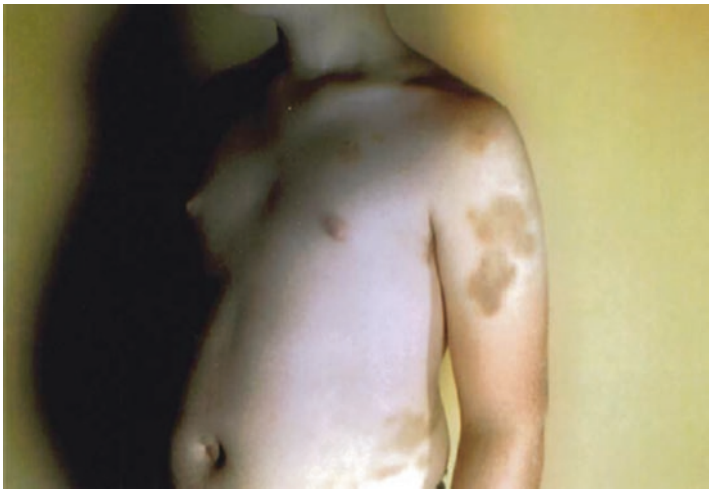

Photo 10.3 Bruising

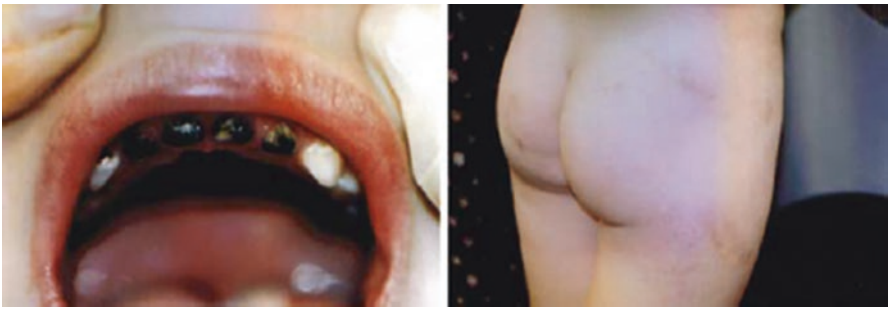

Photo 10.4 Decayed front teeth and bruising

Case 5: Physical Abuse and Neglect

This $4^{1}/_{2}$-year-old boy was taken into protective custody in the aftermath of a violent, domestic altercation between his inebriated parents. In foster care, he was noted to be developmentally delayed, especially in the areas of speech and self-care skills. He was microcephalic and had other physical features consistent with fetal alcohol syndrome. His upper front teeth were carious, and he had deep, old bruising and subcutaneous fat necrosis of the buttocks and outer thigh (see Photo 10.4).

Case 6: Neglect and Physical Abuse

A 16-month-old boy born with global developmental delays and hypotonia had been placed in medical foster care due to allegations of neglect and abandonment. Prior to entering foster care, a developmental assessment was performed confirming

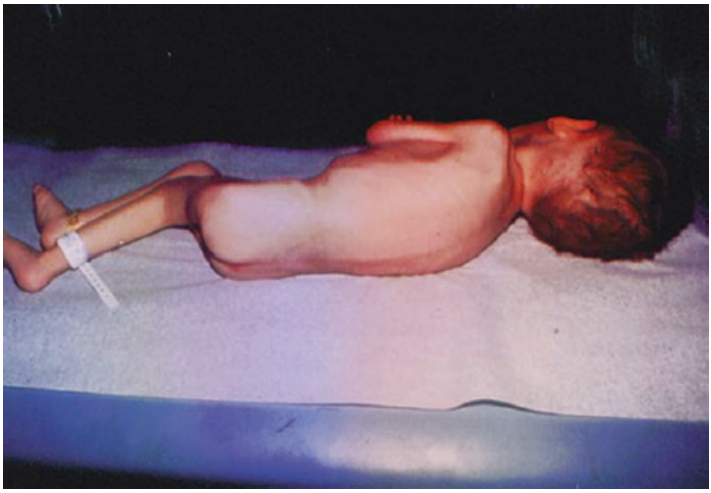

Photo 10.5 Emaciated child with diffuse osteopenia and old fractures

his diagnoses. At the time of the assessment, the child could sit with pelvic support and was beginning to roll over. He had started to finger feed and could hold a bottle by himself. He was alert and social with emerging expressive and receptive language skills. Within days of entering foster care, his condition deteriorated quickly and significantly, including dramatic weight loss, recurrent bruising, broken bones, retinal hemorrhages, and subdural hematomas. He was admitted to the hospital numerous times, each time discharged to his foster mother. The possibility of maltreatment was not initially considered because the foster mother was a nurse. Just prior to his discharge back to foster care after the third hospitalization, the nursing staff consulted the hospital child abuse team. They had long-standing concerns regarding the child's well-being and the foster mother, who exhibited controlling, disruptive, and possessive behavior during each of the child's hospitalizations. Physicians had repeatedly dismissed the nurses' concern. The child abuse team reviewed the child's history and physical examination and recommended a skeletal survey. He was found to have diffuse osteopenia and old fractures of his right proximal femur and left distal femur (see Photo 10.5).

Case 7: Neglect

This 4-year-old was discovered in an extremely deprived environment. He had marked developmental delays, short stature, and abdominal distension. He appeared to be a much younger child than his chronologic age. In foster care, he made significant gains in his development and growth (see Photo 10.6).

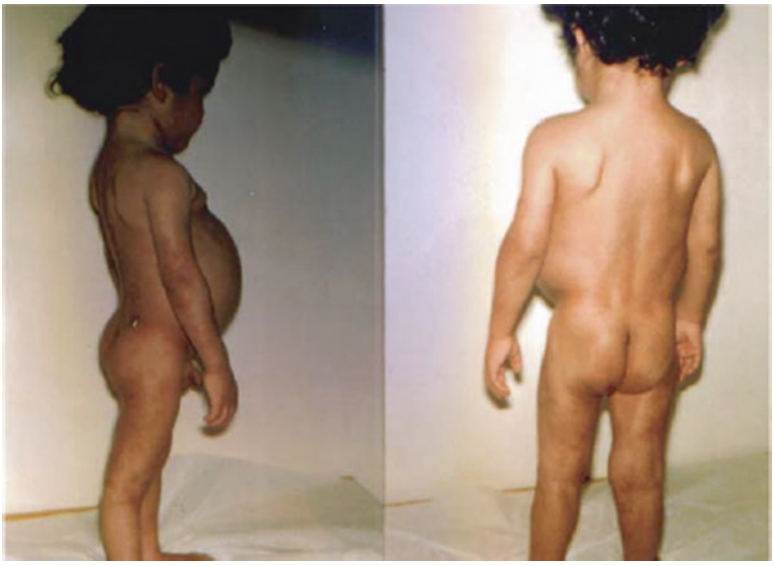

Photo 10.6 Child with short stature and distended abdomen

Case 8: Neglect

A 2-month-old female infant presented to the special-needs clinic to establish care. The child had a severe upper airway anomaly requiring placement of a tracheostomy tube and use of a ventilator to maintain normal breathing. Along with the tracheostomy tube, a gastrostomy tube was placed to ensure the child received adequate nutrition, as eating by mouth was difficult and potentially harmful for the infant. At the second clinic visit, it was noted the mother refused to have the patient weighed (she had been weighed in another clinic earlier that day), and when the mother's inappropriate feeding of the child was broached by the provider, the mother reportedly became agitated and refused to heed the provider's advice. This occurred despite noted weight loss in the infant. Recommendations were again made to the mother, but the mother stated, "The babies in the NICU are too fat, and I will not let my daughter become fat." She also conceded that she had discontinued any gastrostomy tube feedings, giving only oral nutrition.

At each subsequent visit, the infant's weight gain was deemed inadequate, and every attempt to engage the mother was fraught with hostility. The mother refused feeding increases, despite stagnant weight gain. The mother had the patient's gastrostomy tube removed against medical advice. Upon further investigation, it was revealed the child was receiving no therapy interventions and not attaining any developmental gains. After multiple clinic visits, psychiatry was brought in to evaluate the mother, but she refused. The mother then fired the special-needs clinic and the infant's pulmonologist, who both had discussed CPS involvement. The infant was evaluated by a community pediatrician who documented weight loss on two

separate visits and subsequently hospitalized the child. During this hospitalization, the diagnosis of neglect was documented, the gastrostomy tube was replaced, and the child was removed from the mother's custody. The child has since been placed in medical foster care and is growing appropriately and gaining developmental milestones with therapy intervention.

Case 9: Medical Child Abuse

A 2-year-old female followed closely in the special-needs clinic was diagnosed as a victim of medical child abuse after at least 1 year of suspicion by the primary medical provider. The child was a former extremely premature infant who had a prolonged NICU stay and had diagnoses of subglottic laryngeal clefts, ventriculomegaly, bronchopulmonary dysplasia, and reflux. Medical child abuse was initially suspected at 10 months of age, due to more than seven hospitalizations for apneic episodes. The child abuse physician followed the child for 1 year as the primary care pediatrician, and it was noted that the mother repeatedly notified the on-call providers of apneic episodes so severe that CPR was required. On further inquiry, the child always returned to baseline, and the mother was the only witness, despite having home nursing. Seventeen office visits to the special-needs clinic alone were documented over a 1-year period. The mother maintained the use of supportive respiratory equipment and convinced multiple subspecialists to prescribe inappropriate medications, based on symptom report only; the lab testing was normal in these instances. The infant was admitted for a therapeutic separation from the mother after it was determined that the mother repeatedly exaggerated symptoms, likely falsified symptoms, and maintained inappropriate treatments for the child.

While hospitalized and removed from the mother's care, the patient was weaned off her seizure medication after it was determined she did not have seizure activity. Her respiratory support machines were discontinued after studies indicated no need, and the child required only one medication for her mild chronic lung disease. She is currently in the father's custody and has supervised visitation with the mother.

Toward Prevention

Professionals who participate in the evaluation and response for suspected child maltreatment also participate in prevention efforts directed at preventing the problem before it actually occurs and thus avoiding the harm and its aftermath. The Children's Bureau, part of the US Department of Health and Human Services, offers guidance on child maltreatment prevention efforts directed at children with special healthcare needs at the community, family, and child levels of action, which are summarized in Table 10.5.

Table 10.5 Prevention strategies

Prevention level	Focus area	Description
Child "Teaching children with disabilities about the risks of abuse and neglect, as well as improving their ability to advocate for themselves, can help reduce maltreatment among this population" (p. 11)1.1.	*Help children protect themselves*	Involve children at risk of maltreatment in group-based educational opportunities about abuse and neglect Could include involving children in opportunities to: Learn about their body parts and functions What constitutes abuse and neglect How to communicate with a trusted adult if the need arises Distinguish between appropriate and inappropriate social interactions
	Maximize children's communication skills and tools	Provide opportunities to practice using effective communication skills Model healthy relationships and positive interactions with other children and adults and encourage others involved in children's lives to do the same Increasing children's verbal development and communication skills can help them advocate for their own needs and report maltreatment if it does occur
	Reduce children's social isolation	Children with disabilities may have limited involvement in developmentally appropriate activities (e.g., clubs, sports, jobs) that can help reduce social isolation Work with multidisciplinary teams of parents, foster parents, educators, and others to identify opportunities and assist caretakers in: Enrolling their children in appropriate activities Supporting them as they form and strengthen relationships with peers and trusted adults
Family "Parents and other caregivers spend the most time with their children; therefore, it is important to connect them with prevention programs that help them raise their children without resorting to maltreatment" (pp. 9–10)1.1.1.	*Home visiting*	Professional or paraprofessional staff can visit families to provide support and services in their homes. The visitor partners with the family to assess the family's strengths and needs and enhance their protective factors
	Parenting classes	General parenting classes should include a focus on parenting children with disabilities and accessing supports and services
	Support groups	Parents can share their experiences in a supportive group setting and trade information on resources, address issues related to their children's disabilities, and create informal support networks
	Respite care	Taking a break from the demands of caring for a child with disabilities can help parents reduce stress and the risk of abuse or neglect

(continued)

Table 10.5 (continued)

Prevention level	Focus area	Description
Community "…build upon general child maltreatment prevention efforts by incorporating the following strategies to raise awareness of the maltreatment of children with disabilities and help change societal attitudes about children with disabilities" (p. 9)1.1.1.	*Ensure community members are aware of the heightened risk*	Community members may not realize that children with disabilities are at an increased risk for maltreatment or understand how they can better identify, support, and protect children with disabilities who have been or are at risk for maltreatment
	Help others see children with disabilities as valued and unique individuals	Counteract negative attitudes by discussing the strengths of children with disabilities and their families and the unique perspectives they bring to their communities
	Promote inclusion of children with disabilities in everyday life	Identify and address physical and social accessibility barriers for children with disabilities and their families (e.g., access to public buildings and parks, equal opportunities to participate in sports or social events) to promote greater exposure and decrease isolation
	Encourage communities to share the responsibility for the Well-being of children with disabilities	Encourage greater community involvement to create a larger support network for children with disabilities and their families Help create and promote policies and educational opportunities that support the Well-being of this population

Child Welfare Information Gateway 2018. https://www.childwelfare.gov/pubPDFs/focus.pdf

Conclusions

Child maltreatment is a significant public health issue and should be an integral part of pediatric care, particularly for infants, toddlers, and preschoolers less than 5 years of age. Healthcare professionals need to be aware of the increased incidence of maltreatment among children referred to them for care and treatment and, accordingly, need to screen for histories of maltreatment and be alert for signs and symptoms of abuse and neglect. Given the high percentage of children with disabilities among maltreated children, healthcare professionals also need to routinely screen for disabilities so this information can be available to law enforcement and social service personnel in the conduct of child maltreatment investigations. Medical personnel play a key role in the identification and treatment of maltreated children with special healthcare needs. Pediatricians, in particular, play a significant role in the well-being of children with special healthcare needs. It is critical that they be well informed on maltreatment risks and characteristics as well as educate parents, caregivers, and other professionals about them. Pediatricians must not only provide a comprehensive medical evaluation but also play the crucial role in the prevention of child maltreatment as well. In so doing, healthcare professionals can impact the child victims and their families and help shape more informed public health policy.

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