CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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The Pediatrician's Role in Preventing Child Maltreatment: Clinical Report

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Pediatricians have always seen the value of preventing health harms; this should be no less true for child maltreatment than for disease or unintentional injuries. Research continues to demonstrate that maltreatment can be prevented, underscoring the vital roles of both the family and society in healthy childhood development and the importance of strong, stable, nurturing relationships in preventing maltreatment and building the child's resilience to adversity. This clinical report elaborates the pediatrician's multitiered role in supporting relational health from infancy through adolescence, from universal interventions assessing for maltreatment risks and protective factors to targeted interventions addressing identified needs and building on strengths. When maltreatment has already occurred, interventions can prevent further victimization and mitigate long-term sequelae. Advice is provided on engaging community resources, including those that provide food, shelter, or financial support for families in need.

INTRODUCTION

Child maltreatment (physical, sexual, and emotional abuse, neglect) is a complex, multifactorial phenomenon that presents in a bewildering variety of guises. Presenting signs and symptoms range from minor to fatal, from acute to chronic. More than an estimated 7.5 million children are referred to child protective services each year, out of a population of about 80 million. In 2021, 1820 children died of abuse or neglect.[1] These statistics, tragic as they are, are conservative estimates.[2] Child maltreatment can be a source of toxic stress that creates a significant risk of lifelong morbidity for the child, with consequences to social and cognitive development and to both mental and physical health.[3–6]

Most child maltreatment involves family or other trusted caregivers; neglect is the most common manifestation.[7] Maltreatment often results from situations in which adult caregivers lack the necessary resources,

abstract

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education, or supportive relationships to maintain a safe and nurturing environment. Child maltreatment can be thought of as a health risk that derives from a lack of healthy relationships and is often associated with economic or environmental stress.[8]

Prevention of child maltreatment revolves around helping families form and maintain relational health, defined as the safe and stable relationships that protect and nurture a child's growth and development, increasing resilience.[9,10] Supporting relational health offers benefits in healthy child development and well-being beyond keeping children safe from maltreatment. Pediatric health care providers (pediatric HCPs) have a unique opportunity to monitor and support these essential relationships.

This clinical report focuses on the prevention of child maltreatment and makes recommendations to providers of pediatric care who are eager to integrate child maltreatment prevention opportunities into their practice. It does not discuss targeted screening for child maltreatment or its diagnosis, reporting, evaluation, investigation, or treatment. For the purposes of this report, the term child refers to infants, children, adolescents, and young adults; the term pediatric health care provider (pediatric HCP) refers to pediatricians, pediatric medical subspecialists, pediatric surgical specialists, other physicians, and nonphysician clinicians in both ambulatory medicine and hospital medicine practice settings.

FOCUSING ON REDUCING RISKS AND IMPROVING RESILIENCE

For the pediatric HCP, the goals of child maltreatment prevention should be twofold: to minimize risk by anticipating, recognizing, and mitigating family and community stressors, and to increase resilience by enhancing child and family protective factors. In considering approaches to prevention, it is helpful to think of abuse or neglect as symptoms of underlying dysfunction, usually related to diverse and interacting contributors over time. An episode of abuse or neglect can be conceptualized as an imbalance, one in which acute or chronic stressors overcome the caregiver's ability to cope.

Children grow within their families, and families in turn function in the broader context of a larger community. Risk and protective factors for child maltreatment may occur at the level of the child, family, community, and society. Child maltreatment often arises from the interaction of multiple factors. An infant or child with an ongoing medical condition, for example, may make more demands on their parents than would a healthier child. Their parents' ability to provide effective care, in turn, might be challenged by unemployment, depression, or substance use. Some examples of child, parent, family, and community factors associated with child maltreatment are shown in Fig 1.

Conversely, protective factors at the individual, family, and community levels support the development of resilience.[11,12] Maximizing support for resilience at all levels is key to child maltreatment prevention strategies elaborated by the World Health Organization and the Centers for Disease Control and Prevention (CDC).[13,14] Five key preventive factors that help families cope with stresses are succinctly identified in the Center for the Study of Social Policy's Strengthening Families Protective Factors Framework (https://cssp.org/our-work/project/strengthening-families/):

- Parents' ability to manage stress and function well in the face of adversity
- Positive relationships to provide needed support
- Knowledge of parenting and child development
- Concrete support in times of need, particularly housing, food, and access to vital services, such as child care, health care, and transportation
- Interactions that teach children to communicate, self-regulate, and maintain relationships.

Recognizing families' sources of support and limitations enhances the pediatric HCP's ability to meet the specific needs of the family and deliver effective, family-

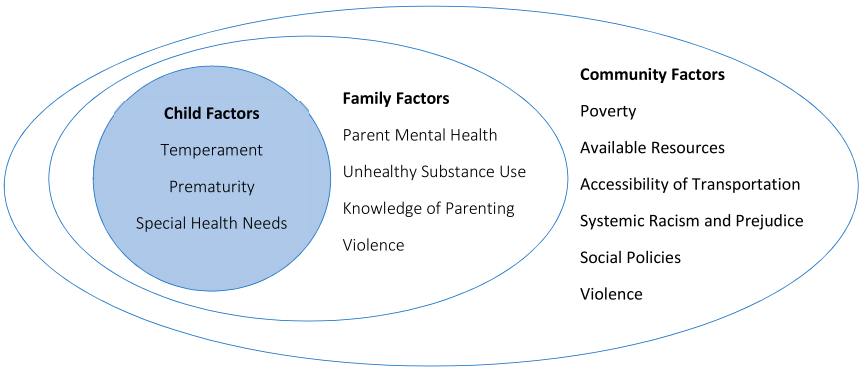

FIGURE 1
Examples of factors contributing to family risk or resilience.

focused care.[15] Especially in early childhood, pediatric HCPs observe and advise families at frequent intervals and can serve as trusted advisors who can facilitate referrals to community resources. The commitment of pediatric HCPs to assess risk and protective factors to promote resilience, although only a first step, can literally be lifesaving.

UNIVERSAL INTERVENTIONS: ASSESSING RISK AND PROTECTIVE FACTORS

History Taking: Including Relational Health

Social histories attuned to relational health should involve not only characteristics of the child but also of the parents, family, and other caregivers in the child's life, extending to the wider community. History taking, observation, and surveillance can identify characteristics particular to the children that are challenging for a parent. Normal variations in infant crying, feeding difficulties, toilet training, and defiant behavior have all been triggering events for physical or emotional abuse. The extra demands posed by a given child's physical, intellectual, or medical challenges, especially when chronic, can also overwhelm some parents' coping abilities, giving way to frustration, anger, and loss of self-control.[16,17] When chronic, stressful medical conditions are correctly identified, anticipatory guidance from the pediatric HCP may help set realistic expectations, reduce caregivers' anxiety, and teach coping and management skills.[18] Conversely, a child's good health, "easy" temperament, cognitive ability, and ability to adapt emotionally can all help the child and family to cope with stressors.[19]

How to Ask About Relational Health

Basic assessment of risks and resilience should be integral to pediatric health care. A universal approach, assessing all families rather than selecting some, can help lessen family concerns about stigma. Pediatric HCPs can explain that assessing all families seeking medical care is an established routine that arises from a shared concern for the child's health. Pediatric HCPs can communicate respect and earn trust by first asking about family protective factors and resilience and by explaining how the clinic may be able to help with problems that are identified. Social information should be updated periodically, such as at well-child visits. It can be useful to start each visit by asking "Has anything changed with your family since our last visit? How are you doing with [previously identified challenge]?"

The Pediatric Intake Form in the *Bright Futures* health supervision guidelines from the American Academy of Pediatrics (AAP), also known as the Family Psychosocial Screen, provides one blueprint for assessing family functioning. *Performing Preventative Service: A Bright Futures Handbook* (available for download at: https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/Pages/default.aspx) is a free companion reference that provides practical instruction and recommends many useful resources for the practitioner, including specific tools and techniques.

A variety of tools for assessing risks and resilience have been published in peer-reviewed literature and range from broad assessments to targeted measures of specific conditions. Some specifically address resilience; others explore conditions often associated with maltreatment, such as intimate partner violence, parental mental health, and unhealthy substance use. A few of these are listed in Table 1.

The AAP Screening Technical Assistance and Resource Center provides valuable and practical help in screening for developmental issues, parental depression, family strengths, and social determinants of health (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Social-Determinants-of-Health.aspx). These tools may be administered during or before the medical encounter, by the pediatric HCP, online, or by office staff.[20] However the questions are asked, it is imperative that all results be reviewed and that responses be addressed with the family. Disclosures of family stresses are often made at some emotional cost, and to ignore them betrays trust, imperiling future communication.[21,22] Acknowledgment should be nonjudgmental and validate the concern. Asking "How do you think this [identified condition] is affecting you and your family?" opens the door to more information and collaborative problem solving. If a problem is not in need of current attention, or the caregivers choose not to discuss it at that time, pediatric HCPs can maintain vigilance, offering help if and when help is wanted.

Relational health questions can trigger emotional responses in caregivers. Pediatric HCPs who choose to ask about parental histories should be prepared to do so in a trauma-informed environment, ready to provide support and referral where needed. Staff training in the consequences of trauma and in avoiding personal and institutional biases can help make the process safe and comfortable for all involved.

Specific factors identified by these tools may reflect the results of racism, historical trauma, or other forms of oppression that have been years in the making. Acknowledgment of system-level stressors by the pediatric HCP may be a potent tool to build rapport with families affected by them and can help in focusing supportive efforts.[23]

Caregivers' histories of their own early adversity have proven useful in predicting problems with their children's development, behavior, and health care use.[24–26] Implications for child maltreatment prevention, however, are less clear. Screening for adverse childhood experience (ACE)s, which assigns a numerical score reflecting

TABLE 1 Examples of Useful Assessment Tools

	Focus	Factors Evaluated	Tool	Questions
Parent or family focused	Risk	Parent or teen depression	PHQ-9 and -2[109,110]	9 and 2, respectively
	Risk	Parental depression	SEEK PQ-R[a]	20
	Risk	Parental unhealthy substance use		
	Risk	Intimate partner violence or domestic violence		
	Risk	Food insecurity		
	Risk	Harsh punishment		
	Risk	Parental (postpartum) depression	Edinburgh Depression Scale[b]	10
Child specific	Risk	Neurodevelopment	Ages and Stages Questionnaire	Varies by age
	Risk	Adolescent substance use	S2BI[c]	3–7 questions depending on patient responses
Protective factors	Resilience	Emotional support	Protective Factors Survey[d]	65
	Resilience	Concrete support		
	Resilience	Nurturing and attachment		
	Resilience	Family Functioning		
	Resilience	Knowledge of parenting and child development		
Positive experiences	Resilience	Perceived safety and security	Benevolent Childhood Experiences Scale[e]	10
	Resilience	Positive and predictive quality of life		
	Resilience	Relational support		
Positive experiences	Resilience	Family support	Positive Childhood Experiences Scale[f]	7
	Resilience	Safety and security		
	Resilience	Relational support		
	Resilience	Community support and belonging		

PQ-R, SEEK Parent Questionnaire–R.

[a] Dubowitz H, Lane WG, Semiatin JN, Magder LS. The SEEK model of pediatric primary care: can child maltreatment be prevented in a low-risk population? *Acad Pediatr.* 2012;12(4):259–268.

[b] Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry.* 1987;150:782–786.

[c] Levy S, Weiss R, Sherritt L, et al. An electronic screen for triaging adolescent substance use by risk levels. *JAMA Pediatr.* 2014;168(9):822–828.

[d] Sprague-Jones J, Counts J, Rousseau M, Firman C. The development of the protective factors survey, second edition: A self-report measure of protective factors against child maltreatment. *Child Abuse Negl.* 2019;89:122–134.

[e] Merrick JS, Narayan AJ, DePasquale CE, Masten AS. Benevolent Childhood Experiences (BCEs) in homeless parents: a validation and replication study. *J Fam Psychol.* 2019;33(4):493–498.

[f] Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive childhood experiences and adult mental and relational health in a statewide sample: associations across adverse childhood experiences levels. *JAMA Pediatr.* 2019;173(11):e193007.

the variety (although not the intensity) of adverse experiences in a child's or caregiver's history, has vocal advocates.[25,27] The state of California recently enacted its ACE-Aware Initiative, training health care providers on ACEs and their importance and providing them payment for each patient screened (https://www.ACEsaware.org/). Critics have raised questions about the practical use of the ACE questionnaire at the individual level, cautioning that further research and development are needed before a widespread program of formal ACE screening is undertaken for patients or caregivers.[4,7,28–31] For this reason, the AAP does not currently recommend universal ACE screening.[32]

Even more important than knowing what is going wrong in a family is knowing what is going strong. Tools are available to help assess resilience or protective factors. Several are listed in Table 1. The Positive Childhood Experiences scale[33] has been useful in researching the predictive value of social support, which has led to Health Outcomes from Positive Experiences,[34,35] a framework that stresses monitoring development in 4 crucial areas: relationships, safe environments, social engagement, and opportunities for emotional growth. Further discussion about assessing for positive experiences can be found on the Health Outcomes from Positive Experiences Web site at https://positiveexperience.org/wp-content/uploads/2021/11/Four-Ways-to-Access-Positive-Childhood-Experiences.pdf.

Including Relational Health in Anticipatory Guidance

Prevention of maltreatment can begin at the very first family contact with the pediatric HCP and continue through all subsequent visits. By anticipating the challenges inherent to childrearing and guiding families through difficult times, pediatric HCPs bolster family resilience before inappropriate

expectations for child behavior can give rise to frequent, harsh, or physically punitive disciplinary efforts. Well-child visits offer valuable opportunities for pediatric HCPs to preemptively discuss anticipated and challenging behavioral and developmental issues ranging from infant crying, toilet training, and discipline to adolescent self-assertiveness and independence.[36,37] Subsequent visits allow follow-up on previously identified issues. The more frequent visits recommended for children and adolescents with disabilities and other special health care needs should also include anticipation of added caregiver stresses and practical guidance on maintaining a healthy parent-child relationship.[38] Table 2 gives examples of opportunities for incorporating child abuse maltreatment prevention into a pediatric health supervision visit by addressing parental support and coping skills at various developmental stages. Although this list is not exhaustive, it highlights key recommendations for anticipatory guidance. The AAP offers a conceptual framework and a variety of practical resources for supporting early relational health at https://www.aap.org/en/patient-care/early-childhood/early-relational-health/.

One well-studied tool for primary prevention of child maltreatment in the office setting is the evidence-informed Safe Environment for Every Kid (SEEK) model (information

TABLE 2 Opportunities to Integrate Child Maltreatment Prevention Into Health Supervision Visits[111]

Age	Parent Coping Skills and Support System
Prenatal or first visit	• Social determinants of health: Living situation or who lives in the home? History of unhealthy substance use or intimate partner violence? Are there financial problems and/or poverty? • Was the pregnancy planned? • Parent and family health and well-being: History of mental health problems? What were the parents' experience(s) with trauma? • How were the parents parented and disciplined? • Who will care for the infant? What is the family's support system?
Newborn	• Social determinants of health changes; • infant crying and calming; • positive parent-newborn interactions and expectations; • family support system: Identify 3 friends or family members who can help (safety line)
First months	• Social determinants of health changes; • infant crying and attachment, loving is not "spoiling"; • normal development and expectations (sleeping and waking, feeding). Positive parent-newborn interactions; • postpartum depression; • family support system
Cruiser or toddler	• Social determinants of health changes; • normal development and age-appropriate expectations (behaviors or temper tantrums, eating, language); • sleep routines and issues; • discipline = teaching; • toilet-training; • importance of routines and play; • family support system
Preschool	• Social determinants of health changes; • sexual development, teach child names for genitalia; • teach child self-stimulation is appropriate in private, but not in public; • safe touch or unsafe touch; • normal development and age-appropriate expectations; • discipline = teaching; • model nonviolent anger management and conflict resolution; • family support system
Middle childhood or school	• Social determinants of health changes; • normal development and age-appropriate expectations, appropriate supervision; • discipline = teaching; • model nonviolent anger management, emotion regulation or coregulation, and conflict resolution; • respect private parts of others and others to do the same; • personal safety; peer pressure; internet use; • family relationships, importance of family routines or time together
Adolescence	• Social determinants of health changes; • normal development and age-appropriate expectations; • discipline = teaching; • dating violence and signs of healthy versus unhealthy relationships; • model nonviolent anger management, emotion regulation or coregulation, and conflict resolution; • family relationships, importance of family routines or time together

at www.SEEKwellbeing.org). SEEK offers a practical approach to help pediatric HCPs address prevalent, targeted risk factors (parental depression, major stress, unhealthy substance use, domestic violence, food insecurity, and harsh punishment) in families with children 0 to 5 years of age. Core components include: (1) online training for pediatric HCPs; (2) the SEEK Parent Questionnaire–R, a brief tool used at selected well-child visits; (3) the Reflect–Empathize–Assess–Plan approach to efficiently assess and initially address problems; (4) principles of Motivational Interviewing; (5) facilitating referrals; and (6) SEEK (or similar) parent handouts customized with information on local resources. Where possible, a social worker or behavioral health professional partners with pediatric HCPs and parents. Findings from 2 large randomized controlled trials found that SEEK reduced rates of child abuse and neglect and harsh punishment.[39,40]

Another more tightly targeted program, the Period of PURPLE Crying,[41] attempted to reduce the community incidence of abusive head trauma (AHT) by educating all parents of newborn infants during their postpartum hospital stay via a brochure and video and obtaining a signed commitment statement indicating their understanding that shaking is harmful. An 8-year follow-up of province-wide implementation in British Columbia (adding home visits and additional reinforcement) showed significant reductions in AHT.[42] Other evaluations, however, although showing improvement in parental knowledge and confidence, were unable to demonstrate any significant reduction in AHT.[43–45]

TARGETED INTERVENTIONS

After risk assessment there may be a need for further evaluation and intervention to help build protective factors and address risk. Targeted (also called "secondary" or "indicated") child abuse prevention interventions focus resources on families with identified risk factors. In some instances, pediatric HCPs or clinic staff can provide education and guidance, such as helping a parent address a child's challenging behaviors. In other instances, such as intimate partner violence, parental depression, or substance use disorders, Pediatric HCPs serve to facilitate referrals—a potentially pivotal role that may make a significant difference in only a few strategic minutes.[46]

Home visitation programs, such as Nurse Family Partnership, Child FIRST, and Healthy Families America, are well researched targeted child maltreatment prevention programs. Qualifying families may include first-time parents, single and/or young parents, low-income households, or those with other heightened risks, depending on the program. Although different models have varying content and emphasis, all programs share a similar approach in which a professional or paraprofessional enters the family's home to offer support, mentorship, and guidance on providing a nurturing and safe environment for the child.[14,47] The evidence regarding home visiting programs in preventing child maltreatment is mixed, possibly reflecting variations in program implementation and focus and the difficulty of ascertaining child maltreatment outcomes. However, certain programs have been associated with up to a 45% reduction of child maltreatment, a decrease in multiple family risk factors,[48–51] decreased harsh parenting practices,[52] and decreased injuries from child maltreatment.[53,54] Programs with the most significant effect have used highly qualified and trained staff, have research-based or quality improvement approaches to program development, and target families with multiple risk factors.[49,50,54,55] More information on home visitation programs can be found in the AAP policy statement "Early Childhood Home Visiting."[47]

Parenting programs, when effective, may enhance family resilience. Although services vary from one program to another, the overarching shared goal is to teach parenting skills to help build a safe and supportive home environment for children. The best studied parenting program is the Positive Parenting Program (often shortened to "Triple P"), which was developed as a tiered series of interventions offering training and support to meet different families' levels of need, from brief interventions to family focused counseling and services addressing specific issues, such as discipline or behavioral concerns. Triple P is not only a prevention program but also has reactive elements to address past maltreatment and recurrence of abuse.[14,56,57] Studies have shown decreases in substantiated child maltreatment, foster care placements, and child injury.[58,59]

Other parenting programs have also shown success in reducing child maltreatment and related risk factors, such as less use of aggressive discipline, including corporal punishment, and less parental support for harsh discipline.[14] The use of corporal punishment is associated with child physical abuse. The AAP policy on the use of effective discipline suggests that "Parents, other caregivers, and adults interacting with children and adolescents should not use corporal punishment (including hitting and spanking)." The AAP also advocates banning the use of corporal punishment in out-of-home educational settings.[37]

Early childhood education programs such as Head Start, Early Head Start, and Child-Parent Center have been shown to be effective in reducing child maltreatment.[60,61] These programs offer preschool enrichment while encouraging family engagement, increasing and strengthening family relationships to promote early child development. As with parenting training, these programs may vary widely. Research has shown that families receiving early childhood education services have fewer child welfare services encounters, fewer out-of-home

placements, and decreased child maltreatment rates, particularly when combined with a home visitation program.

Pediatric HCPs should become familiar with home visitation programs, parenting programs, and early childhood education programs in their communities and learn how to connect their patients' families with these services.

AFTER MALTREATMENT HAS OCCURRED: PREVENTING FUTURE HARM

Children and adolescents who have suffered from child abuse or neglect remain at risk for future maltreatment, even if removed from their homes.[62,63] They are also at increased risk of toxic stress and related poor health effects. The goals of intervention should include preventing further victimization (so-called "tertiary" prevention) and intervening to minimize the effects of previous maltreatment. Success largely depends on strengthening child and family resilience through supportive relationships.[64–66]

Paradoxically, the path to safety for some children often includes further traumatic transitions. Victims may be removed from birth parents, perhaps to kinship care, foster homes, and even adoption. Each move itself may be stressful, all the more for being repeated. Pediatric HCPs can watch for signs and symptoms of dysfunction while helping kinship, foster, and adoptive parents understand this dynamic and respond in a sensitive fashion. Pediatric HCPs will find practical guidance in supporting children and families in foster, kinship, or adoptive care relationships in 2 AAP toolkits: Helping Foster and Adoptive Families Cope With Trauma (https://downloads.aap.org/AAP/PDF/Foster%20Care/hfca_foster_trauma_guide.pdf) and Safe and Sound (https://www.aap.org/en/patient-care/foster-care/safe-and-sound-helping-children-who-have-experience-trauma-and-adversity/).

Patients suffering from toxic stress may present to the pediatric HCP in a variety of ways. Early maltreatment may lead to cognitive challenges and difficulties with mood regulation, which can persist even after the child is in a safe environment. The resultant problematic behaviors may present to the pediatric HCP as symptoms of attention deficit/hyperactive disorder, learning disabilities, depression, or other mood disorders.[6] The presence of such behavioral symptoms should raise a pediatric HCP's concern about previous adversity and toxic stress. Chronic activation of the child's threat response system may produce persistent anxiety that manifests in functional somatic complaints, such as gastrointestinal tract dysfunction, headaches, and sleep disorders.[67,68] The patient's social or medical history may provide additional clues to previous adversities (including those unrelated to maltreatment, such as natural disasters or community violence).

Enrollment in foster or kinship care or a history of other involvement with the child welfare system signal a need for further history and heightened surveillance, even if the child presently appears to be doing well.[69,70] Symptoms arising from previous trauma may not be immediately apparent; behavior may change over time in new environments or developmental stages. The AAP recommends that any history of child maltreatment, along with consequences, such as out-of-home care, warrants provision of mental health services, preferably from therapists familiar with evidence-based trauma therapies.[2]

Understanding a child's trauma history assists a pediatrician in accurate diagnosis and directs therapeutic interventions. When the pediatric HCP is well-informed and aware of the effects of trauma, those effects are less likely to be mistaken for willful defiance or an idiopathic condition that can only be treated with medication. Trauma-aware practices recognize the importance of supportive relationships and work to build resilience in the family and child.[32,71]

Pediatric HCPs can monitor symptoms and the progress of therapeutic interventions by scheduling frequent appointments to assess adherence to recommended treatment or care, address family concerns, and track growth, development, and well-being. The AAP recommends that children and adolescents who have experienced maltreatment be followed more frequently, recommending 3 visits in the first 3 months after maltreatment is identified and every 6 months thereafter.[69]

SOCIOECONOMIC SUPPORT FOR FAMILIES IN NEED

Low family income is statistically associated with child abuse and neglect.[19,72] Public policies that improve the socioeconomic conditions of families are found to have a significant impact on children's health.[73] Caregivers' perception of economic stress and helplessness correlate with harsh punishment and child abuse, and mitigation of these economic conditions improves child safety.[74–76] Research has consistently shown that public policies that alleviate economic stressors are associated with reductions in reports of child abuse and neglect and improved outcomes.[77] A wide variety of programs has been studied. Paid parental leave at the time of birth or adoption of an infant has been shown to significantly reduce AHT.[74] Refundable earned income tax credits have been associated with fewer reported cases of child neglect[78] and are associated with trends toward lower rates of physical and emotional abuse.[79] Families enrolled in the Supplemental Nutrition Assistance Program (SNAP) are involved in significantly fewer reports of child abuse and neglect.[80] States that expanded Medicaid coverage also dramatically decreased reports of child neglect, although abuse reports remained stable.[81] When US states are compared, the incidence of all forms of maltreatment is inversely correlated with total expenditures on benefit programs for families living in poverty.[82] There are

indications that widespread and effective family supports led to reductions in child abuse during the first phase of the coronavirus disease 2019 pandemic.[83,84]

AAP policies on the health effects of poverty (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/practice-tips.aspx) and racism[23] help pediatric HCPs link families with sources of support and provide further discussions of the pediatrician's role in policy formation and advocacy. At the most basic level, the pediatric family-centered medical home can help families by providing information related to federal benefits (including the Special Supplemental Nutrition Program for Women, Infants, and Children, Supplemental Nutrition Assistance Program, and the earned income tax credit) and state programs, notably including paid family and medical leave. Nongovernmental organizations may also assist with legal aid and with shelter, food, and other concrete family supports. Pediatric HCPs and staff can work to form relationships with local resources and collaborate in providing access to those resources in a culturally sensitive and trauma-informed fashion.

The pediatric HCP's larger role extends to advocacy, speaking to policy makers to make services more equitable and accessible for patients. Evidence for policies' impact on child abuse and neglect prevention is available from the CDC's publications *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*[14] and *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Evidence Available*.[85]

UTILIZING RESOURCES OUTSIDE THE MEDICAL FACILITY

Familiarity with resources available in one's community facilitates referrals. Table 3 lists a few types of widely available resources. Ideally, pediatric HCPs can work collaboratively with parents and community agencies without disclosing unnecessary personal information. Familiarity with a community resource ensures a more effective referral.

Most families adhere to beliefs or traditions involving how children should be raised. Many may have relevant experience with previous referrals. Careful listening and consideration may be useful in helping families contextualize the advice that they receive. Verbally confirming the family's understanding and intention can be valuable.

Clinics may consider developing parent handouts with information on community resources and eligibility criteria for common problems (see the AAP Referral Resources Worksheet at https://downloads.aap.org/AAP/documents/STAR-Center-Referral-Resource-Template.docx). Community resource information may be displayed in the waiting area for easy access.[86]

Medical staff can directly help families overcome the all-too-common logistical challenges of connecting with community resources. They should begin by planning with a parent what is needed for the referral (eg, income verification or insurance coverage) and providing contact information for the resource. When time permits or need is pressing, trained staff can be introduced and briefed to help parents set up an appointment.

After any referral, it is always a good idea to follow-up to address any concerns the family might have. This process helps staff to address possible barriers and underscores that the provider feels the referral (and thus the family's need) is important. A wealth of practical tips on office-based referral strategies may be found at https://www.aap.org/en/practice-management/bright-futures/bright-futures-in-clinical-practice/.

BARRIERS TO GOOD PREVENTION PRACTICE

Prevention of child maltreatment builds on skills common to pediatric practice. Nevertheless, some pediatric HCPs identify multiple barriers to effectively assessing patients and providing adequate support related to safety and relational health. Many describe a general lack of comfort with discussing relational topics and feel they lack education and training on evidence-based community resources. Pediatric HCPs may sometimes feel that screening and intervention for relational issues are beyond their purview or pertain to issues beyond remediation or that there is simply too little support and payment for spending the time needed to implement best practices.[87–89]

Although daunting, these challenges may be addressed with education and preparation, to the benefit of all. When pediatric care teams are equipped with knowledge of evidence-based interventions, available community resources, and best coding practices, they can guide families without overburdening their practice. Practices that have incorporated formal screening measures for family stressors and strengths have reported that they are well tolerated and provide added satisfaction for both families and office teams.[29,90] Continued advocacy is needed to help guarantee that public and private insurers will help support these efforts.

Advance planning can greatly improve both efficiency and effectiveness. Scheduling realistically for complicated visits, arranging follow-up visits for ongoing issues, and delegating portions of the appointment (like relational health questions or education) to others in the office may improve patient flow. Creating easy access to contact information for family support resources and educating staff on their various roles and responsibilities establishes practice pathways for commonly encountered situations. Pediatric HCPs and staff should periodically review practice pathways, policies, and mandated reporting requirements for child abuse and neglect.

Screening and coordination of services are characteristic of family-centered medical homes (FCMHs), practices with the ability to follow-up and coordinate referrals for services, maintaining continuity and serving as patient and family advocates within the community. The AAP

TABLE 3 Examples of Resources to Assist Practices in Linking Families to Community Resources

Community Resources	Needs Addressed	Type	Examples
National Hotlines and Websites	Identifies local resources	NGO	https://www.foodpantries.org/
		Federal govt.	https://www.usa.gov/benefits-grants-loans
		NGO	https://www.childcareaware.org/resources/map/
SNAP	Federal program; Provides nutrition benefits to low-income individuals and families through its nationwide network of field offices	Federal govt.	https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Federal program; Helps women and children, up to age 5, with free healthy foods, advice on healthy eating and referrals to health, welfare, and social services	Federal govt.	https://www.fns.usda.gov/wic
SAMSHA Treatment Locator	Locates resources for drug and mental health treatment, by address/zip code	Federal govt.	https://findtreatment.samhsa.gov/
State Government Websites (examples)	Specific Issues (eg, unhealthy substance use)	State govt.	https://dhs.maryland.gov/; https://dphhs.mt.gov/cfsd/; https://dpbh.nv.gov/Programs/Programs/
County Health Departments (example)	Specific Issues (eg, food banks, smoke alarms, mental health)	County govt.	https://mentalhealth.westchestergov.com/
City Websites (example)	Specific Issues (eg, food banks, smoke alarms, mental health)	Local govt.	https://www.fayettevillenc.gov/city-services
Dialing 2-1-1	Widely available; identifies and connects to local resources (eg, food banks, substance use, domestic violence, employment, health care)	NGO (United Way)	https://www.211.org/
Legal Aid Clinics	Help those that are financially eligible with civil legal problems, such as partner violence, employment, and housing	NGO	https://www.mdlab.org/
Aunt Bertha (now FindHelp.org)	Finds resources for problems, such as finding food, help paying bills; enter zip code and targeted problem	NGO	https://www.findhelp.org
The Help Me Grow National Center	Links community resources, such as education, health care, and family services	NGO	https://helpmegrownational.org
Early Head Start	Support parental and infant development and can further enable family success, promoting housing and financial stability	Federal govt.	https://eclkc.ohs.acf.hhs.gov/center-locator

NGO, nongovernmental organization; SAMHSA, Substance Abuse and Mental Health Services Administration.

has long championed the FCMH model.[38,91] Broadening access to FCMHs for all patients will entail advocacy to provide more realistic funding for medical services, care coordination, and family health services.[92]

SPECIAL TOPICS

Sexual Abuse Prevention

In general, children are sexually abused by adults known to them: the majority are family members, health care providers, coaches, religious leaders, and other trusted adults with access to children and adolescents are also perpetrators. Community-based approaches like Darkness to Light's "Stewards of Children" (www.d2l.org) seek to educate adults to recognize and intervene in situations in which risk for sexual abuse is high. These directed strategies have led to improved protective practices in child sexual abuse prevention, such as more stringent background investigations in the hiring process or recruitment of volunteers, minimizing unsupervised time with children, supervising older children with younger children, and recognizing and reporting suspected abuse.[93] Pediatric HCPs who work with school systems, summer camps, after-school programs, and religious or cultural programs should be aware of best practices in preventing sexual abuse.[94]

Early sexual abuse prevention strategies focused on the child: helping potential victims recognize abusive situations and resist, escape, and disclose through teaching children about "good" and "bad" touches.[95] These programs have been criticized for putting the onus of child sexual abuse prevention on the shoulders of victims rather than on the adults responsible for ensuring their safety.[96] The good or bad touch dichotomy also runs the theoretical risk of leading children to confuse healthy sexual urges with something shameful. Although they have produced increases in awareness and disclosures,

victim education programs have not been shown to prevent abuse.

Primary prevention of sexual abuse ideally involves helping families raise their children around healthy, respectful sexual relationships, enhancing a child's self-esteem and communication skills, and providing age-appropriate education on sexual development to child and parents. During office visits, pediatric HCPs can model such respectful behavior. Asking the parent's and the child's permission before a genital examination (or any touch), teaching parents to consistently use proper anatomic names, encouraging discussion of modesty and privacy needs, and providing nonjudgmental anticipatory guidance around sexual issues all may help. Although this approach is advocated as good practice by the AAP,[15] its value in preventing child sexual abuse and adolescent sexual assault remains speculative.

Adolescents

Prevention of abuse in adolescents can be particularly challenging. Unlike infants and children, adolescents spend most of their time out of the home environment and are less likely to present to a medical facility for care. They are older than other pediatric patients, so types of maltreatment such as harsh discipline, emotional abuse, and supervisory neglect are often well established by the time of presentation to a new pediatric HCP.

Presentations of child maltreatment vary with age.[1] Physical abuse is less common in older children and adolescents than in younger children but still occurs, usually in the context of discipline. As teenagers gain independence and the consequences of misbehavior become more threatening, parents who rely on discipline by physical punishment may feel a need to escalate. Injury may result, especially if the adolescent responds in kind.[97,98]

Puberty correlates with an increase in reports of sexual abuse and assault, seen mostly in female adolescents.[99] Child abuse is committed by adult family members or other adults in supervisory capacities (eg, coaches, teachers, and counselors); sexual or physical assault by unrelated adults or peers is more properly termed sexual assault. Such assaults, however, are more commonly seen after previous experience of child sexual abuse, so addressing previous maltreatment is felt to help minimize further victimization.[100,101] The AAP provides guidance for pediatric HCPs on integrating sexuality and teen health maintenance.[102]

Although physical neglect is less common in older patients, emotional, educational, and medical neglect remain, with identification and intervention both complicated by teenagers' growing independence. Adult protective service agencies may be called in to address problems of individuals 18 years or older.

Interventions can also be more difficult, given a history of ongoing maltreatment. Insecure attachment styles may undermine trust and may be abetted by long practice of overt or covert defiance of perceived authority figures. Poor interpersonal relationships at home may impair development of emotional awareness and communication skills are often delayed. In treating older patients, the pediatric HCPs' focus shifts from preventing the onset of abuse to building resilience and prevention of further victimization.

Certain populations of adolescents may be particularly vulnerable. Increased independence and the onset of puberty raise caregivers' fears just as hormonal factors amplify teenagers' emotional responses. Lesbian, gay, transexual, bisexual, and questioning+ teens may suffer emotional and psychological abuse at home.[103] Neurodiverse adolescents and other teenagers with special medical or mental health needs may similarly pay a price for failing to meet caregivers' expectations.[104]

Teenagers will receive medical care in a variety of venues, from conventional medical offices to specialized clinics in schools or the child welfare system. Sometimes caregivers will be present, and other times not. Every attempt should be made to engage teenagers in their own medical care, interviewing privately and consulting on referrals and treatments. Adolescents should be made aware of what can and cannot remain confidential to avoid violating trust.[98,105]

Adolescent health care must be trauma-aware. Pediatric HCPs should stay alert to the possibility of earlier adversities and their possible consequences on perception and behavior, both in the adolescent patient and the caregivers.[32,106]

Coding and Documentation

After the visit, ensuring the practice is compensated for the time and effort spent requires that all services are clearly documented and the patient encounter billed to accurately reflect the care provided and the time spent. The evaluation and management codes published in *Current Procedural Terminology* allow the bill to reflect the work performed, provided those measures are properly documented.[107] All pertinent diagnostic codes should be specified. Documentation of risk factors for child maltreatment or social determinants of health in the patient's record and visit claim form helps document the risk level of the population served and facilitates payment. Subsequent visits that include addressing such problems, such as a visit for asthma that also helps a parent cope with major stress, could rate a higher evaluation and management code.

The AAP resource *Coding for Pediatrics 2021* provides comprehensive information.[108] The AAP also provides an array of web-based coding resources at AAP.org. One such valuable and frequently updated resource is the AAP Trauma and Maltreatment Coding Fact Sheet at

https://downloads.aap.org/AAP/PDF/Trauma_Coding_Fact_Sheet.pdf.

Documentation of sensitive patient or family information (eg, intimate partner violence or a history of previous child abuse) may cause unintentional harm in the landscape of data exchange and patient and family portals and should be stored carefully. Most modern electronic record systems have features to protect such information against inappropriate disclosure.

SUMMARY

Many factors interact to help children and families safely deal with adversity. By prioritizing relational health, pediatric HCPs can guard against child maltreatment and increase their patients' safety, health, and well-being. Trauma-informed, family-centered pediatric care provides the tools to help pediatric HCPs prevent child maltreatment and build resilience, using anticipatory guidance and regular, attentive follow-up. Well-researched targeted interventions are available for families when risk factors for child maltreatment are identified and can help prevent future morbidity after maltreatment has been recognized. Familiarity with community resources, good anticipatory organization, and planning can mitigate the complexity of helping families and children at risk for maltreatment.

GUIDANCE FOR THE PEDIATRICIAN

1. Obtain a thorough social history, initially and periodically, throughout a patient's childhood, including family economic stressors and community conditions.
2. Identify and build on family resilience and protective factors identified in the social history. Child and parent strength and resilience can both prevent maltreatment and mitigate its long-term health effects.
3. Address parents' concerns while reinforcing effective parenting. Acknowledge the frustration and anger that may accompany parenting. Provide anticipatory guidance about parenting challenges that may be stressful or serve as a trigger for child maltreatment. Follow-up on concerns at regular intervals.
4. Guide parents in providing effective, nonphysical discipline. Encourage parents to use alternatives to corporal punishment. Inquire about what methods they have tried, and help parents address particular problematic behaviors.
5. When caring for children with disabilities or chronic illness, be cognizant of their increased vulnerability and watch for signs of maltreatment. Validate parental challenges and provide parents with techniques to manage stress.
6. Be alert to indicators of parental intimate partner violence, unhealthy substance use, and depression. Familiarize yourself with appropriate community resources and know how to respond if a caregiver reports such problems.
7. Encourage caregivers to use their own health care providers as a conduit to needed care. Become knowledgeable about resources in the community and, when appropriate, refer families to these resources.
8. Prepare the physician-led team to accommodate the complex presentations of families undergoing stress. Keeping up-to-date contact information for useful community resources saves time, as does training staff in referral procedures and scheduling follow-up.
9. Advocate for community programs and resources that will provide effective prevention, intervention, and treatment of child maltreatment and for programs that address the underlying problems that contribute to child maltreatment.
10. To prevent further maltreatment of a child or adolescent who has been victimized in the past, offer practical guidance in supporting the child or adolescent to caregivers, monitor frequently for signs and symptoms of toxic stress and continued maltreatment, and recommend therapeutic interventions and mental health services.

AAP RESOURCES

Practice Tips - Screening for Basic and Social Needs and Connecting Families to Community Resources: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/practice-tips.aspx

AAP Trauma-Informed Care Resources: www.aap.org/tic

AAP Early Relational Health Resources: https://www.aap.org/en/patient-care/early-childhood/early-relational-health/

Bright Futures: Brightfutures.aap.org

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ACE: adverse childhood experience
AHT: abusive head trauma
CDC: Centers for Disease Control and Prevention
FCMH: family-centered medical homes
HCP: health care provider
SEEK: Safe Environment for Every Kid
SNAP: Supplemental Nutrition Assistance Program

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