



Maltreatment of Children With Disabilities

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Over the past decade, there have been widespread efforts to raise awareness about maltreatment of children. Pediatric providers have received education about factors that make a child more vulnerable to being abused and neglected. The purpose of this clinical report is to ensure that children with disabilities are recognized as a population at increased risk for maltreatment. This report updates the 2007 American Academy of Pediatrics clinical report “Maltreatment of Children With Disabilities.” Since 2007, new information has expanded our understanding of the incidence of abuse in this vulnerable population. There is now information about which children with disabilities are at greatest risk for maltreatment because not all disabling conditions confer the same risks of abuse or neglect. This updated report will serve as a resource for pediatricians and others who care for children with disabilities and offers guidance on risks for subpopulations of children with disabilities who are at particularly high risk of abuse and neglect. The report will also discuss ways in which the medical home can aid in early identification and intervene when abuse and neglect are suspected. It will also describe community resources and preventive strategies that may reduce the risk of abuse and neglect.

INTRODUCTION

The maltreatment of children, including those with disabilities, is a critical public health issue. For the purposes of this report, children with disabilities include the full spectrum of children and adolescents with any significant impairment in any area of motor, sensory, social, communicative, cognitive, or emotional functioning. Children and youth with special health care needs is a broader group that shares some of the same risks as children with disabilities. These children have chronic medical issues that may cause impairment and, as a group, require significantly more health care than typically developing children.

abstract

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Current data on incidence and prevalence of maltreatment in children with disabilities are limited by varying definitions of disability and lack of uniform methods of classifying maltreatment. There is concern that the incidence of child abuse and neglect is underreported in part because many children with disabilities have communication difficulties and cannot directly report problems.^{1,2} Nonetheless, children with disabilities and special health care needs are at increased risk of child maltreatment. This report updates the previous clinical report published in 2007, "Assessment of Maltreatment of Children With Disabilities."¹

The US Children's Bureau reported that an estimated 678 000 children were determined to be victims of abuse or neglect in 2018.³ Three-fifths (60.8%) of child victims experienced neglect, 10.7% were physically abused, and 7.0% were sexually abused; 15.5% of these children suffered from 2 or more maltreatment types.³ The 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) improved the data collection from states on children with disabilities by mandating that states report the number of children younger than 3 years who are involved in a substantiated case of child maltreatment and are eligible to be referred for early intervention services and the number of children who were actually referred for those services.⁴ It did not require collecting information regarding types of disabilities or the number of children with disabilities who are older than 3 years when they enter the child welfare system.⁴

On the basis of national data from 2015, child victims with a disability accounted for 14.1% of all victims of abuse and neglect.⁴ In that report, children with the following conditions were considered to have a disability: intellectual disability (ID), severe

emotional disturbance, visual or hearing impairment, learning disability, physical disability, behavior problem, or a few other chronic medical conditions. It was believed that children with such conditions are undercounted because not every child received a clinical diagnostic assessment when child maltreatment was suspected. A recent study of the data from the National Survey of Child and Adolescent Well-Being II, which included children older than 3 years, found that nearly one-half of children investigated by child protective services (CPS) were not typically developing.⁵

Child abuse and neglect is reported in 3% to 10% of the population with disabilities.⁶⁻¹⁰ The rate of child abuse and neglect is at least 3 times higher in children with disabilities than in the typically developing population.¹¹ In a recent study by the Federal Bureau of Justice Statistics, during the period from 2011 to 2015, among all people older than 12 years who had disabilities, people between 12 and 15 years of age had the highest rate of violent victimization.⁸

Using data from the National Child Abuse and Neglect Data System, Kistin et al¹² evaluated the incidence and timing of rereferral to CPS, substantiated maltreatment, determined foster care placement for children who had been reported to CPS and had unsubstantiated neglect, and compared typically developing children and children with disabilities. Children with disabilities were re-referred to CPS more frequently, were found to have been abused more frequently, and were more often subsequently placed in foster care.¹² Once placed in foster care, children with ID were more likely to experience placement instability¹³ and were more likely to have adoption disruption and less likely to be reunified with a parent or other family member.¹³

A systematic review of violence against children with disabilities revealed that, overall, children with disabilities are more likely to be victims of violence than their peers without disabilities. However, the authors of that review reported limitations in the literature because of a lack of well-designed research studies, with poor standards of measurement of disability and violence and insufficient exploration about whether violence preceded the disability.¹¹

Child maltreatment may result in the development of disabilities, which in turn can precipitate further abuse. Abusive head trauma, for example, is known to cause disabilities in children.¹⁴ The majority of survivors of abusive head trauma have developmental delays, seizures, motor impairments, feeding difficulties, and later behavioral and educational dysfunction, with only 28% having no impairment.¹⁵ Vision loss can result from occipital cortical injury and optic nerve injury.¹⁶ Neglect is associated with short-term and long-term effects on children's cognitive, socioemotional, and behavioral development.^{17,18} Neglect that occurs early in life can have more profound effects on development.

Injury from abuse is augmented by the impact it has on the cortisol stress response and consequent physiologic impact. Adverse childhood experiences, including child abuse and neglect, cause physiologic disruptions that can persist into adulthood and lead to lifelong poor physical and mental health.¹⁹ Exposure to traumatic events is associated with significant negative effects on long-term cognitive development, such as IQ scores, language development, and academic achievement.²⁰ Specifically, witnessing intimate partner violence in early childhood, particularly during the first 2 years of life, is associated with decreased cognitive scores later in childhood.²¹

FACTORS THAT INCREASE THE RISK OF CHILD ABUSE AND NEGLECT

In general, the causes of abuse and neglect of children with disabilities are the same as those for all children; however, several elements may increase the risk of abuse for children with disabilities. Children with chronic illnesses or disabilities sometimes can place higher emotional, physical, economic, and social demands on their families.²² The financial stress of raising a child with disabilities is often high, and this contributes significantly to family stress.^{23,24} Other studies have found that families of children with disabilities have significantly more out-of-pocket costs for health care expenditures.^{24,25} Caregivers may feel more overwhelmed and unable to cope with the care and supervision responsibilities that are required.²⁵ Lack of respite or other breaks in child care responsibilities for caregivers may contribute to an increased risk of abuse and neglect in children with disabilities. Neglect, the most common form of child maltreatment, is more prevalent in children with disabilities than in children without disabilities.⁷ The complex needs of children with disabilities, in both special health care and educational needs, may result in the failure of the child to receive essential medications, therapies, and appropriate educational placement.^{24,26}

A substance use disorder in the mother is a risk factor for child maltreatment²⁷ and may be the cause of the child's disability. Fetal alcohol spectrum disorder (FASD) is a classic example. The use of alcohol or other substances during pregnancy can cause a range of lifelong physical and behavioral disabilities and IDs.²⁸ Children with FASD often have learning problems and speech and language issues and are typically impulsive, lack focus, and have poor judgment. These problems can be extremely frustrating for any

caregiver of a child with FASD. Parents with ongoing substance use disorders may also be less able to handle their children's challenging behaviors and be more punitive to their children.²⁹

Parenting a child with disabilities is often challenging. Some children with disabilities may not respond to traditional means of reinforcement, and sometimes their behaviors, such as aggressiveness, noncompliance, and communication problems, can become frustrating, thus increasing caregiver stress.³⁰ These behavioral challenges can increase the risk of physical abuse by children's caregivers.²⁶

Parents of a child with a disability may also overestimate their child's capabilities. In one study from the United States, parents of children with disabilities sometimes held unrealistically high expectations for their children.⁹ Unrealistic expectations were also associated with a decreased degree of empathetic awareness of their child's limitations. Parents of children with intellectual or communication problems may sometimes turn to inappropriate physical punishment because of frustration about what they perceive as stubbornness or intentional failure to respond to verbal guidance.³¹ Inappropriate expectations and ignorance of challenges a child with a disability might face can be linked to a higher risk for maltreatment. Pediatric providers can intervene by providing reasonable expectations for parents regarding their children with disabilities.⁹ Parents need information and support to understand their child's abilities and challenges. They also need knowledge about proper strategies to use that are appropriate for the disability-related problems and the developmental status of their child.²⁵

Although the use of aversive procedures and restraints for

children who have disabilities has fortunately been diminishing, in part because of legislative changes (eg, modifications of the Individuals with Disabilities Education Act [Pub L No. 108-446 (2004)]), these practices are still sometimes used in homes, schools, programs, nursing homes, group homes, and other institutions.³² Aversive techniques are procedures that use painful or unpleasant stimuli (such as biting the child, administering a noxious electric stimulus, or applying hot sauce to mucosal surfaces) to modify a behavior, and these techniques are always unacceptable or inappropriate. Restraints are physical measures (such as tie-downs or prolonged seclusion) used to prevent something physical from happening or for punishment. Physical restraints include forced holding, a technique that has been repudiated as being harmful.³³

State laws are often unclear, contradictory, and varied regarding aversive and restraint techniques and do not always consider the techniques maltreatment.³⁴ Pediatricians and others can find additional information about the problems occurring from the use of aversive procedures or the use of restraints from the Web site Stop Hurting Kids (<http://stophurtingkids.com/resources/>). Over the past 20 years, research has demonstrated the effectiveness of alternative measures, commonly called "positive behavioral supports," to change behavior.⁹ Pediatricians are encouraged to advocate for this approach. Information about positive behavioral support guidelines is available from a US Department of Education-funded program, the Technical Assistance Center on Positive Behavioral Interventions and Supports, at www.pbis.org, as well as other national and international programs. The American Academy of Child and Adolescent Psychiatry also provides

guidance on this subject (<https://www.aacap.org>).

The presence of multiple caregivers can either increase or decrease the risk of abuse of children with disabilities. Children with disabilities who require multiple caregivers or providers may have contact with numerous individuals, thereby increasing the opportunity for abuse. However, advantages to having a large number of caregivers are that there are more individuals who may detect the injuries or signs of abuse, and the additional assistance may actually decrease the amount of stress placed on the primary caregivers. Risk may be minimized by careful screening and selection of caregivers, sporadic and unscheduled monitoring of care, and recognizing that any child may become a victim of child abuse and neglect.

Children with disabilities may be unintentionally conditioned to comply with authority, which could result in them failing to recognize abusive behaviors as maltreatment.³⁵ Children with disabilities are often perceived as easy targets because their intellectual limitations may prevent them from being able to discern the experience as abuse and their impaired communication abilities may prevent them from disclosing abuse. Because some forms of therapy may be painful (eg, injections or manipulation as part of physical therapy), a child may not be able to differentiate appropriate pain from inappropriate pain.

ASSOCIATION BETWEEN DISABILITY TYPE AND FORM OF ABUSE

Recent research has evaluated how differences in risk of abuse and neglect correlated with the type and severity of the child's disability. The World Health Organization describes disabilities by the domains of function that are affected (ie, cognition, mobility, self-care, getting along, life activities, and

participation).³⁶ The most severely affected children are at a lower risk of maltreatment than mobile, verbal children who are still delayed, especially those with cognitive disabilities.³⁷ Children who are nonverbal or hearing impaired are more likely than others to experience neglect or sexual abuse.⁴

In an Australian study, researchers examined the relationship between different types of disabilities (eg, Down syndrome, autism) and the rate of substantiated maltreatment allegations.¹⁰ The authors found that children with ID, mental or behavioral problems, or conduct disorder had an increased risk of an abuse allegation and for a substantiated allegation. In contrast, children with autism had a lower risk than children with Down syndrome, and those with birth defects or cerebral palsy had the same risk as children without disability after adjusting for child, family, and neighborhood risk factors. The type of abuse was not specified.

In another study from South Carolina, researchers examined the relationship between autism spectrum disorder (ASD) and ID and child maltreatment.³⁸ There were higher odds of reported and substantiated maltreatment among children with ASD only, ASD plus ID, and ID only, compared with a control group after controlling for sociodemographic factors. In a 2018 study from Tennessee, children with ASD had more referrals to a child abuse hotline than those without ASD, although substantiation rates were similar between the 2 groups.³⁹ In a 2018 study using data from the National Survey of Child and Adolescent Well-Being II data, children with multiple developmental delays were more likely to have recurrence of child abuse reporting.⁴⁰

Physical Abuse

Sullivan and Knutson found that children with a disability were 3.79 times more likely to be physically

abused than those without a disability.⁴¹ Helton and Cross³⁷ also found that there is an association between disability and physical abuse. Rather than comparing children on the basis of diagnosis, they compared children on the basis of their level of functioning. The highest rates of physical abuse were in children with mild cognitive disabilities and no motor disability. Paradoxically, children whose disabilities are less severe are more likely to be the victims of physical abuse. These authors stated,

“Conceptually, we can hypothesize that children with minor impairment are at greater risk because they have a complicated mix of dysfunctionality and functionality. Their dysfunctionality increases the probability that they will act in a way that elicits a negative reaction from parents, while their functionality increases their parents' expectations of them and increase their ability to take actions that may frustrate their parents.”³⁷

Harsh discipline, whether physical or verbal, can negatively affect children emotionally. Therefore, it is important to counsel parents of children with and without special needs about methods of discipline specifically as they relate to the developmental level of their child.⁴²

Neglect

In their study, Van Horne et al followed the risks of substantiated maltreatment in a cohort of children younger than 2 years with cleft lip and palate, Down syndrome, and spina bifida. In this study, the authors found that, although children with Down syndrome had the same rate of overall substantiated maltreatment as typically developing peers, children with cleft lip and palate and spina bifida had 2 times the rate of maltreatment. However, the risk of medical neglect was significantly greater among all 3 birth defect groups than in the unaffected group of children. The medical complexity of these children may account for the

increase in medical neglect.⁷ In a follow-up study by Van Horne et al⁴³ on children aged 2 to 10 years with the same disabilities, children with cleft lip and palate, Down syndrome, and spina bifida all had a higher rate of medical neglect compared with children who were unaffected. In a study by McDonnell et al,³⁸ children with ASD alone, ASD plus ID, and ID alone were found to be at greater risk of physical neglect. Children with disabilities and unsubstantiated referrals for neglect experienced future maltreatment sooner and more often than other children.¹²

Sexual Abuse

In addition to physical abuse and neglect, children with disabilities are at an increased risk for being sexually abused.^{41,44} Caldas and Bensity⁴⁴ studied children aged 6 to 17 years in the school setting and examined types of abuse, profiles of the victims of abuse, and profiles of the abusers. They found that children with disabilities are at 3 times the risk of sexual abuse compared with typically developing peers. The children with the greatest risk of abuse were children who had special education classroom supports. One-half of these abused children were victimized by peers, and one-half were victimized by school personnel. In a 2007 study from Israel, researchers found that children with disabilities were more likely to suffer more severe forms of sexual abuse.⁴⁵

Multiple factors have been found to contribute to this increased rate of sexual abuse in children with disabilities, including the increased number of caregivers that children with disabilities encounter and limited access to information and training on personal safety and sexual abuse prevention.^{44,46} Parents support education on human sexuality but are uncertain of how this topic should be presented to their

child with IDs or communicative or motor disabilities.⁴⁷

It is also important to recognize that health care providers have been implicated in sexual abuse of children with disabilities.⁴⁸ Data about the incidence and prevalence of sexual abuse by health care providers are sparse and do not allow a thorough analysis of the incidence of the types of abuse or the types of perpetrators because the terms “health care provider” or “health care worker” encompass many subgroups, including physicians, nurses, and therapists. Given the increased number of health care providers that children with disabilities routinely encounter, it is essential that the prohibition of sexual abuse and exploitation be discussed and taught during the training of all health care providers. The 2011 American Academy of Pediatrics (AAP) policy statement “Protecting Children From Sexual Abuse by Health Care Providers” is an excellent resource to help with this training.⁴⁸

Emotional Abuse

In a study from the United Kingdom, children with conduct disorder, nonconduct psychological disorders, or speech and language difficulties were associated with a higher likelihood of child protection registration for emotional abuse.⁴⁹ Children with a psychiatric diagnosis are at higher risk for psychological maltreatment and emotional abuse.⁵⁰ In a study from Turkey, children with attention-deficit/hyperactivity disorder (ADHD) were found to have higher rates of emotional abuse than controls.⁵¹ In a retrospective study of adults with and without ADHD, adults with ADHD reported higher rates of emotional abuse experienced as children when compared with adults who did not have ADHD.⁵²

PEDIATRICIAN’S ROLE

Pediatricians and other health care providers need to be actively involved

in the prevention, identification, and assessment of possible maltreatment of children with disabilities. Recognizing that these children are at a much higher risk is essential. It is important to assess whether immunizations and other well-child care are up to date and to ensure that necessary appointments with specialists or for illness or injuries are kept. Many children with disabilities have a team of professionals (including but not limited to teachers, paraprofessionals, and medical providers) who regularly interact with them and have direct knowledge about the limitations, abilities, and behaviors of that individual child. By working closely with these professionals, the pediatrician can gather additional insight into any concerns about maltreatment and use this information to guide the medical evaluation.

Pediatricians and other health care providers play a key role in evaluating and documenting medical conditions that may or may not predispose children with disabilities to injury. For example, documenting the presence of, or a risk for, osteopenia, is helpful in assessing fractures that may occur later. Self-injurious behaviors, such as headbanging and self-scratching, can elicit a CPS referral.⁵³ Careful and thorough documentation is often key in making a determination about whether an injury is consistent with abuse or is a result of self-injurious behavior. Health care providers can document abnormal physical examination findings, observed behaviors, and reported behaviors to establish the problem list for children with disabilities. Many electronic health records now have the capability to add digital photographs and “for your information” flags and alerts to the charts that can aid in assessing future injuries or changes in behavior based on preexisting conditions. This documentation is

useful for collaboration with in-hospital providers, such as emergency medicine providers, hospitalists, and critical care providers who may also be part of the system of care for children with disabilities who are victims of abuse and neglect.

If abuse or neglect is suspected after a careful assessment, a report must be made to the appropriate CPS agency.⁵⁴ Collaboration with a multidisciplinary child abuse team or child abuse pediatrician can provide both technical assistance in the evaluation and guidance with the reporting process. Pediatricians may also need to educate CPS about medical findings to assist with the investigation by CPS. Careful consideration should be given regarding whether the evaluation is best completed in the outpatient versus inpatient setting. There are advantages and disadvantages to both; however, the safety of the child needs to be kept at the forefront in the decision-making process. If there are reports of self-injurious behavior that have not previously been documented or observed by a third party, an inpatient evaluation should be considered to observe the child's behaviors as part of the full medical evaluation.

Appropriate medical treatment can be provided for any identified injuries, infections, or other conditions. Each case of abuse or neglect that is clinically confirmed or strongly suspected requires a multidisciplinary treatment plan. Behavioral health referrals to clinicians experienced with caring for children with disabilities needs to be considered as part of the treatment plan. Evidence-based trauma therapy is available for children with disabilities, although this type of specific therapy may not be available in all communities (<https://www.nctsn.org/resources/facts-traumatic-stress-and-children-developmental-disabilities>).

Pediatricians are responsible for the transition of care to adult physicians but may continue to manage patients beyond their 18th birthday when they are no longer minors. When patients enter adulthood, abuse concerns are then referred to adult protective services. Pediatricians can familiarize themselves with adult protective services in their state.

Prevention

Support and assistance with parenting skills are often needed by families, and the need is greater for families with children and youth with special health care needs or disabilities. Pediatricians, as trusted family advisors, can acknowledge family needs, provide encouragement, and address parents' physical, social, and mental health needs.⁵⁵ They can present disability-specific injury prevention guidelines to help the family minimize injury.⁵⁶ The availability of parent support groups, respite care, and home health services should be explored, and referrals may be made when appropriate. Pediatricians can learn about services for parents of children with disabilities, such as respite and medical waiver subsidies and programs specific to each state and how to qualify for such funds.⁵⁷ Table 1 lists some resources for families of children with disabilities.

During each health supervision encounter, pediatric providers can address the medical, social, economic, behavioral, and psychological needs of the child and the family. Proactively addressing discipline concerns and encouraging positive parenting are especially needed in this population.⁵⁸ The AAP published a report strongly discouraging spanking and providing alternative discipline practices.⁴² It is helpful to recognize and support child and family strengths at each encounter.⁵⁵ The AAP provides several resources for positive parenting (eg, www.healthychildren.org⁵⁹; *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Fourth Edition⁶⁰; and *Connected Kids*⁶¹). Pediatricians can share other positive parenting resources with families as well, such as the Centers for Disease Control and Prevention's *Essentials for Parenting Toddlers and Preschoolers* (<http://www.cdc.gov/parents/essentials/overview.html>).

All children, with or without disabilities, benefit from a medical home consisting of a health care professional who is readily accessible to the family to answer questions, help coordinate care, and discuss concerns.⁶² A medical home may incorporate other professionals, including social workers, to help with accessing resources. The medical home can also collaborate with

TABLE 1 Resources for Families of Children With Disabilities

Resources	
Financial	Supplemental Security Income (SSI), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid waiver, therapist fees, Title V maternal and child health services programs for children and youth with special health care needs
Respite or extended care	Respite centers, baby-sitting, after-school programs, emergency respite, residential supports
Specialized medical needs	In-home nursing services, durable medical equipment
Emotional support	Support groups, counseling services for families, family-to-family health information centers
Educational support	IFSPs, IEPs, special education teachers and paraprofessionals
Recreational opportunities	Camps, after-school recreation, sports

IEP, Individualized Education Program; IFSP, Individualized Family Service Plan.

partners from other disciplines, including education, child care, mental health, and faith-based organizations. While working with families of children with disabilities, health care providers can educate and encourage them to work with community agencies that provide the resources and services they need to improve the child's care and the family's coping. Child abuse prevention, including indicators of abuse, can be discussed with parents and caregivers, especially those dealing with children with disabilities, and taking into account the family's language and culture.⁵⁵

Education

In-service training for CPS and adult protective service workers, law enforcement professionals, health care professionals, child care providers, early childhood educators, teachers, and judges is crucial, and protocols are necessary for the identification, reporting, and referral of all cases of suspected child maltreatment in all schools, programs, and institutional settings. Experts in either child maltreatment or childhood disabilities can assist with this educational endeavor. General pediatricians can help local school districts with training in positive behavioral interventions and supports.³² Education on risk factors for maltreatment of children with disabilities is important.

Pediatricians can be important role models to parents, trainees, and others. Pediatricians and other health care providers who provide care for children with disabilities can avoid using physical restraints during procedures for these children. Often, taking the time to explain procedures in terms appropriate to developmental level or other ways to prepare a child can make restraints unnecessary except in situations when children are dangerous to themselves or others. Even when some types of restraints are needed,

such as to prevent a child from scratching at newly repaired lacerations, such restraints should be as comfortable and as minimal as possible and used for the shortest time feasible. Pediatricians can also be flexible about performing procedures, such as delaying blood draws that are not essential.

Pediatricians may also assist in education about child abuse to peers, residents, medical students, and other health care students. All health care professionals need adequate training to monitor children with disabilities for signs of abuse and neglect and to screen suspected victims of child maltreatment for possible delays or disabilities.⁶³

Advocacy

The pediatrician, in providing the medical home and acting as the patient's and family's advocate, may review care that is provided by various agencies and resources. Much of this advocacy effort can be performed by coordinating efforts and ensuring that recommendations are implemented.⁵⁷ By providing prevention-based continuity of care, additional patient needs, such as changes in services, can be expediently identified and resolved.

Pediatricians play an important advocacy role in their relationships with various governmental and nongovernmental agencies. AAP chapters can also have an influential role in these arenas. State, educational, social, foster care, financial, and health care systems often function in isolation from each other, with little coordination or communication.³⁵ Foster children with disabilities and their foster parents, for example, often suffer from lack of adequate support systems.¹ Community involvement can often lead to the development of needed resources, including child care and respite services for families with a child with a special health care

need.⁶ Pediatricians can advocate for the caregivers to receive financial support to access services, such as respite. Communication with schools and other systems with which families interact is another avenue to increase the awareness of the needs of children who have disabilities and/or special health care needs.

As child advocates, pediatricians are in an ideal position to influence public policy by sharing information and giving educational presentations on child maltreatment and the needs of children with disabilities. There can be advocacy for training in recognizing both abuse and findings that mimic abuse for providers of children with disabilities.

Pediatricians can advocate for state policies that mandate CPS agencies to gather disability information on child maltreatment cases. Pediatricians can emphasize the devastating costs of child maltreatment to legislators, policy makers, and the public. Pediatricians can advocate for state Medicaid programs to provide prompt automatic Medicaid eligibility at enrollment in foster care, including kinship care. Pediatricians can also advocate for health care not to be disrupted if a child with disabilities is placed into Medicaid managed-care plans that do not have the child's existing specialists in network. Pediatricians can also advocate for proper coverage in both private and public insurance plans. In the case of primary care, there should be a time-limited presumptive authorization extended to a current primary care provider for well visits and timely immunization visits. Pediatricians can advocate that Medicaid programs pay for services necessary for the effective transition of care when there must be a change in specialty providers. Pediatricians can also advocate for screening procedures for potential employees in educational, recreational, and residential settings to help ensure the safety of all children in their care.³²

SUMMARY

Children with disabilities are a vulnerable population at increased risk of child abuse and neglect and, therefore, merit special attention to reduce this risk. Children with milder forms of disability are at higher risk of abuse and neglect than more profoundly affected children.

Certain types of disabilities are associated with different forms of abuse. Children with behavioral difficulties are at a greater risk for physical abuse. Children who are nonverbal or hearing impaired are more likely to experience neglect or sexual abuse. Children with multiple developmental delays are more at risk for recurrence of child abuse reporting. Conduct disorder, nonconduct psychological disorders, speech and language difficulties, and ADHD are associated with emotional abuse.

Addressing financial struggles, family stress, and the long-term needs of these children can reduce the risk of child abuse and neglect. Pediatricians are a unique resource to children with disabilities through the medical home model and in multidisciplinary teams.

GUIDANCE FOR PEDIATRICIANS

1. Recognize signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities, and understand mandatory, state-specific reporting requirements for child and adult protective services.
2. Use each medical visit as an opportunity to assess family well-being.
3. Understand that families of children with disabilities benefit from assistance in addressing their child's abilities and needs. Provide reasonable expectations for parents regarding their children with disabilities and be prepared to offer concrete suggestions about

how to respond to common developmentally based challenges for the child with a disability.

4. Refer families of children with disabilities to available community resources and agencies that provide necessary services designed to aid children with disabilities and their families.
5. Structure discussions about appropriate discipline within well-child visits for the child with a disability. Parents may be uncertain as to how to deal with discipline, especially for children who are verbal but developmentally delayed, so provide guidance on positive parenting. Consider referring these families to specialists with expertise in parenting skills for children with disabilities.
6. Be actively involved with both educational and medical treatment plans developed for children with disabilities and participate in collaborative team approaches.
7. Advocate at the state and local level for system changes that support at-risk children and those with disabilities and their families.

SUGGESTED RESOURCES

- A Call to Action: Ending Crimes of Violence against Children and Adults with Disabilities: this report includes recommendations on policy, surveillance systems and data collection, violence prevention, intervention, and research needs. Available at: https://www.aucd.org/docs/annual_mtg_2006/symp_marge2003.pdf.
- www.pbis.org: this Web-based resource offers information about programs supporting positive behavioral parenting for families and other caregivers.
- Toolkit for medical providers about trauma-informed practice from the

National Child Traumatic Stress Network. Available at: <http://www.nctsn.org/trauma-types/pediatric-medical-traumatic-stress-toolkit-for-health-care-providers>.

Stop Hurting Kids: this Web site was created by the Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS,) a coalition of organizations and advocates who dedicate their time and resources to ending restraint and seclusion abuse in US schools. Available at: <http://stophurtingkids.com/resources/>.

Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. Available at: <https://brightfutures.aap.org/Pages/default.aspx>.

American Academy of Pediatrics. Connected Kids: Safe, Strong, Secure. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx>.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ADHD: attention-deficit/hyperactivity disorder
ASD: autism spectrum disorder
CPS: child protective services
FASD: fetal alcohol spectrum disorder
ID: intellectual disability

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REFERENCES

- Hibbard RA, Desch LW; American Academy of Pediatrics Committee on Child Abuse and Neglect; American Academy of Pediatrics Council on Children With Disabilities. Maltreatment of children with disabilities. *Pediatrics*. 2007;119(5):1018–1025
- Prkachin KM, Solomon PE, Ross J. Underestimation of pain by health-care providers: towards a model of the process of inferring pain in others. *Can J Nurs Res*. 2007;39(2):88–106
- US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child maltreatment 2018. Available at: <https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2018.pdf>. Accessed July 10, 2020
- Child Welfare Information Gateway. *The Risk and Prevention of Maltreatment of Children with Disabilities*. Washington, DC: US Department of Health and Human Services, Children's Bureau; 2018
- Helton JJ, Lightfoot E, Fu QJ, Bruhn CM. Prevalence and severity of child impairment in a US sample of child maltreatment investigations. *J Dev Behav Pediatr*. 2019;40(4):285–292
- Turner HA, Vanderminden J, Finkelhor D, Hamby S, Shattuck A. Disability and victimization in a national sample of children and youth. *Child Maltreat*. 2011;16(4):275–286
- Van Horne BS, Moffitt KB, Canfield MA, et al. Maltreatment of children under age 2 with specific birth defects: a population-based study. *Pediatrics*. 2015;136(6). Available at: www.pediatrics.org/cgi/content/full/136/6/e1504
- Harrell E. *Crime Against People With Disabilities, 2009-2015—Statistical Tables*. Washington, DC: Bureau of Justice Statistics, US Department of Justice; 2017. Available at: www.bjs.gov/index.cfm?ty=pbdetail&iid=5986. Accessed September 9, 2020
- Zand DH, Pierce KJ, Nibras S, Maxim R. Parental risk for the maltreatment of developmentally delayed/disabled children. *Clin Pediatr (Phila)*. 2015; 54(3):290–292
- Maclean MJ, Sims S, Bower C, Leonard H, Stanley FJ, O'Donnell M. Maltreatment risk among children with disabilities. *Pediatrics*. 2017;139(4): e20161817
- Jones L, Bellis MA, Wood S, et al. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet*. 2012; 380(9845):899–907
- Kistin CJ, Tompson MC, Cabral HJ, Sege RD, Winter MR, Silverstein M. Subsequent maltreatment in children

- with disabilities after an unsubstantiated report for neglect. *JAMA*. 2016;315(1):85–87
13. Slayter E, Springer C. Child welfare-involved youth with intellectual disabilities: pathways into and placements in foster care. *Intellect Dev Disabil*. 2011;49(1):1–13
 14. Frasier LD. Abusive head trauma in infants and young children: a unique contributor to developmental disabilities. *Pediatr Clin North Am*. 2008;55(6):1269–1285, vii
 15. Nuño M, Ugiliweneza B, Zepeda V, et al. Long-term impact of abusive head trauma in young children. *Child Abuse Negl*. 2018;85:39–46
 16. Levin AV. Retinal hemorrhages: advances in understanding. *Pediatr Clin North Am*. 2009;56(2):333–344
 17. Blaisdell KN, Imhof AM, Fisher PA. Early adversity, child neglect, and stress neurobiology: from observations of impact to empirical evaluations of mechanisms. *Int J Dev Neurosci*. 2019;78:139–146
 18. Maguire SA, Williams B, Naughton AM, et al. A systematic review of the emotional, behavioural and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse. *Child Care Health Dev*. 2015;41(5):641–653
 19. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e232
 20. Pechtel P, PizzaGalli DA. Effects of early life stress on cognitive and affective function: an integrated review of human literature. *Psychopharmacology (Berl)*. 2011;214(1):55–70
 21. Enlow MB, Egeland B, Blood EA, Wright RO, Wright RJ. Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study. *J Epidemiol Community Health*. 2012;66(11):1005–1010
 22. Peer JW, Hillman SB. Stress and resilience for parents of children with intellectual and developmental disabilities: a review of key factors and recommendations for practitioners. *J Policy Pract Intell Disabil*. 2014;11(2):92–98
 23. Witt WP, Litzelman K, Mandic CG, et al. Healthcare-related financial burden among families in the U.S.: the role of childhood activity limitations and income. *J Fam Econ Issues*. 2011;32(2):308–326
 24. Murphy N. Maltreatment of children with disabilities: the breaking point. *J Child Neurol*. 2011;26(8):1054–1056
 25. Romley JA, Shah AK, Chung PJ, Elliott MN, Vestal KD, Schuster MA. Family-provided health care for children with special health care needs. *Pediatrics*. 2017;139(1):e20161287
 26. Goudie A, Narcisse MR, Hall DE, Kuo DZ. Financial and psychological stressors associated with caring for children with disability. *Fam Syst Health*. 2014;32(3):280–290
 27. Dubowitz H, Kim J, Black MM, Weisbart C, Semiatin J, Magder LS. Identifying children at high risk for a child maltreatment report. *Child Abuse Negl*. 2011;35(2):96–104
 28. Centers for Disease Control and Prevention. Fetal alcohol spectrum disorders (FASDs). Available at: <https://www.cdc.gov/ncbddd/fasd/index.html>. Accessed March 22, 2021
 29. Miller BA, Smyth NJ, Mudar PJ. Mothers' alcohol and other drug problems and their punitiveness toward their children. *J Stud Alcohol*. 1999;60(5):632–642
 30. Ouyang L, Fang X, Mercy J, Perou R, Grosse SD. Attention-deficit/hyperactivity disorder symptoms and child maltreatment: a population-based study. *J Pediatr*. 2008;153(6):851–856
 31. Scaramella LV, Leve LD. Clarifying parent-child reciprocities during early childhood: the early childhood coercion model. *Clin Child Fam Psychol Rev*. 2004;7(2):89–107
 32. Turnbull HR, Wilcox BL, Stowe M, Raper C, Hedges LP. Public policy foundations for positive behavioral interventions, strategies, and supports. *J Posit Behav Interv*. 2000;2(4):218–230
 33. Mohr WK, Petti TA, Mohr BD. Adverse effects associated with physical restraint. *Can J Psychiatry*. 2003;48(5):330–337
 34. Kutz GD. *Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers*. Washington, DC: US Government Accountability Office; 2009. Available at: <https://www.gao.gov/products/GAO-09-719T>. Accessed September 9, 2020
 35. Sullivan P, Cork PM. *Developmental Disabilities Training Project*. Omaha, NE: Center for Abused Children with Disabilities, Boys Town National Research Hospital, Nebraska Department of Health and Human Services; 1996
 36. World Health Organization. International classification of functioning, disability and health. Available at: www.who.int/classifications/icf/en/. Accessed September 9, 2020
 37. Helton JJ, Cross TP. The relationship of child functioning to parental physical assault: linear and curvilinear models. *Child Maltreat*. 2011;16(2):126–136
 38. McDonnell CG, Boan AD, Bradley CC, Seay KD, Charles JM, Carpenter LA. Child maltreatment in autism spectrum disorder and intellectual disability: results from a population-based sample. *J Child Psychol Psychiatry*. 2019;60(5):576–584
 39. Fisher MH, Epstein RA, Urbano RC, Vehorn A, Cull MJ, Warren Z. A population-based examination of maltreatment referrals and substantiation for children with autism spectrum disorder. *Autism*. 2019;23(5):1335–1340
 40. Perrigo JL, Berkovits LD, Cederbaum JA, Williams ME, Hurlburt MS. Child abuse and neglect re-report rates for young children with developmental delays. *Child Abuse Negl*. 2018;83:1–9
 41. Sullivan PM, Knutson JF. Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse Negl*. 2000;24(10):1257–1273
 42. Sege RD, Siegel BS; Council on Child Abuse and Neglect; Committee on Psychosocial Aspects of Child and Family Health. Effective discipline to

- raise healthy children. [published correction appears in *Pediatrics*;143(2): e20183609]. *Pediatrics*. 2018;142(6): e20183112
43. Van Horne BS, Caughy MO, Canfield M, et al. First-time maltreatment in children ages 2-10 with and without specific birth defects: a population-based study. *Child Abuse Negl*. 2018;84: 53–63
 44. Caldas SJ, Bensy ML. The sexual maltreatment of students with disabilities in American school settings. *J Child Sex Abuse*. 2014;23(4):345–366
 45. Hershkowitz I, Lamb ME, Horowitz D. Victimization of children with disabilities. *Am J Orthopsychiatry*. 2007; 77(4):629–635
 46. Servais L. Sexual health care in persons with intellectual disabilities. *Ment Retard Dev Disabil Res Rev*. 2006;12(1): 48–56
 47. Eastgate G, Scheermeyer E, van Driel ML, Lennox N. Intellectual disability, sexuality and sexual abuse prevention - a study of family members and support workers. *Aust Fam Physician*. 2012; 41(3):135–139
 48. Committee on Child Abuse and Neglect. Protecting children from sexual abuse by health care providers. *Pediatrics*. 2011;128(2):407–426
 49. Spencer N, Devereux E, Wallace A, et al. Disabling conditions and registration for child abuse and neglect: a population-based study. *Pediatrics*. 2005;116(3):609–613
 50. Cuevas CA, Finkelhor D, Ormrod R, Turner H. Psychiatric diagnosis as a risk marker for victimization in a national sample of children. *J Interpers Violence*. 2009;24(4):636–652
 51. Sari Gokten E, Saday Duman N, Soylu N, Uzun ME. Effects of attention-deficit/hyperactivity disorder on child abuse and neglect. *Child Abuse Negl*. 2016;62: 1–9
 52. Rucklidge JJ, Brown DL, Crawford S, Kaplan BJ. Retrospective reports of childhood trauma in adults with ADHD. *J Atten Disord*. 2006;9(4):631–641
 53. Minshawi NF, Hurwitz S, Fodstad JC, Biebl S, Morriss DH, McDougle CJ. The association between self-injurious behaviors and autism spectrum disorders. *Psychol Res Behav Manag*. 2014;7:125–136
 54. Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005; 116(2):506–512
 55. Mattson G, Kuo DZ; Committee on Psychosocial Aspects of Child and Family Health; Council on Children With Disabilities. Psychosocial factors in children and youth with special health care needs and their families. *Pediatrics*. 2019;143(1):e20183171
 56. Gaebler-Spira D, Thornton LS. Injury prevention for children with disabilities. *Phys Med Rehabil Clin N Am*. 2002;13(4):891–906
 57. Friedman SL, Kalichman MA; Council on Children with Disabilities. Out-of-home placement for children and adolescents with disabilities. *Pediatrics*. 2014; 134(4):836–846
 58. Office of Special Education Programs, US Department of Education. Positive behavioral interventions and supports. Available at: <https://www.PBIS.org>. Accessed October 22, 2018
 59. American Academy of Pediatrics. HealthyChildren.org. Available at: www.healthychildren.org/English/Pages/default.aspx. Accessed August 13, 2019
 60. Hagan JF, Shaw JS, Duncan PM, eds.. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017
 61. American Academy of Pediatrics. Connected kids: safe, strong, secure. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx>. Accessed September 9, 2020
 62. Medical Home Initiatives for Children With Special Needs Project Advisory Committee. American Academy of Pediatrics. The medical home. *Pediatrics*. 2002;110(1 pt 1):184–186
 63. Botash AS, Church CC. Child abuse and disabilities: a medical perspective. *APSAC Advisor*. 1999;12:10–13, 18