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Child Abuse & Neglect



Recurrent concerns for child abuse: Repeated consultations by a subspecialty child abuse team



Jennifer Martindale^{a,*}, Alice Swenson^b, Jamye Coffman^c, Alice W. Newton^d, Daniel M. Lindberg^{e,f}, for the ExSTRA Investigators

^a Department of Emergency Medicine, SUNY Downstate, 450 Clarkson Avenue, Box 1228, Brooklyn, NY 11203, USA

^b Children's Hospital of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226, USA

^c Cook Children's Medical Center, 801 7th Avenue, Fort Worth, TX 76104, USA

^d Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114, USA

^e Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, 13123 East 16th Avenue B390, Aurora, CO 80045, USA

^f The Department of Emergency Medicine, University of Colorado School of Medicine, 13123 East 16th Avenue B390, Aurora, CO 80045, USA

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ABSTRACT

Physically abused children may be repeatedly reported to child protection services and undergo multiple medical evaluations. Less is known about recurrent evaluations by hospital-based child abuse teams for possible abuse. The objectives of this study were to determine the frequency of repeated consultations by child abuse teams and to describe this cohort in terms of injury pattern, perceived likelihood of abuse, disposition plan, and factors related to repeat consultation. This was a prospectively planned, secondary analysis of data from the Examining Siblings to Recognize Abuse (ExSTRA) research network. Subjects included children younger than 10 years of age who were referred to child abuse subspecialty teams at one of 20 U.S. academic centers. Repeat consultations occurred in 101 (3.5%; 95% CI 2.9–4.2%) of 2890 subjects. The incidence of death was 4% (95% CI 1–9%) in subjects with repeated consults and 3% (95% CI 2–3%) in subjects with single consults. Perceived likelihood of abuse from initial to repeat visit remained low in 33% of subjects, remained high in 24.2% of subjects, went from low to high in 16.5%, and high to low in 26.4% of subjects. Themes identified among the subset of patients suspected of repeated abuse include return to the same environment, failure to comply with a safety plan, and abuse in foster care. Repeated consultation by child abuse specialists occurs for a minority of children. This group of children may be at higher risk of subsequent abuse and may represent an opportunity for quality improvement.

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Child physical abuse is often a chronic, progressive, and fatal disease (Alexander, Crabbe, Sato, Smith, & Bennett, 1990; Deans et al., 2013; Thackeray, 2007). Despite growing awareness, the diagnosis of child abuse is often delayed or missed entirely (Jenny, Hymel, Ritzen, Reinert, & Hay, 1999). Some preexisting injuries are only recognized as having been inflicted when a child returns for care with more severe or obvious abuse (Alexander et al., 1990; Ewing-Cobbs et al., 1998; Ravichandiran et al., 2010; Rubin, Christian, Bilaniuk, Zazyczny, & Durbin, 2003). Missing the diagnosis of child abuse could

* Corresponding author.

result in more severe injury or death (King, Kiesel, & Simon, 2006; Oral, Yagmur, Nashelsky, Turkmen, & Kirby, 2008; Ricci, Giantris, Merriam, Hodge, & Doyle, 2003).

Despite legal mandates to do so in every state, physicians do not report some cases of suspected abuse to child protective services (CPS), even when they have a reasonable concern for abuse (Flaherty et al., 2008). The standard for reporting to child protection agencies is interpreted variably by generalists and specialists (Laskey, Sheridan, & Hymel, 2007; Levi & Brown, 2005; Levi, Brown, & Erb, 2006; Lindberg, Lindsell, & Shapiro, 2008). Responses of child protection agencies are similarly variable (U.S. Department of Health and Human Services [DHHS], 2011). In the absence of gold-standard diagnostic tests for abuse for most cases (Southall, Plunkett, Banks, Falkov, & Samuels, 1997), CPS is faced with complicated decisions which require balancing the likelihood of recurrent abuse with the goal of family preservation. As a result, some children with inflicted injuries are returned to the same abusive environment in which the injuries occurred. Studies of children who are repeatedly reported to CPS or undergo multiple medical evaluations have been conducted to identify risk factors associated with recidivism and re-abuse (Dakil, Sakai, Lin, & Flores, 2011; Deans et al., 2013; Fluke, 2008; Kohl, Jonson-Reid, & Drake, 2009). However, there are no published data about recidivism for children seen by a hospital-based, subspecialty child abuse team.

Multidisciplinary, hospital-based child abuse teams have been established to assist clinicians and CPS workers caring for children with injuries indicative of abuse (Block, 1998; Block & Palusci, 2006). Because child abuse team consultation implies at least some concern for abuse, children who return after an initial consultation may represent a missed opportunity for abuse prevention.

Purpose

The primary objective of this observational study was to determine the frequency of repeated consultations by child abuse teams among children evaluated for possible physical abuse. The secondary objective was to describe demographics, mortality, injuries, level of suspicion for abuse, dispositions, and typographical themes associated with repeated consultation in this cohort of individuals.

Method

Study design

This is a prospectively planned secondary analysis of the Examining Siblings To Recognize Abuse (ExSTRA) research network, an observational study of 20 hospital-based, subspecialty child abuse teams in the United States conducted between January 2010 and April 2011 (Lindberg, Shapiro, Laskey, Pallin, Blood, & Berger, 2012). Each participating center and the data-coordinating center obtained approval for the parent study from their local Institutional Review Board (IRB). This secondary analysis of data, purged of all individual identifiers, was determined by each IRB to be exempt from IRB review as human individuals research.

Inclusion criteria and data collection

Child abuse teams collected data from all children less than 10 years old who underwent subspecialty evaluation for concern for physical abuse. Although the parent study of the ExSTRA research network focused on siblings and other contact children, this analysis deals only with index children and does not include data from siblings or other contacts of children evaluated with concern for abuse. Investigators reported whether their team had previously evaluated each index child or any of their contacts. Investigators recorded data for the initial consult retrospectively for individuals whose initial visit occurred before the start of the study enrollment period and prospectively for individuals with multiple visits during the 15-month enrollment period.

Abstracted information was limited to that which is acquired in the normal course of clinical care. Participants were asked to record the disposition of the individual and to rate the likelihood of child physical abuse based on a previously published 7-point ordinal scale (Lindberg et al., 2008; see Table 1). Participants included the disposition of each individual in one of

Table 1
Rating scale for perceived abuse likelihood.

Number	Summary statement
1	Definitely not inflicted injury
2	No concern for inflicted injury
3	Mild concern for inflicted injury
4	Intermediate concern for inflicted injury
5	Very concerning for inflicted injury
6	Substantial evidence of inflicted injury
7	Definite inflicted injury

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