Child Neglect: Guidance for Pediatricians

Howard Dubowitz, MD, MS,* Angelo Giardino, MD, PhD,† and Edward Gustavson, MD

OBJECTIVES

After completing this article, readers should be able to:

1. **Suggest an approach to child neglect that focuses on children's basic needs rather than on omissions in care by caregivers.**
2. **Describe different manifestations of neglect.**
3. **Provide key principles for assessment and management of neglect.**
4. **Describe unique aspects of specific types of child neglect.**

Why Is Child Neglect an Important Issue for Pediatricians?

Child neglect is the most common form of child maltreatment, accounting for more than 50% of all cases reported to child protection services (CPS). The 1993 National Incidence Study of Child Abuse and Neglect, based on the identification of maltreatment by community professionals, identified 30 cases of neglect per 1,000 children in the population, a very conservative estimate. The morbidity and mortality associated with neglect also are substantial. Physical problems include injuries, ingestions, inadequately treated illnesses, dental problems, malnutrition, neurologic deficits, and the approximately 50% of the estimated 2,000 annual fatalities that are attributed to child maltreatment. Psychological problems include difficulties with attachment in infancy, impaired cognitive development and learning difficulties, emotional and behavior problems, and delinquent and criminal behavior. Addressing child neglect falls well within the broad mission of pediatrics to protect children and enhance their health and well-being. Pediatricians have many opportunities to identify child neglect and to intervene. Finally, all 50 states have laws requiring physicians (and others) to report child neglect to CPS.

Professor of Pediatrics, University of Maryland School of Medicine, Baltimore, MD.

†Associate Chair, Pediatrics, The Children's Hospital of Philadelphia, Philadelphia, PA.

What is Child Neglect?

Child neglect usually is defined as parental omissions in care that result in actual or potential harm to the child. In general, CPS requires clear evidence of harm, unless the risks are obviously serious, such as when young children are left unattended. Some states exclude situations attributed to poverty.

We suggest a richer and more constructive framework for defining neglect. If our purpose is to enhance children's safety and health, not to blame parents, neglect can be defined as occurring when children's basic needs are not adequately met. Using this definition, neglect may be attributed to child, parent, family, or community factors, and the response (including whether to report to CPS) can be guided by an understanding of the etiology of the problem, the severity of the neglect, and the availability of different options. Basic needs include adequate food, health care, clothing, nurturance, protection, supervision, education, and a home. Parents are primarily responsible for ensuring that these basic needs are met, but other important factors beyond parental behavior contribute to their ability to do so. A broad, child-focused definition identifies basic needs of children that are not met and suggests interventions that might be appropriate (eg, a visiting nurse) regardless of whether CPS criteria are met.

The following points pertain to this definition of neglect:

- Both actual and potential harm are of concern; if harm seems unlikely, it probably is unwarranted to consider a given situation as neglect.
- Both psychological and physical harm are of concern.
- Both short- and long-term harm are of concern.
- The adequacy of care exists on a continuum from excellent to very poor; different degrees of inadequacy require different responses.
- Neglect usually involves a pattern (eg, repeatedly missing school), although it can occur with single lapses in care (eg, infant left alone in a bath).
- The assessment of neglect must consider the cultural context in which children's needs are met (eg, different ways of showing affection, caring).

Manifestations of Possible Neglect Encountered by Pediatricians

Pediatricians may encounter a variety of forms of neglect.

- Noncompliance (nonadherence) with health-care recommendations
- Delay or failure in getting health care
- Hunger, failure to thrive, and unmanaged morbid obesity
- Drug-exposed newborns, older children
- Ingestions; injuries; exposure to second-hand smoke, guns, domestic violence; failure to use car seats/belts (may reflect inadequate protection from environmental hazards)
- Emotional (eg, excessive quietness or apathy in a toddler), behavior (eg, repetitive movements), and learning problems, especially if not being addressed; extreme risk-taking behavior (may reflect inadequate nurturance, affection, or supervision)
- Inadequate hygiene, perhaps contributing to medical problems
- Inadequate clothing, perhaps contributing to medical problems
- Unmet educational needs
- Abandoned children
- Homelessness

The goal of this article is to provide practical information for the brief assessment and initial management of different types of neglect. Some of these require screening (eg, hunger); others may be

observed (eg, failure to thrive). We first offer "core issues" or general principles for assessing and managing all of the types of neglect, followed by a brief description of each form of neglect, adding specific issues pertaining to its assessment and management. Systematic screening is recommended during child health supervision visits to help prevent neglect or to detect problems that may not be apparent. It is beyond the scope of this article to detail the assessment and management of all the issues raised.

Core Issues for Assessing Child Neglect

1. Do the circumstances indicate that the child's need(s) is (are) not being adequately met? To what extent? Is there evidence of actual harm? Is there evidence of potential harm, based on knowledge of the child (eg, severe asthma) or epidemiologic data (eg, risk from not wearing a bike helmet)?

2. Is there a pattern of neglect? For how long has there been a problem? Are there indications of other forms of neglect? Has CPS been involved?

3. What is contributing to the neglect? Consider factors at different levels:
   - –Child (eg, child does not tell parent about the problem)
   - –Parent (eg, parent is ignorant about the condition and the need for help; depressed)
   - –Family (eg, domestic violence/other stresses, social isolation)
   - –Community (eg, poor access to health care, few parent supports)

4. What strengths/resources are available?
   - –Child (eg, child wants to play sports, requiring better health; child likes school)
   - –Parent (eg, parent interested in knowing more about child's condition)
   - –Family (eg, other family members willing to help)
   - –Community (eg, programs for parents, families)

5. What interventions have been tried and with what results? Knowing the details of the interventions can be useful (eg, agency name, nature of the intervention, frequency of contacts, duration). What has the pediatrician done to address the problem?

6. What is the prognosis? Is the family motivated to improve the circumstances and accept help or is the family resistant? Are suitable resources, formal or informal, available?

Core Issues for the Management of Child Neglect

By employing a systematic approach, the clinician usually can provide the most thorough assessment and management of child neglect.

1. Convey concerns to the family kindly but forthrightly about why one is worried.

2. State an interest in helping or suggest another pediatrician.

3. Address contributory factors, prioritizing those most important and amenable to being remedied (eg, recommending treatment for the mother's depression compared with diminishing neighborhood violence).

4. Begin with the least intrusive approach, usually not CPS.

5. Recognize that neglect often requires long-term intervention, support, follow-up.

6. Try to ensure continuity of care as primary clinician.

7. Establish specific objectives (eg, family will always use a car seat) with measurable outcomes (eg, family reports routine use of car seat at next visit).

8. Engage the family in developing the plan, soliciting their input and agreement.

9. Build on family strengths (eg, a parent's wish to see his or her child do well).

10. Encourage informal supports (ie, family, friends).

11. Consider support through religious affiliation.

12. Consider need for concrete services (eg, Medical Assistance, Temporary Assistance to Needy Families [TANF], Food Stamps).

13. Be knowledgeable about community resources and facilitate referrals.

14. Consider need to involve CPS, particularly when there is serious harm or risk or when less intrusive interventions have failed. Even when a CPS report is substantiated, the vast majority of children remain with their parents and are not placed in foster care. Therefore, constructive efforts to work with families are needed.

15. Provide support, follow-up, review of progress, and adjustment of plan if needed.

Types of Neglect

NONCOMPLIANCE (NONADHERENCE) WITH HEALTH-CARE RECOMMENDATIONS

Definition

Health-care recommendations are not implemented, resulting in actual or potential significant harm (eg, a child who has severe asthma is not getting/taking prescribed treatment).

Assessment

Screen: "Do you have trouble getting medical care or medicines for your child?"

- Is the child's condition clearly attributable to the lack of care? Alternatively, the condition may be inherently severe (eg, "brittle" diabetes) or the treatment inadequate.
- What are the possible barriers to care? Lack of health insurance, inability to afford medication, transportation, ignorance, parental health beliefs, child's feelings/attitude (eg, denial of a chronic disease), poor skills to implement treatment (eg, use inhaler), difficult treatment regimen.
- Has the doctor-family communication been clear? Were the recommendations in writing? Was the plan agreed on? Were concerns addressed? Is there continuity and trust in the doctor-family relationship?

Management

- Make treatment practical, set priorities, simplify the regimen, and provide cues (eg, take this with breakfast and at bedtime).
- Communicate clearly, avoid jargon, give written instructions, and emphasize the importance of the treatment.

- Follow-up: phone, office, or in the home (eg, visiting nurse) to help ensure that treatment is implemented. Consider the timing of follow-up; the longer the period, the lower the likelihood that follow-up will occur.

DELAY OR FAILURE IN GETTING HEALTH CARE

Definition

Delay or failure in getting health care resulting in actual or probable significant harm (eg, infant who has protracted symptoms presents with severe dehydration, child who has serious mental health problems is not receiving help).

Assessment

Screen: "Do you have trouble getting medical care or medicines for your child?"

- Is the treatment deemed necessary and likely to have a significant benefit compared with the alternative being used or no treatment? (If not, neglect is not a serious concern.)
- Does the family hold religious or cultural views that led to the child not receiving medical care? What exactly are these views? Do they conform to the subgroup as suggested? What efforts have been made in the past to convey concerns and negotiate an acceptable compromise regarding health care?
- Would a reasonable layperson have recognized the need for treatment by a parent (ie, the health care parents usually provide) or by a professional? The "reasonableness" standard is particularly important to CPS and the judicial system.

Management

- Education of families and children is key to having them know under what circumstances health care should be sought. This pertains to both chronic diseases and acute conditions (eg, acute gastroenteritis and potential dehydration).
- Sensitivity, respect, and humility are important in addressing religious or cultural differences. Some knowledge of the religion and culture is recommended.
- There should be clear harm or risk of harm and a significantly preferable alternative to justify intervening.
- Avoid two approaches: ethnocentrism—the belief that one's own culture is best—and cultural relativism—the view that all cultures are equal, precluding any judgment of another's cultural practice. Sometimes a widely accepted cultural practice may be clearly damaging (eg, female genital mutilation).
- Seek compromise where appropriate (eg, arrangements with Jehovah's Witnesses to have bloodless surgery).
- Rather than limiting intervention to the individual case, it helps to approach community leaders. This broader approach diminishes the risk of ostracizing a family that deviates from its culture and may help to avoid further instances of neglect.

INADEQUATE FOOD

Definition

Inadequate food may present as failure to thrive (FTT) or "growth deficiency" or as repeated hunger. FTT usually is defined as growth that is less than expected, reflected by the weight for age or height for age falling below the 5th percentile, the weight for height falling below the 10th percentile, or the weight for age falling across two major percentiles. Severe and chronic undernutrition impedes brain growth, as reflected by the head circumference. Poor growth raises concern about the adequacy of the diet, especially if there is no other explanation (eg, Down syndrome). However, children can experience significant hunger and still grow normally.

Assessment

Screen: "Do you sometimes have trouble getting enough food for your family?" Review growth pattern, note possible trend toward FTT.

- Does the growth pattern clearly suggest FTT or is the child "normal but small"? ("Severe" = <60% ideal body weight [IBW], "moderate" = 60% to 74% IBW, "mild" = 75% to 85% IBW; IBW = average weight for age)
- A detailed dietary history and a description of feeding behavior are needed; if possible, direct observation of a feed/snack often is useful. A nutritionist or dietitian is recommended if poor growth persists or if there is moderate FTT.
- Is there enough food? Is the family receiving benefits (eg, Special Supplemental Nutrition Program for Women, Infants, and Children) if eligible? Important to ask about "food security" (ie, the regular availability of adequate food).
- How does the parent feel about the child's growth? Is the parent concerned? Too concerned? Is there a generally caring, nurturing approach? Is the parent aware of the child's cues and able to respond appropriately? What is the nature of their relationship?
- Screening laboratory tests: complete blood count, electrolytes, lead, purified protein derivative of tuberculin, and urinalysis and culture.

Management

A comprehensive approach to managing FTT is listed in the Suggested Reading. A few issues will be highlighted:

- Management needs to be guided by a clear understanding of the contributing problems. Often, a good initial strategy is to try supportive and educational approaches (eg, how to bolster the diet). If unsuccessful, nutrition, social work, behavior/developmental/mental health consultations and a parent aide/home visitor should be considered; interdisciplinary evaluation is optimal. If FTT persists and is moderate-to-severe, assess the benefit of an extensive outpatient evaluation versus hospitalization and consider a CPS referral and the possible need for substitute care.
- Findings on the history and examination should guide laboratory tests; avoid a "shotgun" approach. If FTT persists, consider assessment of ferritin and zinc levels, a sweat test, examination of stool for ova and parasites, and measurement of pH and heme.

DRUG-EXPOSED NEWBORNS AND OLDER CHILDREN

Definition

In utero exposure to illegal drugs is a form of neglect, as is direct and

indirect (ie, passive inhalation) exposure of older children. In addition, exposure to alcohol and tobacco can harm the fetus, constituting neglect.

Assessment

Screen (during pregnancy): "Have you been smoking? Have you ever felt that you ought to cut down on your drinking? Have you been using any drugs?" After the newborn period: "Does anyone at home smoke or use drugs or alcohol?" Consider using one of the brief standardized measures to screen for alcoholism (eg, CAGE).

- What is the nature of the drug exposure: type, frequency, and duration?
- How has substance abuse affected parenting and the child?
- What efforts have been made to obtain help, with what results? When? Where?
- Is the parent motivated to engage in drug treatment? Is treatment available?

Management

- Directly convey concerns about risks of drugs and substance abuse to the parent (and child).
- Facilitate treatment, rather than just saying "no."
- Encourage use of informal supports, such as other family members to help with caregiving.
- Consider CPS referral and the need for close follow-up.

INADEQUATE PROTECTION FROM ENVIRONMENTAL HAZARDS

Definition

Avoidable exposure to well-known environmental hazards, in and out of the home, is a form of child neglect. Examples include: poisonous substances within reach of young children, smoking around children who have pulmonary conditions, exposure to domestic violence, riding a bike without a helmet, failure to use a car seat or seat belt, and access to a loaded gun.

Assessment

Screen: "Are all poisons and other dangerous items out of reach? If your child rides a bike, does he or she wear a helmet? Do you have a smoke alarm that is in working condition? Does anyone smoke at home? Is there a gun in your home? Is anyone harassing you, making you afraid, or physically hurting you?"

- What is the history of injuries, ingestions?
- What is the parent's and child's understanding of the hazard(s) and of preventive strategies?
- What is the parent's understanding of the child's developmental capabilities and limitations?
- What efforts have been made to educate the family and help access resources?
- American Academy of Pediatrics leaflets on poisoning prevention, bike helmets, smoke alarms, guns, and domestic violence have useful information for assessing and managing these issues.

Management

- Convey the importance of preventing injuries and other conditions from environmental hazards, a major health problem for children.
- Children who are "injury prone" may be at the extreme of risk-taking behavior and need extra guidance and supervision.
- Provide appropriate educational materials, reinforcing two to three key, developmentally timed (eg, walkers and gates for infants/toddlers) recommendations.
- Refer to community resources (eg, car seat, smoke alarm, bike helmet programs).

INADEQUATE SUPERVISION, ABANDONMENT

Definition

Neglect occurs when children are not supervised in accordance with their developmental needs, resulting in clear risks to their health and well-being (eg, an infant left unattended in a bath tub, a preschooler left home alone, a teenager out overnight without parental approval). Abandonment is the extreme form and has been defined as occurring when children are not "claimed" within 2 days; teenagers may be forced to leave the home.

Assessment

Screen: "Are there times when you need to leave your child alone or you're not sure where he or she is?"

- How often is the child left alone? What time(s) of day?
- Does the child have ready access to an adult? Who and how?
- How has the child been prepared for being alone? Is the neighborhood safe?
- What are the family's options for child care?
- What is the family's understanding of the risks of inadequate supervision?

Management

- Educate parent about the risks of inadequate supervision.
- Strongly urge counseling for problems regarding teenagers and eviction.
- Facilitate suitable child care arrangements; refer to community resources.
- Guide parents to prepare children for potential dangers when alone (eg, what to do if a stranger comes to the door, whom to call for help).
- Abandonment clearly requires CPS involvement.

INADEQUATE AFFECTION, NURTURANCE, LOVE

Definition

The child does not receive adequate affection, nurturance, love; the child does not have a secure sense that parent feels positively about him or her and that the parent clearly cares about or is able to care for him or her (eg, infant of a depressed mother whose need to be comforted is often unmet, preschooler whose parents abuse drugs and who seldom receives positive attention from them, teenager who receives little parental supervision and feels that her parents are uninterested in her and not supportive of her emotionally).

Assessment

Screen: "Do you often feel down, depressed, or hopeless? How are you managing with the kids?"

- How does the parent describe the child and his or her feelings toward the child? Is there a positive

tone that includes warmth and affection?

- What kinds of things does the parent do to show the child affection, caring (eg, holding him, hugging, saying "I love you")?
- Is there something about the child that is difficult for the parent to accept (eg, product of an unwanted pregnancy, child physically resembles the father who has deserted the family)?
- How satisfied is the parent with his or her role as a parent? What is the parent's view of how "good" a parent he or she is (ie, sense of efficacy)?
- What does the child say about his or her perception of the parent's (or any caregiver's) approach to him? "Who can you talk to if you're scared about something or if you're feeling bad?" "Who do you think loves you?"
- Observation is especially important. Does the interaction between parent and child reveal warmth, affection, and caring? A child's excessive quietness or compliance may be a symptom of neglect or abuse. Repetitive movements may represent self-stimulation in a neglectful environment.
- Paying attention to different parenting styles and cultural influences is critical. Affection and caring can be expressed in many ways.

Management

- Convey concern that the child may not be receiving the necessary love.
- Convey developmental information as appropriate (eg, "It's OK to pick up your infant when she cries; you won't spoil her", "Your child really needs to know you love him; how can you clearly show him this?", "It often feels like teens don't want their parents around, but they still need to know they're loved and cared for (we all do!)."
- Address contributory factors (eg, recommend treatment if the mother appears depressed, suggest a parenting group for those needing support and information about parenting, and encourage clear and respectful communication among family members).
- Address the child's needs via one's own support (eg, " I think you're a terrific kid"), involving other family members, a preschool program, or a "Big Brother/Sister." For children showing actual harm (eg, emotional or behavior problems, extreme risk-taking behavior), therapy or substitute care may be needed.

EDUCATIONAL NEEDS NOT BEING MET

Definition

A child's educational needs are neglected when the child is not enrolled in school, when a child fails to attend without a satisfactory reason (>2 d/mo), and when special educational needs are not adequately met. "Home schooling," if organized appropriately, appears to be an acceptable alternative.

Assessment

Screen: "How are things going at school?" Ask about behavior, learning, and peer relations.

- If not enrolled or truant, why? How much school has been missed? What has the parent done? What has the school done?
- If problems have been identified, what assessment has been done? What has been recommended? What has been implemented? What results have there been?
- Request permission to talk to a teacher to help clarify the situation.

Management

- Impress on the family the importance of a sound educational foundation for life.
- Examine strategies for ensuring school attendance.
- Encourage the family to be feisty advocates, demanding appropriate evaluation and services.
- Support the family in obtaining the evaluation and services; consider alternative evaluation clinics.

INADEQUATE HYGIENE

Definition

Child repeatedly does not meet basic standards of hygiene (eg, child is obviously smelly or filthy, not just scruffy).

Assessment

- Is there a pattern of poor hygiene? Are there other forms of neglect? Poor hygiene may be a marker of difficulty in meeting other important needs of children.
- What do the parent and child think about hygiene?
- Has anyone else said anything? Has the child been teased about this?
- What barriers are there, such as lack of access to washing facilities?
- Is the family amenable to improving their hygiene?

Management

- Discuss with the family the need for adequate hygiene and potential problems with the child's health and emotional development if he or she is teased or avoided.
- Emphasize hygiene around all handling of food.
- Refer to a clinic, social worker, or other community resources such as the Department of Social Services (DSS) if help is needed with utilities or if less intrusive efforts have failed.

INADEQUATE CLOTHING

Definition

Child repeatedly wears clothing that is obviously unsuitable for the weather or poorly fitting (eg, lack of jacket in very cold weather, painfully small shoes).

Assessment

- Is there a pattern of inadequate clothing? Are there other forms of neglect? Inadequate clothing may be a marker of difficulty in meeting other important needs of children.
- What do the parent and child think about the clothing? Are they new to the climate?
- Has anyone else said anything? Has the child been teased about this? Has inadequate clothing contributed to physical problems (eg, frostbite)?
- Is a lack of resources contributory? What has been tried to find low-cost clothing?
- Is the family amenable to improving this problem?

Management

- Discuss the need for adequate clothing and potential problems with the child's physical and mental health (if teased or shunned). Explain the risks of cold and hot weather.
- Refer to resources for low-cost clothing; consider social work or DSS referral.

HOMELESSNESS

Definition

The family is forced to sleep in a homeless shelter, on the street, or in a car.

Assessment

Screen: "Have you been homeless in the last year?"

- If homeless: What happened? How often were you homeless? Is this still a problem? What have you tried? Would you like help?

Management

Refer to appropriate resources for housing assistance.

Conclusion

Our approach to child neglect focuses on basic needs of children that may not be met. In view of the overlap that often exists among different types of neglect, we offer "core" guiding principles for assessing and managing those issues. The guidance in this article must be adapted to the individual clinician's circumstances.

Acknowledgment

This work originated at the Child Abuse and Neglect Leadership Conference in Chicago, June 1997. We would like to acknowledge the contribution of others in our working group: Sara Schuh, MD, Wendy Wright, MD, and Lavdena Orr, MD.

SUGGESTED READING

Bithoney WG, Dubowitz H, Egan H. Failure to thrive/growth deficiency. *Pediatr Rev.* 1992;13:453–459

Bradley KA, Boyd-Wickizer J, Powell SH, Burman ML. Alcohol screening questionnaires in women: a critical review. *JAMA.* 1998;280:166–171

Cutts DB, Pheley AM, Geppert JS. Hunger in mid-western inner-city young children. *Arch Pediatr Adolesc Med.* 1998;152: 589–593

Dubowitz H. Neglect of children's health care. In: Dubowitz H, ed. *Neglected Children: Research, Practice and Policy.* Thousand Oaks, Calif: Sage Publications; 1999

Dubowitz H, Black M, Starr R, Zuravin S. A conceptual definition of child neglect. *Criminal Justice and Behavior*. 1993;20: 8–26

Glascoe FP, Oberklaid F, Dworkin PH, Trimm F. Brief approaches to educating patients and parents in primary care. *Pediatrics.* 1998;101(6):e10

Horwitz SM, Leaf PJ, Leventhal JM, Forsyth B, Speechley KN. Identification and management of psychosocial and development problems in community-based, primary care pediatric practices. *Pediatrics*. 1992; 89:480–485

Jellinek MS, Murphy JM, Little M, Pagano ME, Comer DM, Kelleher KJ. Use of pediatric symptom checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. *Arch Pediatr Adolesc Med.* 1999;153:254–260

Liptak GS. Enhancing patient compliance in pediatrics. *Pediatr Rev.* 1996;17:128–134

PIR QUIZ

Quiz also available online at www.pedsinreview.org.

1. The 1993 National Incidence Study of Child Abuse and Neglect found that the number of identified cases of neglect per 1,000 children in the population is *closest* to
   A. 3
   B. 10
   C. 30
   D. 100
   E. 300

2. A *true* statement about the usual definition of child neglect is:
   A. A parent or guardian is the perpetrator.
   B. Actual physical injury is child abuse rather than neglect.
   C. Hunger without evidence of growth failure rules out neglect.
   D. Refusing chemotherapy following a third relapse of acute leukemia is medical neglect.
   E. Situations due to poverty are excluded by state mandate nationwide.

3. Useful principles guiding the management of child neglect (applying the proposed definition) include all of the following, *except*:
   A. Consider the role that informal support from friends and family can play.
   B. Convey concern about the neglect to the family.
   C. Identify family strengths on which to build.
   D. Immediately report the neglect to Child Protective Services.
   E. Recognize that neglect often requires long-term support and intervention.

Child Neglect: Guidance for Pediatricians

Howard Dubowitz, Angelo Giardino and Edward Gustavson

Pediatrics in Review 2000;21;111
DOI: 10.1542/pir.21-4-111

Child Neglect: Guidance for Pediatricians

Howard Dubowitz, Angelo Giardino and Edward Gustavson

Pediatrics in Review 2000;21;111
DOI: 10.1542/pir.21-4-111