IN THE SUPREME COURT OF OHIO

JANE DOE, INDIVIDUALLY AND AS NEXT FRIEND OF HOLLY ROE, A MINOR Appellants, -vs- MARLINGTON LOCAL SCHOOL DISTRICT, et al. Appellees.	Case No. 07-1304 On Appeal from the Judgment Entered in the Stark County Court of Appeals, Fifth Appellate District Court of Appeals Case No. 00102

MERIT BRIEF OF *AMICUS CURIAE* OHIO LEGAL RIGHTS SERVICE SUPPORTING APPELLANT JANE DOE, INDIVIDUALLY AND AS NEXT FRIEND OF HOLLY ROE, A MINOR, et al.

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STATEMENT OF INTEREST OF AMICUS CURIAE OHIO LEGAL RIGHTS SERVICE

Ohio Legal Rights Service (OLRS) is an independent state agency designated by the Governor as the federally mandated protection and advocacy system for people with disabilities. *See* R.C. 5123.60; Section 15041 *et seq*, Title 42, U.S.Code. Under both state and federal law, OLRS investigates abuse, neglect and rights violations affecting people with disabilities, and pursues administrative, legal, and policy remedies to those violations.

OLRS has litigated many issues involving the rights of people with disabilities including employment discrimination, access to the courts, civil commitment, community integration, and free, appropriate public education. *See, e.g., State v. Lott* (2002) 97 Ohio St. 3d 303, 779 N.E. 2d 1011 (*amicus curiae* in case involving standard for assessment of mental retardation in capital cases); *Popovich v. Cuyahoga County Court of Common Pleas* (6th Cir. 2002), 276 F. 3d 808(*amicus curiae* counsel in ADA Title II case involving access to court for hearing impaired individual); *Board of Education of Austintown Local School District v. Mahoning County Board of Mental Retardation and Developmental Disabilities* (1993) 66 Ohio St. 3d 355, 613 N.E. 2d 167 (IDEA requires county school to serve children residing at developmental center); *Heller v. Doe by Doe*, 509 U.S. 312 (1993), (*amicus curiae* counsel for organizations of people with

disabilities in case involving civil commitment rights of people with mental retardation); *Martin v. Voinovich* (S.D. Ohio 1993), 840 F. Supp. 1175 (ADA Title II community integration case); *Cordrey v. Euckert* (1991), 499 U.S. 938 (1991), 111 S. Ct. 1391, *denying cert. Cordrey v. Euckert* (6th Cir. 1990), 917 F. 2d 1460 (special education services for children who need an extended school year).

As Ohio's protection and advocacy agency, *Amicus* OLRS has considerable experience investigating and monitoring cases of abuse and neglect of children with disabilities and representing students with disabilities and their parents to enforce the right to receive a free appropriate public education under the Individuals with Disabilities Education Act (IDEA), Sections 1400, *et seq.*, Title 20, U.S.Code. OLRS annually represents hundreds of children with disabilities in school settings including representing children with disabilities in special education cases before administrative bodies and in federal courts. *Amicus* urges this Court to reconsider the responsibilities of school districts to ensure that children with disabilities are kept free from harm while in school, as well as while going to and from school. These issues affect children with disabilities throughout Ohio.

STATEMENT OF FACTS

The appellants' Merit Brief provides a detailed fact pattern in which appellant Holly Roe, a ten-year old child with learning, communication, and

emotional disabilities attributable to mild mental retardation, was over a period of time repeatedly sexually assaulted by another "special needs" student while on the bus ride home from school during the 2004-2005 school year. She was sexually assaulted on dozens of separate occasions while in the presence of the school bus driver.

The bus driver admitted she sometimes noticed the children crawling under the seats, but believed the children were "playing."[1] The fifteen year-old perpetrator, Mr. Boe[2], was known to Marlington Local School District to require special supervision because of his serious history of misconduct, which included criminal charges for punching his father, physically attacking his teacher and biting the classroom aide who attempted to intervene, and had been placed on probation for these events.[3]

Holly Roe and her parents filed suit, and the defendant-appellee below moved for summary judgment, which was denied by the trial court.[4] The Marlington School District appealed, and the Fifth District Court of Appeals reversed judgment in favor of Marlington. Appellants timely appealed to this Court on July 19, 2007. On 10/31/07 this Court declined jurisdiction and dismissed the appeal. A motion for reconsideration was filed on 11/13/07, and the

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[1] Wright deposition at p. 44
[2] On the motion of the boy's parents, the trial court had ordered he be identified only by this fictional name.
[3] Behner deposition at 18, 22-40, and Exhibits 1-5 thereto.
[4] See 3/31/06 Trial Court Order, attached to Appellants' Memorandum in Support of Jurisdiction.

Court accepted the appeal on 12/26/07.

ARGUMENT IN SUPPORT OF PROPOSITION OF LAW

Proposition of Law No. 1: A school bus driver's negligent failure to supervise and control obvious misbehavior by special needs students on her school bus constitutes "negligent operation" of the school bus, for purposes of R.C. 2744.02(B)(1).

The Court of Appeals erred in finding as a matter of law that the conduct of this bus driver and Marlington Local School District could not have constituted negligent operation of the school bus.

R.C. 2744.02(B)(1) is an exception to the general immunity established in R.C. 2744.02(A)(1), and imposes liability on political subdivisions for injury, loss, or death caused by the negligent operation of any motor vehicle by their employees.[5] Although "operation" is undefined, Ohio law is clear that it includes more than simply "driving" a motor vehicle.

Two cases from the Sixth District, *Groves v. Dayton Public Schools, et al.*(1999), 132 Ohio App. 3d 566, 725 N.E. 2d 734, and *Doe v. Dayton Public School District Board of Education* (1999), 137 Ohio App. 3d 166, 738 N.E. 2d 390, found that "operation" as used in R.C. Chapter 2744 includes more than the

[5] Although R.C. 2744.02(B)(1)(a)-(c) provides full defenses to any liability imposed by the motor vehicle exception to immunity, these defenses relate to police, fire, and EMS calls and do not apply to this case.

mere act of operating the motor vehicle. In *Groves*, the bus driver's negligence in assisting a disabled student from the bus was found to be part of "operating" the bus,[6] and in *Doe* the court reiterated that "operation of a motor vehicle" includes more than "manipulation of the vehicle's controls during its travel,[7] although the court's application of a proximate cause standard resulted in an affirmation in *Doe*.[8]

A bus driver's operation of a school bus involves more than simply starting the engine and driving the bus down the street without collision. Ohio Adm. Code 3301-51-10, 3301-83-08, and 3301-83-10 establish requirements applicable to the driver which spell out what the operation of a school bus requires. Ohio Adm. Code 3301-51-10, Transportation of Children with Disabilities, includes a state requirement which, if followed by appellees, may have eliminated the appellant's injuries. The provision specifies that "[d]rivers and transportation aides must have access to appropriate information about the child to the degree that such information might affect safe transportation and medical wellbeing while being transported." Ohio Adm. Code 3301-51-10(D)(3)

The State of Ohio has created strong public policy to prevent the abuse and neglect of children and adults with mental retardation or other developmental

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[6] Groves at 570
[7] Doe at 171
[8] *Id.*

disabilities. This public policy is manifested through a variety of statutory and regulatory requirements. The provisions include background check requirements for applicants of direct service positions with County Boards of Mental Retardation and Developmental Disabilities,[9] an Abuser Registry,[10] a system of required reporting of Major Unusual Incidents,[11] Failure to Report requirements,[12] criminal penalties for Failure to Report[13], and Court-Ordered Protective Services.[14]

A narrow interpretation of the scope of the exception for "operation of a motor vehicle" runs counter to the state's public policy of protecting the health and safety of children, especially children with disabilities. Courts should be wary of limiting exceptions to immunity when the exception is part and parcel of Ohio's larger scheme of protecting children with disabilities. Ohio's public policy of protecting children is served by favoring the exception, rather than focusing on the general rule of immunity. In light of this strong public policy regarding the protection of children with disabilities, the strained reading of "operation of a motor vehicle" to not encompass the obligation to control student behavior while traveling on the bus is inappropriate.

The State of Ohio's public policy regarding protection of children with

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[9] R.C. 5126.28 and R.C. 5126.281.
[10] R.C. Secs 5123.50-5123.54.
[11] R.C. 5123.604, Ohio Admin. Code Chap. 5123:2-17.
[12] R.C. 5123.61.
[13] R.C. 5123.99(B).
[14] R.C. 5126.30-5126.34.

disabilities is clearly justified. In written testimony provided to the Committee on Education and the Workforce Select Education Subcommittee of the United States House of Representatives,[15] the extent of maltreatment of children with disabilities is demonstrated to be substantial.

> Children with disabilities are, on average, 3.4 times more likely to be maltreated. Broken down by form of maltreatment, children with disabilities are 3.88 times more likely to experience emotional abuse, 3.79 times more likely to be physically abused, 3.76 times more likely to be victims of neglect, and 3.14 times more likely to be sexually assaulted than children without disabilities

Similarly, a study by the Boys Town National Research Hospital found that children with disabilities are at greater risk of becoming victims of abuse and neglect than children without disabilities. This study showed that children with disabilities are 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than are

[15]Testimony by the Consortium for Citizens with Disabilities (CCD) Task Force on Child Abuse and Neglect, August 2, 2001, p. 2, attached as Appendix 1).

children without disabilities[16].

Ohio has established strong public policy to prevent abuse and neglect of children with disabilities, public policy created through a variety of statutory and regulatory requirements. These children are even more vulnerable to abuse than children without disabilities. Courts should be wary in limiting exceptions to immunity when Ohio's larger public policy concerns would be compromised. *Amicus* urges this Court to ensure that school districts provide these children with a safe environment as they are transported to and from school.

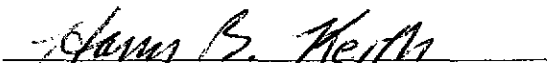
CONCLUSION

For the reasons stated herein, *Amicus Curiae* Ohio Legal Rights Service respectfully urges this Court to reverse the judgment entered by the Fifth District Court of Appeals, and to remand this matter to the trial court for further proceedings. The only just result would be to permit the appellants to have their day in court.

[16]Maltreatment of Children With Disabilities, Roberta A. Hibbard, et al., Pediatrics, Vol. 119, No. 5, May 2007, p. 3, attached as Appendix 2).

Respectfully submitted,

OHIO LEGAL RIGHTS SERVICE



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CERTIFICATE OF SERVICE

A copy of the foregoing Merit Brief of amicus curiae has been served by regular U.S. Mail to the following counsel of record this 17th day of March, 2008:

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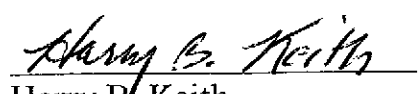
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APPENDIX

Child Abuse Task Force Testimony, August 2, 2001, Appx.-1

Maltreatment of Children With Disabilities, Roberta A. Hibbard, et al., Pediatrics, Vol. 119, No. 5, May 2007, p. 3, Appx.-2

Consortium for Citizens with Disabilities

Testimony for

The Committee on Education and the Workforce Select Education Subcommittee
United State House of Representatives

Hearing on

Child Abuse Prevention and Treatment Act

August 2, 2001

Room 2175 Rayburn House Office Building

Submitted by:

Consortium for Citizens with Disabilities
Task Force on Child Abuse and Neglect

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The Consortium for Citizens with Disabilities (CCD) Task Force on Child Abuse and Neglect is pleased to submit written testimony on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) to the House Select Education Subcommittee of the Committee on Education and the Workforce.

CCD is a coalition of approximately 100 national disability organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

In 2001, the Consortium for Citizens with Disabilities made a significant and purposeful decision to establish a Task Force on Child Abuse and Neglect and to work in tandem with the National Child Abuse Coalition for one important goal - the prevention of child abuse and neglect. Children with disabilities are particularly vulnerable to child abuse, and child abuse may result in the acquisition or development of disabilities, which may, in turn, make children even more vulnerable for further abuse.

Appendix 1

According to an HHS report released in April 2001, substantiated cases of child abuse and neglect investigated by child protective service (CPS) agencies numbered an estimated 826,000 children nationally in 1999. States report that nearly half (44.2%) of the child victims or their families in confirmed cases of child abuse and neglect receive no treatment or any other kind of services following investigation of the report. Deaths from child maltreatment remain unacceptably high: an estimated 1,100 children died of abuse or neglect in 1999 alone. And, as noted above, near-fatal child maltreatment leaves thousands of children permanently disabled each year.

Children with disabilities are, on average, 3.4 times more likely to be maltreated. Broken down by form of maltreatment, children with disabilities are 3.88 times more likely to experience emotional abuse, 3.79 times more likely to be physically abused, 3.76 times more likely to be victims of neglect, and 3.14 times more likely to be sexually assaulted than children without disabilities.

In addition to disabilities being a contributing factor to maltreatment, maltreatment can cause disabilities. The National Center on Child Abuse and Neglect (now, Office on Child Abuse and Neglect) determined that 36.6 percent of the substantiated cases of maltreatment in a 1993 study sample caused disabilities. Near-fatal child maltreatment leaves 18,000 children permanently disabled each year (United States Department of Health and Human Services, 1995).

In addition to the unconscionable human costs, the financial costs of the child maltreatment-disabilities dynamic are staggering. Approximately 22 percent of maltreated children have learning disorders requiring special education. According to a study by Health and Human Services, the future lost productivity of severely abused children is $658 million to $1.3 billion, if their impairments limit their potential earnings by only five to ten percent.

Such alarming statistics on the child maltreatment/disabilities nexus provide a cogent argument for attending to disability concerns in CAPTA. Toward that end, CCD's priorities for the current reauthorization of CAPTA are as follows:

- Comprehensive health and developmental evaluations - Each child for whom there is an open case with Child Protective Services should be referred for a comprehensive health and developmental evaluation, if one has not already been done.
- Respite care services - Respite care should be more available, accessible, and affordable for families who are at risk of abuse and neglect, especially those families of children and/or parents with disabilities. Respite should be considered a core service of child abuse prevention programs.
- Equal protection for all children -All children should receive equal protection from abuse and neglect, including medical neglect, regardless of the health status, disabling condition, or any other characteristic of the child or child's parent(s)/caregiver(s).

Rationale

Comprehensive Health and Developmental Evaluations: Chernoff et al. (1994) determined that over 90% of the foster care children in their study had an abnormality in at least one body system. While identification and treatment of the medical, developmental, and mental health problems of children have been shown to decrease the amount of time a child spends in out of home placements and increase the likelihood that he or she will experience stable living situations (Horwitz, Owens, and Simms, July 2000), numerous systemic and direct service barriers prevent many children in the child welfare system from receiving adequate health care (GAO, 1995). It is time for CAPTA to address this issue when a child is first referred to CPS for an investigation.

Respite: Research has demonstrated that respite is a successful, effective and cost-saving child abuse and neglect prevention strategy. One of the first comprehensive, comparative respite care studies of families with a disabled member found significant beneficial outcomes. This is especially noteworthy, given that children with disabilities are at much greater risk of abuse or neglect. The National Respite Coalition has summarized the effectiveness data for respite

care in preventing child abuse and neglect, in enhancing family stability and lowering stress, and in reducing out-of-home placements. (See NRC testimony for the record).

However, respite is in short supply and the demand is great. During an average week, nearly 1,500 families representing 3,425 children are turned away from respite and crisis care programs because resources to meet the need are absent. In a 1998 survey of respite programs nationwide, half had families waiting for respite care at the time of the survey (ARCH National Resource Center on Respite and Crisis Care, 1999).

Recommendations

CCD believes that these priorities are essential in the prevention and treatment of all children, not just children with disabilities. In support of these legislative priorities, CCD is requesting the inclusion of the legislative language in CAPTA being put forth by the National Child Abuse Coalition and lend our particular support to the following:

- Make Prevention a National Priority. Preventing abuse and neglect of children from happening in the first place should be a national priority. Billions of dollars are spent on protecting and serving children once they are in the CPS and foster care system, while only minimal investments are made in up-front prevention. Redirecting CAPTA will keep children safe and avert the long-term consequences and more costly out-of-home placements that result from serious abuse.
- Comprehensive Health and Developmental Evaluations: CAPTA will include discretionary funding for developing model programs in the provision of comprehensive health and developmental screenings. A required element of CPS intake protocol for selected pilot sites would be a determination of the child's health care coverage and an appropriate referral based on that determination.
- Respite Services Should be Preserved as One of Core Community-Based Child Abuse and Neglect Prevention Strategies: CAPTA should be the basic source of funding for proven effective community-based prevention programs, including the identified core programs of respite care, home visiting, parent mutual support, parent education, and family resource services.
- Strengthen Role of Families of Children with Disabilities, Parents with Disabilities. Recognizing that children with disabilities are at increased risk of abuse and neglect and that abuse is a significant cause of disabilities, CCD strongly supports all existing and NCAC proposed language in CAPTA Title II, which requires the involvement of families of children with disabilities, parents with disabilities, and agencies and organizations who work with families of children with disabilities to be an integral component of every aspect of program implementation and evaluation.
- Increased Funding is Critical for Prevention. Funding should be authorized at $500 million for Title II, which represents a modest commitment to support prevention of child abuse and neglect through CAPTA. It is also the amount necessary to begin to bring promising practices to scale and to keep local programs from having to turn families away from effective prevention services they are seeking voluntarily. CCD also supports an increase in Title I's authorization level to $500 million and to $100 million for research and demonstration.
- Enhance Accountability. CCD also supports the National Child Abuse Coalition's proposal to increase program and state accountability through improved reporting requirements to demonstrate effective and efficient use of funds under and in accordance with the Act.

In addition to requesting Chairman Hoekstra and his colleagues on the Select Education Subcommittee to include the above outlined language in CAPTA, CCD also requests that Chairman Hoekstra and the other distinguished Subcommittee members encourage their colleagues on the House Appropriations Committee to increase funding for CAPTA to their full authorization levels for FY 02.

Finally, CCD recommends that all children receive equal protection from abuse and neglect, including medical neglect. CCD's proposal is for CAPTA to include report language that precludes states from discriminatory practices in the provision of child abuse and neglect prevention and treatment services based on the health status, disability status, race, income, native language, ethnicity, religion, insurance coverage, gender, or any other characteristic of the child or the

child's parent(s)/caregiver(s).

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Maltreatment of Children With Disabilities

Roberta A. Hibbard, Larry W. Desch, and the Committee on Child Abuse and Neglect and and Council on Children With Disabilities

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The online version of this article, along with updated information and services, is located on the World Wide Web at:
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Appendix 2

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CLINICAL REPORT

Maltreatment of Children With Disabilities

Guidance for the Clinician in Rendering Pediatric Care

Roberta A. Hibbard, MD, Larry W. Desch, MD, and the Committee on Child Abuse and Neglect and Council on Children With Disabilities

ABSTRACT

Widespread efforts are being made to increase awareness and provide education to pediatricians regarding risk factors of child abuse and neglect. The purpose of this clinical report is to ensure that children with disabilities are recognized as a population that is also at risk of maltreatment. Some conditions related to a disability can be confused with maltreatment. The need for early recognition and intervention of child abuse and neglect in this population, as well as the ways that a medical home can facilitate the prevention and early detection of child maltreatment, are the subject of this report.

INTRODUCTION

The maltreatment of children, including those with disabilities, is a critical public health issue. For purposes of this report, the terms "disability" and "special health care needs" include the full spectrum of physical, mental, and emotional impairment. 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. Nonetheless, children with disabilities and special health care needs are at increased risk of child maltreatment. This report is an update to the previous policy statement, "Assessment of Maltreatment of Children With Disabilities."[1]

The Children's Bureau reported that an estimated 872 000 children were determined to be victims of abuse or neglect in 2004.[2] More than 60% of child victims experienced neglect, almost 20% were physically abused, and 10% were sexually abused. Of the 36 states that reported on disabilities, child victims who were reported with a disability accounted for 7.3% of all victims. Children with the following conditions were considered as having a disability: mental retardation, emotional disturbance, visual impairment, learning disability, physical disability, behavioral problems, or another medical problem. It was believed that these conditions were underrecognized and underreported, because not every child received a clinical diagnostic assessment when child maltreatment was suspected.

Child maltreatment may result in the development of disabilities, which in turn can precipitate further abuse.[3] Studies have been unable to accurately document the extent or rate of abuse among children with disabilities or determine if disabilities were present before the abuse or were the direct result of maltreatment.[4] It should be emphasized also that several case reports and epidemiologic data remind us that the natural history of some medical conditions can include conditions that mimic child maltreatment.[5,6]

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Key Words
child neglect, child maltreatment, developmental disabilities, child abuse, physical abuse, child sexual abuse

Abbreviations
CPS—child protective services
AAP—American Academy of Pediatrics

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The numbers of children who survive disabling medical conditions as a result of technologic advances and children who are recognized and identified as having disabilities are increasing.[7] The rates of child maltreatment have been found to be high in the child population in general and in children with blindness, deafness, chronic illness, developmental delays, behavioral or emotional disorders, and multiple disabilities.[8] Minimal research on child abuse has focused specifically on children with disabilities; further study is indicated and has been encouraged.[9,10]

The Child Abuse and Prevention, Adoption, and Family Services Act of 1988 (Pub L No. 100–294) included a mandate to study the incidence of child maltreatment among children with disabilities. This research was funded by the National Center on Child Abuse and Neglect and conducted by the Center for Abused Children With Disabilities at the Boys Town National Research Center.[8] A study by Westat, Inc, determined the incidence of abuse among children with disabilities and the relationship between child abuse and disabilities.[9] Data were collected from 35 child protective services (CPS) agencies across the country, and results indicated that 14.1% of children whose maltreatment was substantiated by CPS workers had 1 or more disabilities. A Nebraska study that used an electronic merger of hospital, central registry, foster care review board, and law enforcement records found disabilities to be twice as prevalent among maltreated children in hospitals as among hospital controls, which is consistent with the hypothesis that disabilities increase the risk of maltreatment. The data are also consistent with the hypothesis that maltreatment contributes to disabilities.[11]

According to research performed by the Boys Town National Research Hospital, children with disabilities were found to be at greater risk of becoming victims of abuse and neglect than were children without disabilities. The study showed that children with disabilities are 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than are children without disabilities.[8] Another study found the overall incidence of child maltreatment to be 39% in 150 children with multiple disabilities admitted to a psychiatric hospital. Of those children, 60% had been physically abused, 45% had been neglected, and 36% had been sexually abused.[12] In a 2000 study of more than 4500 maltreated children, Sullivan and Knutson[13] observed children with disabilities to be 3.76 times more likely to be neglected, 3.79 times more likely to be physically abused, and 3.14 times more likely to be sexually abused when compared with children without disabilities.[13] Children with behavioral disorders were found to be at the highest risk of all types of maltreatment, and neglect was the most common form of maltreatment across all disability types. A relative-risk matrix for all types of maltreatment among children with specific disabilities was developed. In 1 recent study, caregivers reported that 18.5% of children with autism had been physically abused and 16.6% had been sexually abused.[14] Spencer et al[15] concluded that children with disabling conditions are at increased risk of child abuse and neglect, although the type of maltreatment varies with the specific disabling condition.

LIMITATIONS OF CURRENT RESEARCH

The prevalence of maltreatment of children with disabilities is difficult to calculate, because states do not use comparable definitions of child abuse and neglect. Another major problem with the published literature is the variable definition of "disabilities."[4] The Centers for Disease Control and Prevention describes developmental disabilities as a diverse group of severe chronic conditions that are attributable to mental and/or physical impairments and result in problems with major life activities such as language, mobility, learning, self-help, and independent living. The Americans With Disabilities Act[16] defines "disability" as a physical or mental impairment that substantially limits 1 or more of the major life activities of an individual. This definition includes all types of disabilities, including physical disabilities, cognitive or learning disabilities, motor and sensory dysfunctions, mental illness, or any other kind of physical, mental, or emotional impairment.[17] Perrin[18] reported that most childhood chronic health conditions do not cause disability. The Maternal and Child Health Bureau has defined children with special health care needs as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[19] The term "children with special health care needs" is less limiting than some other terms.[20]

Legal definitions do not always match clinical data. Child development evaluations do not always allow an immediate and precise diagnosis of extent or type of disability, and some studies rely on evaluations by untrained observers. Therefore, evaluation of research efforts is hindered by different definitions of terms (eg, disabilities and maltreatment), noncomparable methods, various study sample sizes, and lack of uniform data collection. Furthermore, changes in reporting laws and societal attitudes can occur during a study period.[21]

Another problem that has been cited in the literature is the lack of recognition and documentation of disabilities by CPS workers and their lack of training on evaluating children with disabilities.[4] In the study by Westat,[9] analyses were based on CPS workers' opinions rather than data empirically derived from physicians or other professionals trained to diagnose disabilities. Bonner et al[4] demonstrated that since 1982, correct and consistent use of a CPS-created system of collecting information regarding disabilities in maltreated children

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had decreased, suggesting that disabilities were unlikely to be identified as children enter the CPS system. A survey of 51 state CPS agencies found that in 86% of states, CPS workers used a standardized form to record child-maltreatment cases, but in only 59% of those states did the workers record information regarding preexisting disabilities on the form.[22]

The Westat study was limited to intrafamilial cases.[9] Because it is well known that individuals other than family members can commit harm to children, statistics limited to intrafamilial cases would be likely to underestimate the overall incidence of maltreatment among children with disabilities.

Along with the lack of well-designed research on maltreatment is the lack of research on how to respond to children with disabilities who have been maltreated. A needs assessment of parents, educators, and CPS investigators in 2000 revealed that knowledge and experience in child maltreatment were lacking.[23] Most respondents were interested in training, with recognition of maltreatment in the child with a disability as a top priority. In this same report, a collaborative team-approach response was recommended.

CAUSAL FACTORS

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 often place higher emotional, physical, economic, and social demands on their families.[21] For example, a physical disability that causes difficulty in ambulation can place a child at risk of accidental falls. Therefore, much closer supervision will be needed, which itself can be stressful. Parents with limited social and community support may be at especially high risk of maltreating children with disabilities, because they may feel more overwhelmed and unable to cope with the care and supervision responsibilities that are required.[17] Lack of respite or breaks in child care responsibilities can contribute to an increased risk of abuse and neglect. Finally, the added requirements of special health care and educational needs can result in failure of the child to receive needed medications, adequate medical care, and appropriate educational placements, resulting in child neglect.[17]

Numerous problems have been cited with the provision of care for foster children with disabilities. Foster parents sometimes are not told about a child's medical and emotional problems and are, therefore, not sufficiently educated or prepared to deal with the specific condition. Other problems for foster children with disabilities include lack of permanent placement, lack of a medical home, lack of financial support, and inappropriately prepared foster parents.[3]

Parents or caregivers may feel increased stress because children with disabilities may not respond to traditional means of reinforcement, and sometimes these children's behavioral characteristics (eg, aggressiveness, noncompliance, and communication problems) may become quite frustrating.[8] Behavioral challenges in children who have disabilities may further increase the likelihood of physical abuse.[17]

Parents of children with communication problems may resort to physical discipline because of frustration over what they perceive as intentional failure to respond to verbal guidance. It has been noted paradoxically, however, that families who report higher stress levels may actually have greater insight into problems associated with caring for a disabled child, whereas parents with a history of neglect of a child may not experience the level of stress that a more involved parent may experience.[24]

Although the use of aversive procedures and restraints for children who have disabilities has been fortunately 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 used sometimes in homes, schools, programs, and institutions.[25] Aversive techniques are procedures that use painful or unpleasant stimuli to modify a behavior that has been found to be unacceptable or inappropriate. Restraints are physical measures (such as tie-downs or prolonged seclusion) used to prevent something physical from happening or for "punishment." This includes "therapeutic holding," which has been repudiated as being harmful.[26] During the past 20 years, much research has demonstrated the effectiveness of alternative measures, commonly called "positive behavioral supports," to change behavior.[25] Pediatricians and others who could use additional information about the problems that occur from the use of aversive procedures or restraints can easily get this guidance from the Web sites of organizations such as the Association for the Severely Handicapped (www.tash.org/IRR/resolutions/res02aversive.htm) and the Autism National Committee (www.Autcom.org/restraints.html). Information about positive behavioral support guidelines is available from a US Department of Education–funded program, the Technical Assistance Center on Positive Behavioral Interventions & Supports (www.Pbis.org), and other national and international programs. The American Academy of Child and Adolescent Psychiatry also provides guidance on this subject (www.aacap.org/page.ww?section=Policy+Statements&name=Coercive+Interventions+for+Reactive+Attachment+Disorder).

The presence of multiple caregivers may heighten or reduce the risk of abuse of the child. Infrequent contact of a child with disabilities with other children and adults may make them uniquely vulnerable to molestation because there is decreased opportunity for the child to

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develop a trusting relationship with an individual to whom he or she may disclose the abuse[17] and decreased opportunity to learn to resist molestation. On the other hand, children with disabilities who require multiple caregivers or providers may have contact with numerous individuals, thereby increasing the opportunity for abuse, including sexual 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 lessen 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 an open mind to recognition that any child may become a victim.

Children with disabilities often have limited access to critical information pertaining to personal safety and sexual abuse prevention. Children who have increased dependency on caregivers for their physical needs may be accustomed to having their bodies touched by adults on a regular basis. Parents may object to their child being provided with education on human sexuality, because they may feel that their children will never be in sexually risky situations because of their special needs. However, children with disabilities may be unintentionally conditioned to comply with authority, which could result in them failing to recognize abusive behaviors as maltreatment.[8] 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 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), the child may not be able to differentiate "appropriate" pain from "inappropriate" pain.

PEDIATRICIAN'S ROLE

Pediatricians should be aware that the presence of disabilities in a child is a risk factor for victimization and that disabilities can also be the result of child maltreatment. The pediatrician should work with families, other health care professionals, and other community resources to ensure the safety of all children, including those with disabilities. The following should be considered.

Identification and Reporting

Pediatricians always need be alert to signs or symptoms that are suggestive of abuse, no less in children with disabilities than in others. However, recognizing the signs and symptoms of maltreatment among children with disabilities may be difficult, because many children may not be able to verbalize that they were abused or they may not understand that what took place was wrong.[17] Because it is common for the physical examination to be normal, especially in sexual abuse and emotional maltreatment, a high index of suspicion in selected cases is warranted.

Familiarity with the natural history of disorders that may mimic child abuse can prevent the misdiagnosis of child maltreatment.[27–29] Children with motor and balance disabilities may experience increased injuries from accidents. Children with neurosensory disabilities may be predisposed to fractures, and in the absence of pain, there may be a delay in seeking medical attention. For example, children with spina bifida have a high risk of fracturing a paralyzed, desensitized limb.[5] Children with severe nutritional deficiency and immobility or chronic steroid use may develop demineralized bones that fracture easily. Children with blood dyscrasias may have bruises of varying ages in unusual places. There are also reports of a variety of disabling conditions that mimic child maltreatment, including methylmalonic aciduria and glutaric aciduria, which can manifest as chronic subdural effusions and mild retinal hemorrhages, with other telltale findings including neurodevelopmental problems.[6,30]

Awareness of injury patterns from inflicted versus noninflicted trauma is important for pediatricians and other professionals who work with children. Signs and symptoms of maltreatment in children with disabilities are commonly ignored, misinterpreted, or misunderstood. Furthermore, many schools, programs, and institutions may have a disincentive to recognize or report child maltreatment because of fear of negative publicity or loss of funding or licensure. Pediatricians may want to act proactively with these entities so that concerns and referrals are more forthcoming if questions or problems arise.

If abuse or neglect is suspected after a careful assessment, a report must be made to the appropriate CPS agency. Every child suspected of being abused or neglected needs a thorough evaluation by an experienced professional.[31] The evaluation process should consist of a structured interview with the child, if possible, and a comprehensive physical examination including appropriate laboratory and radiologic studies as indicated. In many situations, a consultation with a developmental pediatrician, pediatric neurologist, child abuse pediatrician, or other expert in children with disabilities is also indicated.

Treatment

Appropriate medical treatment for injuries, infections, or other conditions should be provided. Each case of abuse or neglect that is clinically confirmed or strongly suspected needs a multidisciplinary treatment plan, which includes a mental health assessment and treatment component that is appropriate for the child's cognitive and developmental level and counseling for the family. This child and family treatment plan should be integrated

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with other intervention plans that may already have been developed for the child. Federal legislation requires that each child identified as having a disability should have a written plan of service (an individualized family service plan for children from birth to 3 years of age or an individualized education plan for children 3 through 21 years of age).[32,33] The pediatrician should also make appropriate medical recommendations and provide treatments that are preventive or prescriptive. The pediatrician may help the family explore available child care and respite services. A discussion of injury-prevention guidelines for children with disabilities is also helpful.[34] Although pediatricians can have input into the process, removal of the child from the home or therapeutic foster care placement is at the discretion of the CPS agency only after a thorough investigation.

Education

In-service training for CPS 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 child maltreatment and childhood disabilities would be the main group to assist with this educational endeavor. However, general pediatricians can have important roles, for example, with local school districts. In addition, education on risk factors for maltreatment of children with disabilities should be emphasized.

Pediatricians can also be important role models to parents, trainees, and others. In their own offices, clinics, or hospital settings, pediatricians and others who provide care for children with disabilities should not rush to use physical restraints during procedures for these children. Often, taking the time to explain procedures in terms appropriate to developmental level or in other ways to prepare such 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 may also have roles to assist in the education about child abuse to their 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 disabilities.[35]

Prevention

Support and assistance with parenting skills are often needed by families, especially families who have children with special health care needs. Medical and nonmedical needs of the child and family should be addressed at each health supervision visit. Child and family strengths should be recognized and fostered at each encounter. Family stressors should be identified and addressed, and referrals for appropriate support services should be made. Disability-specific injury-prevention guidelines can be presented to help the family minimize injury.[34] The availability of parent support groups, respite care, and home health services may be explored, and referrals may be made when appropriate. Pediatricians can help educate parents of children with disabilities about the various respite and medical waiver subsidies and programs specific to each state and how to qualify for such funds. Pediatricians can explain the need for getting placed on the inevitable waiting lists for these programs as early as possible. The American Academy of Pediatrics (AAP)–sponsored medical home Web site (www.medicalhomeinfo.org) is an important resource for the pediatrician to find out more information on these programs, including state-by-state resources.

All children with or without disabilities need a medical home that consists of a health care professional who is readily accessible to the family to answer questions, help coordinate care, and discuss concerns.[36] Medical home is an approach to providing comprehensive primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. Families should be encouraged and assisted by these health care professionals to work with a variety of agencies and disciplines and pursue resources and services that they need. Child abuse prevention, including indicators of abuse, should be discussed with parents and caregivers.[23,24] Neurodevelopmental and developmental-behavioral pediatricians and child neurologists who are trained and experienced in the diagnosis and evaluation of children with disabilities can also serve as excellent resources to both the general pediatricians and the families.

Advocacy

The pediatrician, in providing the medical home and acting as his or her patient's and family's advocate, may review care that is provided by the various agencies and resources. Much of this advocacy effort can be performed by coordinating efforts and ensuring that recommendations are made and followed.[36] By providing this careful follow-up, if child maltreatment is suspected, the need for appropriate referrals can be identified immediately.

Pediatricians play an important advocacy role in their relationships with various governmental and nongovernmental agencies. State AAP chapters also have an important role in these arenas. State, educational, social, foster care, financial, and health care systems often function in isolation from each other, with very little coordination or communication.[8] Community involvement

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can also encourage the development of needed resources, including child care and respite services for families with a child with a special health care need. Foster children with disabilities and their foster parents often suffer from lack of adequate support systems.[4] Communication with schools and other systems with which families interact is another avenue for heightening 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. They should advocate for state practices or policies that mandate CPS agencies to gather disability information on child-maltreatment cases. Pediatricians should emphasize the devastating costs of child maltreatment to legislators, policy-makers, and the public.[4] Pediatricians should 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.[37]

One resource that is useful to the pediatrician is the report *A Call to Action: Ending Crimes of Violence Against Children and Adults With Disabilities*.[38] This is a report that includes recommendations on policy, surveillance systems and data collection, violence prevention, intervention, and research needs.[38] The Oregon Institute on Disability & Development has developed prevention resources that may be useful to the pediatrician (www.ohsu.edu/research/oidd/oakspublication.cfm).

GUIDANCE FOR THE PEDIATRICIAN

1. Be capable of recognizing signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities.
2. Be familiar with disabling conditions that can mimic abuse or pose an increased risk of accidental injury that can be confused with abuse.
3. Because children with disabilities are at increased risk of maltreatment, remain vigilant not only in assessment for indications of abuse but also in offerings of emotional support and provision of equipment and resources to meet the needs of children and families.
4. Ensure that any child in whom maltreatment has been identified is evaluated thoroughly for disabilities.
5. Advocate for all children, especially those who have disabilities or special health care needs, to have a medical home.[36] If a child is hospitalized and does not have a medical home, the inpatient attending physician can help the family secure one before discharge, preferably as early as possible in the hospital course.[39]
6. Be actively involved with treatment plans developed for children with disabilities and participate in collaborative team approaches.
7. Use health supervision visits as a time to assess a family's strengths and need for resources to counterbalance family stressors and parenting demands.
8. Advocate for changes in state and local policies in which system failures seem to occur regarding the identification, treatment, and prevention of maltreatment of children with disabilities.
9. Advocate for the implementation of positive behavioral supports and elimination of aversive techniques and unnecessary physical restraints in homes, schools, and other educational and therapeutic programs (both public and private), institutions, and settings for children who have disabilities.
10. Advocate for better health care coverage by both private insurers and governmental funding.

CONCLUSIONS

The AAP supports the belief that pediatricians play a significant role in the prevention, identification, and treatment of child abuse and neglect, especially in children with disabilities, who are at increased risk of maltreatment. Children suspected of being maltreated should be evaluated for developmental, physical, and mental health disabilities. In addition, CPS workers and others involved in the investigation of child maltreatment should work closely with pediatricians to identify disabilities in children.[16] Every effort should be made to ensure the safety of children through collaboration with families, other health care professionals, schools, CPS agencies, and other appropriate resources.

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THE RISE OF IN-STORE CLINICS: THREAT OR OPPORTUNITY?

"The recent acquisition by the pharmacy chain CVS of MinuteClinic, a chain of in-store clinics founded in Minnesota, has put this model of primary care delivery back in the spotlight. Although still not widespread, the model is increasing in prevalence . . . and appeals to several stakeholders: payers note that primary care is less expensive when delivered at in-store clinics than when provided in a doctor's office or emergency room, patients value the convenience and low price, entrepreneurs see a profitable business model, and proponents of consumer-driven health care see services that can be paid for out of health savings accounts. Physicians, however, express concern about the quality of care and the potential impact on their businesses. The typical in-store clinic is a kiosk—a small, thin-walled structure located inside a store—staffed by a nurse practitioner. The clinics differ from the old 'doc-in-the-box' model in that they are neither routinely staffed by a physician nor intended to provide all primary care services. Indeed, the range of services—posted as a 'menu' on the company's Web site or on the kiosk—is strikingly small, including common adult vaccinations, screening tests, and treatment for simple conditions. . . . But for these circumscribed services, the clinics provide a compelling value proposition. Care is intended to be quick, inexpensive, and convenient; visits and waiting times are short, the charge is usually less than $50, and extended hours are offered along with ample parking. It's not surprising, then, that patients and investors have taken notice. . . . Some wonder whether this model is a 'disruptive innovation'—that is, a service or technology that enters a market at the low end, initially not performing as well as higher-end incumbents, then improves until it captures the whole market."

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Maltreatment of Children With Disabilities

Roberta A. Hibbard, Larry W. Desch, and the Committee on Child Abuse and Neglect and and Council on Children With Disabilities

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