Practice Parameters for Child Abuse and Neglect

Upward of 70% of children and adolescents entering the foster care system have been physically abused and neglected and/or sexually abused prior to foster care. It is mandatory that children and adolescents entering foster care be screened for a history or signs or symptoms of abuse and neglect. At entry, the local commissioner of social services has the obligation of ensuring the safety and well-being of children and adolescents in foster care. Because children and adolescents may be victimized in their foster placements or during visitation with their parents or relatives, continued monitoring for signs and symptoms of abuse and neglect while in care also is essential. It is particularly important to monitor the quality of the relationship between children and adolescents and their foster and birth parents; this is especially true for children who are preverbal or developmentally delayed because they are more likely to be victimized. Child abuse and neglect screenings and evaluations need to be conducted in a timely fashion by an experienced health care professional.

Two types of child abuse and neglect visits are discussed in this chapter. Medical screening for child abuse should be a part of every medical encounter with children and adolescents in foster care. Health care professionals who work with these children must be skilled in identifying indicators of child abuse and neglect.

More detailed medical child abuse evaluations should be conducted whenever there is suspicion of physical or sexual abuse or neglect. Child abuse evaluations are best conducted by a team of expert professionals (ie, child abuse team or center) to minimize the trauma

to children, maximize documentation, and ensure appropriate treatment and referrals. A single comprehensive evaluation for child sexual abuse should be conducted by the most experienced available professional(s) to avoid the trauma of multiple interviews and examinations.

In addition to a brief description of child abuse and neglect screening and evaluation, this chapter provides a format for triaging children and adolescents who are suspected of being victims of sexual abuse and steps to take if abuse or neglect is suspected.

Parameters for Child Abuse and Neglect

Child Abuse and Neglect Screening

Purpose

1. To ensure the safety of the child or adolescent
2. To identify signs or symptoms of abuse and neglect, including but not limited to behavioral indicators such as enuresis, encopresis, nightmares, sexual knowledge inappropriate for the child's age, and sexualized behaviors
3. To obtain appropriate medical treatment for children or adolescents who have been abused and neglected; in particular, to identify children who need acute medical or mental health intervention
4. To involve the appropriate authorities, including child protective services (CPS) and law enforcement
5. To communicate information obtained from the examination to the agency with care and custody of the child

Time Frame

- At entry into care as part of the admission screen.
- Child abuse and neglect screening is part of every health encounter.
- Whenever there is concern expressed by the foster or birth parents, any caregiver, or any health care professional involved with the child.

- At return to foster care from discharge or from an absence without leave.
- At return from unsupervised visitation, if a concern is raised.
- At discharge from foster care.

Performed By

Screening interviews and examinations may be performed by *qualified* agency medical personnel or the primary care physician. An impartial party should screen children or adolescents alleging abuse by agency personnel.

Attended By

This will vary depending on individual circumstances. The health care professional should be guided by the comfort and safety of the child.

Components

Child abuse and neglect screening should be incorporated into health care encounters in ways that are sensitive to the child's fears and anxieties and yet allow the identification of physical findings and provide sufficient information to determine if further evaluation is warranted.

1. Interview—a brief, problem-focused private interview of the child, if appropriate
2. Observations to include
   - Child's affect
   - Height and weight (and head circumference if younger than 3 years)
   - Skin examination for bruising, burns, or other signs of trauma; the examination should include nails and hair
   - Range of motion of joints and extremities
   - Genital and anal survey, if indicated, for bruising, lacerations, burns, bleeding, discharge, and integrity of the tissues

Child Abuse and Neglect Evaluation

Purpose

1. To ensure the safety of the child
2. To identify signs and symptoms of abuse and neglect
3. To document findings of abuse and neglect
4. To obtain appropriate medical treatment for children who have been abused and neglected; in particular, to identify children who need acute medical intervention
5. To appropriately refer children who have been abused or neglected for mental health care services; in particular, those in need of acute mental health intervention
6. To involve the appropriate authorities, including CPS and law enforcement
7. To communicate information obtained from the interview and evaluation to the agency with care and custody of the child

Time Frame

This will depend on the acuity of the issue that has been identified. Immediate evaluation should occur when there is

- A disclosure by the child.
- The presence of any indicators of child abuse and neglect on screening.
- Any child or adolescent identified as a perpetrator of sexual abuse.
- Any child residing in the same home as an identified victim of child physical or sexual abuse or neglect.
- Concern of abuse raised by the foster or birth parents, any caregiver, or any health care professional involved with the child.

Performed By

Evaluations should be performed by health care professionals trained and experienced in child abuse. Specialized professional examinations minimize trauma for the child and maximize documentation. A complete examination for child sexual abuse should be performed by the most highly skilled medical professional available. Multiple

interviews and/or examinations should be avoided to minimize trauma to the child. An impartial party should evaluate children or adolescents alleging abuse by agency personnel.

Components

1. Interview by the most skilled interviewer available; interview should be conducted with the child privately, following guidelines developed by the American Professional Society on the Abuse of Children (*see* "Internet Resources" under "Bibliography" in this chapter).
2. Observation of affect.
3. Height and weight (and head circumference if younger than 3 years).
4. Thorough directed physical examination including skin, nails, hair, mouth, extremities, genitalia, and anus.
5. Documentation, including sketches, and a detailed descriptive narrative; appropriate photographic documentation is strongly recommended.
6. Imaging and laboratory studies as clinically indicated.

Child Sexual Abuse—Triage and Evaluation

Purpose

1. To ensure the safety of the child
2. To identify signs and symptoms of child sexual abuse, including but not limited to nightmares, enuresis, encopresis, sexual knowledge inappropriate for the child's age, and sexualized behaviors inappropriate for age
3. To document findings of child sexual abuse
4. To obtain appropriate medical treatment for children who have been sexually abused; in particular, to identify children who need acute medical intervention
5. To appropriately refer children who have been sexually abused for mental health care services, especially those in need of acute mental health intervention

6. To involve the appropriate authorities, including CPS and law enforcement
7. To communicate information obtained from the examination to the agency with care and custody of the child

Time Frame

This will depend on the acuity of the issue identified (*see* "Components" below).

Performed By

Evaluations should be performed by health care professionals trained and experienced in child sexual abuse evaluations. Specialized evaluations minimize the trauma for the child and maximize documentation. Multiple interviews and/or examinations should be avoided to minimize trauma to the child. An impartial party should evaluate children or adolescents alleging abuse by agency personnel.

Components

1. Emergency evaluations for child sexual abuse—same day
   - Criteria
     - History of sexual abuse occurring within preceding 72 hours
     - Vaginal or rectal bleeding, pain, or trauma within preceding 72 hours
   - Where
     - Child abuse team or center is preferred at all times because of the specialty training of the personnel.
     - In lieu of a child abuse team or center, the most highly skilled available health care professional is the next most acceptable choice. This is likely to be the staff of the pediatric emergency department. In some cases, pediatricians or gynecologists with appropriate child sexual abuse training may be alternatives.

2. Urgent evaluations for child sexual abuse—within 2 to 5 days
   - Criteria
     - Abuse occurring within the last 3 to 14 days and the child is living in a safe environment
     - The presence of vaginal discharge or suspicion of a sexually transmitted disease, even if the exact timing of the abuse is unknown
   - Where
     - The preferred health care professional is a regional child abuse team or center.
     - Ambulatory care facilities capable of such evaluations. This may include pediatricians or gynecologists with appropriate child sexual abuse training and experience. (A child abuse team or center is preferred.)
3. All other child sexual abuse evaluations—within 2 weeks
   - Criteria
     - Abuse occurring more than 10 to 14 days in the past and the child is living in a safe environment
     - Any child residing in the same home as a child diagnosed as a victim of child sexual abuse
     - Any child who sexually approaches another child
     - Any child who is identified on screening or examination as having behavioral or physical indicators of child sexual abuse
   - Where
     - A child abuse team or center is always the preferred health care professional.
     - Ambulatory sites with personnel having appropriate child sexual abuse training and experience are adequate. (A child abuse team or center is preferred.)

Steps to Take if Child Abuse or Neglect Is Suspected

- The safety and well-being of the child is the primary concern; the child must have a safe place to live.
- A CPS referral must be made whenever child abuse and neglect inflicted by a person in a caregiving role are suspected. Health care professionals are mandated reporters. Law enforcement most likely will need to be notified. Health care professionals should familiarize themselves with the reporting system in their own states.

Write in your local reporting system information here.

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- Notify the child's caseworker or agency; communicate the results of the screening or evaluation to the caseworker or agency.
- History and physical findings must be thoroughly documented.
- A single comprehensive child sexual abuse evaluation should be conducted by professionals trained and experienced in sexual abuse in a setting that is quiet and comfortable for the child. In lieu of a child abuse team or center, the examination should be conducted by the most highly skilled health care professional available.
- The child should receive whatever medical care is deemed necessary in a timely fashion.
- Appropriate referral for counseling should be made.

Bibliography

Adams JA, Botash AS, Kellogg N. Differences in hymenal morphology between adolescent girls with and without a history of consensual sexual intercourse. *Arch Pediatr Adolesc Med.* 2004;158:280–285

American Academy of Child and Adolescent Psychiatry. Practice parameters for the forensic evaluation of children and adolescents who may have been physically or sexually abused. *J Am Acad Child Adolesc Psychiatry.* 1997;36(suppl):37S–56S

American Academy of Pediatrics, Committee on Adolescence. Care of the adolescent sexual assault victim. *Pediatrics.* 2001;107:1476–1479

American Academy of Pediatrics, Committee on Bioethics. Religious objections to medical care. *Pediatrics.* 1997;99:279–281

American Academy of Pediatrics, Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. *Pediatrics.* 1999;103:186–191

American Academy of Pediatrics, Committee on Child Abuse and Neglect. Shaken baby syndrome: rotational cranial injuries—technical report. *Pediatrics.* 2001;108:206–210

American Academy of Pediatrics, Committee on Child Abuse and Neglect. When inflicted skin injuries constitute child abuse. *Pediatrics.* 2002;110:644–645

American Academy of Pediatrics, Committee on Child Abuse and Neglect and Committee on Bioethics. Forgoing life-sustaining medical treatment in abused children. *Pediatrics.* 2000;106:1151–1153

American Academy of Pediatrics, Committee on Child Abuse and Neglect and Committee on Children With Disabilities. Assessment of maltreatment of children with disabilities. *Pediatrics.* 2001;108:508–512

American Academy of Pediatrics, Committee on Child Abuse and Neglect; American Academy of Pediatric Dentistry, Ad Hoc Work Group on Child Abuse and Neglect. Oral and dental aspects of child abuse and neglect: joint statement of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry. *Pediatrics.* 1999;104:348–350

American Academy of Pediatrics, Committee on Drugs. Neonatal drug withdrawal. *Pediatrics.* 1998;101:1079–1088

American Academy of Pediatrics, Committee on Hospital Care and Committee on Child Abuse and Neglect. Medical necessity for the hospitalization of the abused and neglected child. *Pediatrics.* 1998;101:715–716

American Academy of Pediatrics, Section on Child Abuse and Neglect. *A Guide to References and Resources in Child Abuse and Neglect.* 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 1998

American Professional Society on the Abuse of Children, Task Force on Medical Evaluation of Suspected Child Abuse. *Photographic Documentation of Child Abuse: Practice Guidelines.* Chicago, IL: American Professional Society on the Abuse of Children; 1995

Benger JR, McCabe SE. Burns and scalds in pre-school children attending accident and emergency: accident or abuse? *Emerg Med J.* 2001;18:172–174

Berenson AB. A longitudinal study of hymenal morphology in the first 3 years of life. *Pediatrics.* 1995;95:490–496

Berenson AB, Chacko MR, Wiemann CM, Mishaw CO, Friedrich WN, Grady JJ. Use of hymenal measurements in the diagnosis of previous penetration. *Pediatrics.* 2002;109:228–235

Berenson AB, Grady JJ. A longitudinal study of hymenal development from 3 to 9 years of age. *J Pediatr.* 2002;140:600–607

Botash AS. Child sexual abuse. In: Bechtel K, Konop R, Wolfram W, Halamka J, Plantz SH, eds. *Emergency Medicine.* 2004. Available at: http://www.emedicine.com/emerg/topic369.htm. Accessed June 17, 2004

Botash AS. *Evaluating Child Sexual Abuse: Education Manual for Medical Professionals.* Baltimore, MD: The Johns Hopkins University Press; 2000

Botash AS. Examination for sexual abuse in prepubertal children: an update. *Pediatr Ann.* 1997;26:312–320

Botash AS. Vaginitis. In: Howes DS, Talavera F, Zwanger M, Halamka J, Plantz SH, eds. *Emergency Medicine.* 2002. Available at: http://www.emedicine.com/emerg/topic631.htm. Accessed June 23, 2004

Botash AS, ed. *Child Abuse Prevention, Evaluation, and Treatment: Toolkit for Medical Providers.* New York, NY: New York State Department of Health; 2004. Available at: http://child-abuse.com/champ/tool. Accessed June 22, 2004

Botash AS, Jean-Louis F. Imperforate hymen: congenital or acquired from sexual abuse? *Pediatrics.* 2001;108:e53. Available at: http://pediatrics.aappublications.org/cgi/content/full/108/3/e53. Accessed June 17, 2004

Britton H. Emotional impact of the medical examination for child sexual abuse. *Child Abuse Negl.* 1998;22:573–579

Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines 2002. *MMWR Recomm Rep.* 2002;51(RR-6):1–78. Available at: http://www.cdc.gov/std/treatment/default.htm. Accessed June 17, 2004

Christian CW, Lavelle JM, De Jong AR, Loiselle J, Brenner L, Joffe M. Forensic evidence findings in prepubertal victims of sexual assault. *Pediatrics.* 2000;106:100–104

Davis HW, Zitelli BJ. Childhood injuries: accidental or inflicted? *Contemp Pediatr.* January 1995;12:94–112

DiGiuseppe DL, Christakis DA. Continuity of care for children in foster care. *Pediatrics.* 2003;111:e208–e213. Available at: http://pediatrics.aappublications.org/cgi/content/full/111/3/e208. Accessed June 17, 2004

Dubowitz H. Preventing child neglect and physical abuse: a role for pediatricians. *Pediatr Rev.* 2002;23:191–196

Emans SJH, Laufer MR, Goldstein DP. *Pediatric and Adolescent Gynecology.* 4th ed. Philadelphia, PA: Lippincott-Raven; 1998

Finkel MA, Ricci LR. Documentation and preservation of visual evidence in child abuse. *Child Maltreat.* 1997;2:322–330

Flaherty EG, Sege R, Mattson CL, Binns HJ. Assessment of suspicion of abuse in the primary care setting. *Ambul Pediatr.* 2002;2:120–126

Friedrich WN, Fisher J, Broughton D, Houston M, Shafran CR. Normative sexual behavior in children: a contemporary sample. *Pediatrics.* 1998;101:e9. Available at: http://pediatrics.aappublications.org/cgi/content/full/101/4/e9. Accessed June 17, 2004

Giardino AP, Christian CW, Giardino ER. *A Practical Guide to the Evaluation of Child Physical Abuse and Neglect.* Thousand Oaks, CA: SAGE Publications; 1997

Gold MA. Emergency contraception. *Adolesc Med.* 1997;8:455–462

Heger A, Emans SJH, Muram D. *Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas.* 2nd ed. New York, NY: Oxford University Press; 2000

Hibbard RA. Triage and referrals for child sexual abuse medical examinations from the sociolegal system. *Child Abuse Negl.*1998;22:503–513

Holmes, MM. The clinical management of rape in adolescents. *Contemp Pediatr.* July 1998;15:62–79

Jenny C. Medical issues in sexual abuse. In: Briere J, Berliner L, Bulkley JA, Jenny C, Reid T, eds. *The APSAC Handbook on Child Maltreatment.* Thousand Oaks, CA: SAGE Publications; 1996:195–205

Kahn JA, Emans SJ. Gynecologic examination of the prepubertal girl. *Contemp Pediatr.* March 1999;16:148–159

Kairys SW, Johnson CF, American Academy of Pediatrics Committee on Child Abuse and Neglect. The psychological maltreatment of children—technical report. *Pediatrics.* 2002;109:e68. Available at: http://pediatrics.aappublications.org/cgi/content/full/109/4/e68. Accessed June 23, 2004

Kellogg ND, Parra JM, Menard S. Children with anogenital symptoms and signs referred for sexual abuse evaluations. *Arch Pediatr Adolesc Med.* 1998;152:634–641

Lonergan GJ, Baker AM, Morey MK, Boos SC. From the archives of the AFIP. Child abuse: radiologic-pathologic correlation. *Radiographics.* 2003;23:811-845

Lyons TJ, Oates RK. Falling out of bed: a relatively benign occurrence. *Pediatrics.* 1993;92:125–127

Muram D. The medical evaluation of sexually abused children. *J Pediatr Adolesc Gynecol.* 2003;16:5–14

Muram D, Arheart KL, Jennings SG. Diagnostic accuracy of colposcopic photographs in child sexual abuse evaluations. *J Pediatr Adolesc Gynecol.* 1999;12:58–61

Myers JE. Expert testimony regarding child sexual abuse. *Child Abuse Negl.* 1993;17:175–185

New York State Department of Health. *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault.* 2002. Available at: http://www.health.state.ny.us/nysdoh/sexual_assault. Accessed June 23, 2004

New York State Department of Health, New York State Office of Children and Family Services. *Guidelines: Child and Adolescent Sexual Offense Medical Protocol.* Albany, NY: New York State Dept of Health; 1997

New York State Office of Children and Family Services. *Summary Guide for Mandated Reporters in New York State.* Available at: http://www.ocfs.state.ny.us/main/publications/Pub1159.pdf. Accessed June 17, 2004

Schutzman SA, Barnes P, Duhaime AC, et al. Evaluation and management of children younger than two years old with apparently minor head trauma: proposed guidelines. *Pediatrics.* 2001;107:983–993

Schwartz AJ, Ricci LR. How accurately can bruises be aged in abused children? Literature review and synthesis. *Pediatrics.* 1996;97:254–257

Schwartz ID. Failure to thrive: an old nemesis in the new millennium. *Pediatr Rev.* 2000;21:257–264

Siegel RM, Schubert CJ, Myers PA, Shapiro RA. The prevalence of sexually transmitted diseases in children and adolescents evaluated for sexual abuse in Cincinnati: rationale for limited STD testing in prepubertal girls. *Pediatrics.* 1995;96:1090–1094

Siegfried EC, Frasier LD. Anogenital skin diseases of childhood. *Pediatr Ann.* 1997;26:321–331

US Department of Health and Human Services National Clearinghouse on Child Abuse and Neglect Information. *In Focus: The Risk and Prevention of Maltreatment of Children with Disabilities.* 2001. Available at: http://nccanch.acf.hhs.gov/pubs/prevenres/focus.cfm. Accessed June 17, 2004

Wissow LS. Child abuse and neglect. *N Engl J Med.* 1995;332:1425–1431

Internet Resources

American Academy of Pediatrics: www.aap.org

American Professional Society on the Abuse of Children: www.apsac.org

AAP District II, New York State, Task Force on Health Care for Children in Foster Care.
Fostering Health: Health Care for Children and Adolescents in Foster Care, 2nd edition. 2005