HASSENFELD CHILDREN'S HOSPITAL AT NYU LANGONE

Sala Institute for Child and Family Centered Care

Race and Bias in Child Abuse Diagnosis and Reporting

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Vincent J. Palusci, M.D., M.S., F.A.A.P.
Professor of Pediatrics
New York University
Grossman School of Medicine

Ann S. Botash, M.D., F.A. A.P.
Distinguished Teaching Professor, Pediatrics
SUNY Upstate Medical University

Presenter Disclosures

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Stock ownership/Corporate boards-employment	In the past 12 months, presenters have had no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial service(s) discussed in this CME activity.
Off-label uses	We do not intend to discuss an unapproved/investigative use of a commercial product/device in our presentation.

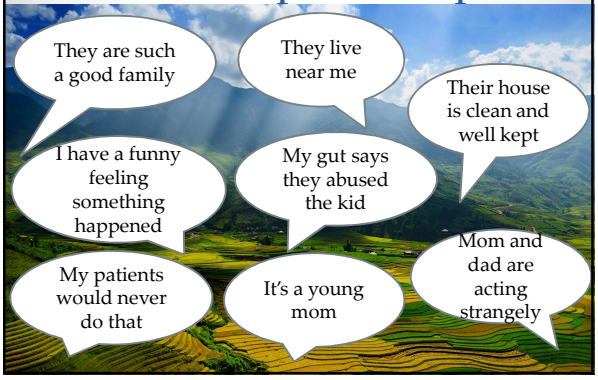
Learning Objectives

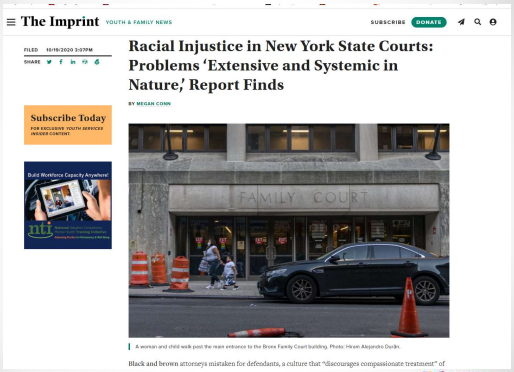
1. Review statistics regarding associations of race and ethnicity with child maltreatment reports;
2. Describe racism and bias in child abuse medicine including how it can affect pediatric patients, medical diagnosis, and mandated reports;
3. Discuss case examples and explore potential steps to reduce racism and bias in healthcare for child maltreatment.

Ground Rules for Session

https://blog.rendia.com/culture/

The Landscape of Suspicion





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All US Confirmed Reports, NCANDS 2019

Confirmed Child Maltreatment Reports, by Type and Race/Ethnicity, NCANDS 2019

Race*	PA**	SA	PM	NE	MN	Child Population***
Non-Hispanic American Indian and Alaskan Native alone	1,950	914	2,468	14,045	234	615,950
rate per 1,000	*3.17*	*1.48*	*4.01*	*22.80*	*0.38*	
rate ratio compared to NonHispanic White	*1.99*	*1.78*	*7.11*	*3.40*	*1.96*	
Non-Hispanic Asian alone	1,387	737	528	6,863	159	3,684,072
rate per 1,000	*0.38*	*0.20*	*0.14*	*1.86*	*0.04*	
rate ratio compared to NonHispanic White	*0.24*	*0.24*	*0.25*	*0.28*	*0.22*	
Non-Hispanic Black alone	**33,298**	**11,669**	**6,471**	**126,236**	**4,976**	**10,007,157**
rate per 1,000	***3.33***	***1.17***	***0.65***	***12.61***	***0.50***	
rate ratio compared to NonHispanic White	***2.09***	***1.40***	***1.15***	***1.88***	***2.57***	
Non-Hispanic Native Hawaiian and Other Pacific Islander alone	496	252	301	1,677	40	447,059
rate per 1,000	*3.37*	*1.71*	*2.05*	*11.40*	*0.27*	
rate ratio compared to NonHispanic White	*2.12*	*2.06*	*3.63*	*1.70*	*1.41*	
Non-Hispanic White alone	**58,499**	**30,509**	**20,666**	**246,343**	**7,095**	**36,682,894**
rate per 1,000	***1.59***	***0.83***	***0.56***	***6.72***	***0.19***	
rate ratio compared to NonHispanic White	***1.00***	***1.00***	***1.00***	***1.00***	***1.00***	
Hispanic or Latino	17,946	13,770	10,186	117,916	3,287	18,687,565
rate per 1,000	*0.96*	*0.74*	*0.54*	*6.31*	*0.17*	
rate ratio compared to NonHispanic White	*0.60*	*0.89*	*0.97*	*0.94*	*0.90*	
Non-Hispanic Two or More Race Groups						3,214,455
rate per 1,000						
rate ratio compared to NonHispanic White						
Total less than 18y	**113,576**	**57,851**	**40,603**	**513,080**	**15,771**	**73,039,150**
rate per 1,000	***1.56***	***0.79***	***0.56***	***7.02***	***0.22***	

*Child Abuse data derived from NCANDS Child File 2019 does not includes fatalities. Reports not individual children.
**May be more than one CM type per report
***Population data from Kids Count (datacenter.kidscount.org/data/tables/103-child-population-by-race)

PA= Physical abuse; SA = sexual abuse, MN = medical neglect; PM = psychological maltreatment. Up to 4 per report.
1. Data derived from NDACAN Child File FFY2019
2. 2019 Child Population data from National Kids Count / US Census Bureau
3. Rate per 1,000 in race/ethnicity matched child population

Negative Outcomes Associated with Racism

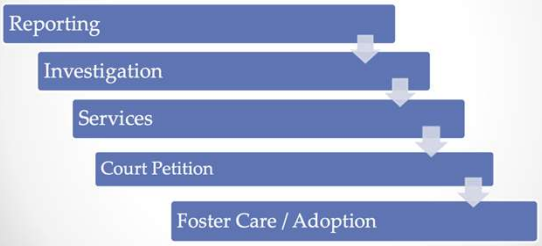
- Racism has significant adverse effects on the individual who receives, commits, and observes racism (Trent and AAP, 2019).
- Racism is a core social determinant of health that is a driver of health inequities with health effects similar to, if not more than, traditional ACEs (Trent and AAP, 2019).
- Current research with adequate comparisons provides no robust evidence to support the idea that children have worse outcomes from child welfare system involvement, but few studies focused on Black children (Barth et al, 2020).

Possible explanations

Researchers reviewed identified four possible explanations (CWIG, 2016):

- Disproportionate and disparate needs of children and families of color, particularly due to higher rates of poverty
- Racial bias and discrimination exhibited by individuals (e.g., caseworkers, mandated and other reporters)
- Child welfare system factors (e.g., lack of resources for families of color, caseworker characteristics)
- Geographic context, such as the region, state, or neighborhood.

Key Stages Where Bias Can Affect Outcomes in Child Protection



Reporting

- A Toronto child welfare agency in 2015 found that Black children were five times more likely than White children to be reported for maltreatment when compared to White children (Children's Aid Society of Toronto, 2015).
- Black children are reported at approximately twice the rate of white children. It is unknown if this disproportionality is attributable to higher risk or to bias in reporting or assessment (Drake et al. 2011).
- Report rates are based on poverty and other risk factors and not race (Lanier et al. 2014).
- Reports decrease among mandated reporters who take care of children with increasing family poverty (Kim et al. 2018).
- Higher rates of substantiated and unsubstantiated reports based on geographical SES (Marco et al. 2020).

Investigation

- African American children are more likely to be screened in and confirmed, and these effects are not limited to the U.S. (Boatswain-Kyte et al; NCANDS, 2018; Trent and AAP 2019; Barth et al. 2020).
- Morton and colleagues (2011) found that rates of disparity actually decreased as Black American children moved across the system, serving to return population-based disparity values closer to 1 for every decision point after investigation.

Services

- For AHT, communities with more need receive fewer prevention services (Beaulieu 2020).
- While representing 9% of the general population in 2011 in Canada, Black children represented 24% of children receiving child protection services (Boatswain-Kyte et al, 2020).

Court Petition

- African American children are more likely to be brought to court (Boatswain-Kyte et al, 2020).

Foster Care / Adoption

- Black children were five times more likely than White children to enter out-of-home placement (Boatswain-Kyte et al, 2020).
- Not only are there more children and youth of color in foster care, but they are more likely to remain in care for longer periods of time, re-enter care and age out of care without permanence (Advocacy in Action, 2020)

Disproportionality in the U.S. Child Protection System

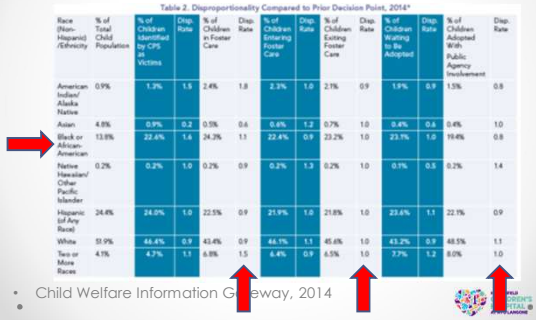


Table 2. Disproportionality Compared to Prior Decision Point, 2014*

Race (Non-Hispanic) /Ethnicity	% of Total Child Population	% of Children Identified by CPS as Victims	Disp. Rate	% of Children in Foster Care	Disp. Rate	% of Children Entering Foster Care	Disp. Rate	% of Children Exiting Foster Care	Disp. Rate	% of Children Waiting to Be Adopted	Disp. Rate	% of Children Adopted With Public Agency Involvement	Disp. Rate
American Indian/ Alaska Native	0.9%	1.3%	1.5	2.4%	1.8	2.3%	1.0	2.1%	0.9	1.9%	0.9	1.5%	0.8
Asian	4.8%	0.9%	0.2	0.5%	0.6	0.6%	1.2	0.7%	1.0	0.4%	0.6	0.4%	1.0
Black or African-American	13.8%	22.4%	1.6	24.3%	1.1	22.4%	0.9	23.2%	1.0	23.1%	1.0	19.4%	0.8
Native Hawaiian/ Other Pacific Islander	0.2%	0.2%	1.0	0.2%	0.9	0.2%	1.3	0.2%	1.0	0.1%	0.5	0.2%	1.4
Hispanic (of Any Race)	24.4%	24.0%	1.0	22.5%	0.9	21.9%	1.0	21.8%	1.0	23.6%	1.1	22.1%	0.9
White	51.9%	46.4%	0.9	43.4%	0.9	46.1%	1.1	45.6%	1.0	43.2%	0.9	48.5%	1.1
Two or More Races	4.1%	4.7%	1.1	6.8%	1.5	6.4%	0.9	6.5%	1.0	7.7%	1.2	8.0%	1.0

- Child Welfare Information Gateway, 2014

US Confirmed Medical Reports, NCANDS 2019

Race*	PA**	SA	PM	NE	MN	Child Population***
Non-Hispanic American Indian and Alaskan Native alone	238	64	91	1,556	65	615,950
rate per 1,000	*0.39*	*0.10*	*0.15*	*2.53*	*0.11*	
rate ratio compared to NonHispanic White	*1.41*	*1.56*	*3.99*	*2.95*	*2.02*	
Non-Hispanic Asian alone	183	48	23	719	47	3,684,072
rate per 1,000	*0.05*	*0.01*	*0.01*	*0.20*	*0.01*	
rate ratio compared to NonHispanic White	*0.18*	*0.20*	*0.17*	*0.23*	*0.24*	
Non-Hispanic Black alone	**6,365**	**1,537**	**383**	**18,288**	**1,721**	**10,007,157**
rate per 1,000	***0.64***	***0.15***	***0.04***	***1.83***	***0.17***	
rate ratio compared to NonHispanic White	***2.32***	***2.31***	***1.03***	***2.13***	***3.30***	
Non-Hispanic Native Hawaiian and Other Pacific Islander alone	54	25	14	197	13	147,057
rate per 1,000	*0.37*	*0.17*	*0.10*	*1.34*	*0.09*	
rate ratio compared to NonHispanic White	*1.34*	*2.56*	*2.57*	*1.56*	*1.70*	
Non-Hispanic White alone	**10,068**	**2,438**	**1,359**	**31,460**	**1,912**	**36,682,894**
rate per 1,000	***0.27***	***0.07***	***0.04***	***0.86***	***0.05***	
rate ratio compared to NonHispanic White	***1.00***	***1.00***	***1.00***	***1.00***	***1.00***	
Hispanic or Latino	2,706	1,391	486	13,497	766	18,687,565
rate per 1,000	*0.14*	*0.07*	*0.02*	*0.72*	*0.04*	
rate ratio compared to NonHispanic White	*0.53*	*1.12*	*0.63*	*0.84*	*0.79*	

PA= Physical abuse; SA = sexual abuse, MN = medical neglect; PM = psychological maltreatment. Up to 4 per report.
1. Data derived from NDACAN Child File FFY2019
2. 2019 Child Population data from National Kids Count / US Census Bureau
3. Rate per 1,000 in race/ethnicity matched child population

Rate-Ratios for Disproportionality

- Compares the proportions reported for two populations:
  - Total number of victims for Population A / Number of children in Population A
  - divided by
  - Total number of victims for population B / Number of children in population B
- A rate-ratio greater than one means that Population A is more likely to be reported than Population B

Comparison of Non-Hispanic Black/White Victim Rate-Ratios (Confirmed reports, NCANDS 2019)

CM Types	Medical	vs	Total
OVERALL	**2.20**	**vs**	**1.84**
Physical Abuse	2.32	vs	2.09
Sexual Abuse	2.31	vs	1.40
Psych Maltreatment	1.03	vs	1.15
Neglect	2.13	vs	1.88
Medical Neglect	3.30	vs	2.57

Health, Bias and Child Maltreatment Reporting

- Associations between race and increased CM have been reported in administrative data.
- Bias has been recognized within the medical community since the 1970s, and it has been suggested that it accounts for at least some of these effects since it can result in significant diagnostic errors
- Stereotypes link race and social class to child abuse diagnosis.
- To the extent that medical sources were more likely to report physical and medical neglect, this may explain at least part of the increased rates for certain racial groups to have disproportionately higher numbers of confirmed reports in NCANDS.

Sedlak 2010; Drake 2011; Boatswain-Kyte et al; Maguire-Jack et al. 2015; Najdowski, 2018; NCANDS 2018; Trent and AAP, 2019

Where is Bias in Health Care?

- Hospitals
- Physicians in general
- Nurses
- Social Workers
- Pediatricians
- Child Abuse Pediatricians
- **ALL OF THEM!**

Hospital Reports (1985)

- Using NIS data -- hospitals failed to report almost half of cases meeting the study's definition of abuse (Hampton and Newberger, 1985)
- Although not specifically looking for bias, these issues distinguished reported from non-reported cases:
  - income
  - mother's role in abuse
  - emotional abuse
  - race
  - maternal employment
  - sexual abuse

Hampton, R. L., Newberger, E. H. (1985). Child abuse incidence and reporting by hospitals: Significance of severity, class, and race. *American Journal of Public Health*, 75, 56-60.

Physician Implicit Bias

- Physicians held an implicit association between European Americans relative to African Americans and the concept of "compliant patient" and for African Americans relative to European Americans and the concept of "preferred medical care."
- Medical care differed by patient race in 1 of 4 case vignettes. No significant relationship was found between implicit and explicit measures, or implicit measures and treatment recommendations.
- Pediatricians held less implicit race bias compared with other MDs and others in society. Among pediatricians we found evidence of a moderate implicit "perceived patient compliance and race" stereotype.
- Further research is needed to explore whether physician implicit attitudes and stereotypes about race predict quality of care.

Sabin et al., 2008

Bias in Pediatric Health Care

- Black children received opioid analgesia significantly less frequently than White children for appendicitis in EDs (12.2% vs 33.9%, adjusted odds ratio = 0.2).
- Compared with their White peers, African American children had 3.43 times the odds of dying within 30 days after surgery, 18% relative greater odds of developing postoperative complications, and 7% relative higher odds of developing serious adverse events.
- Racial and ethnic differences in COVID-19 related disruptions have been seen, but not in mental health risk, protective factors, perceived stress, or child abuse potential.
- Class? Race? Income? Insurance? Access to care? Comorbidities?

Goyal et al. *JAMA Pediatrics*, 2015; Baetzel et al. *Pediatrics*, 2020; Brown et al. 2020 (in press)

AHT Evaluation and Reporting

- Jenny, Hymel et al. (1999):
  - 31.2% of 173 abused children with head injuries had been seen by physicians after AHT and the diagnosis was not recognized.
  - More likely in very young White children from White, intact families.
  - 27.8% were reinjured after the missed diagnosis.
  - 4 of 5 deaths might have been prevented by earlier recognition of abuse.

AHT Evaluation and Reporting

- Hymel et al. (2018) described the evaluation and reporting of young children admitted to a pediatric intensive care unit:
  - Significant race/ethnicity-based disparities in AHT evaluation and reporting were observed almost exclusively in lower risk non-White patients.
  - The authors concluded, "*in the absence of local confounders, these disparities likely represent the impact of local physicians' implicit bias in 2 of their study sites.*"

Fractures and AHT

- For fractures, Lane and colleagues (2002) found that under-represented minority (URM) children were more likely to be evaluated and reported, even after controlling for the likelihood of abusive injury.
  - *"It is possible that biases on the part of mandated reporters may contribute to these differences."*
- Wood and colleagues (2010) noted fewer skeletal surveys done among White infants evaluated for traumatic brain injury.
- Lane and colleagues (2012) found that young age, male gender, and poverty were risk factors for abusive abdominal trauma.

Lane, W. G., Rubin, D. M., Monteith, R., Christian, C.W. (002). Racial differences in the evaluation of pediatric fractures for physical abuse. *Journal of the American Medical Association*, 288(13), 1603-1609.
Lane, W. G., Dubowitz, H., Langenberg, P., & Dischinger, P. (2012). Epidemiology of abusive abdominal trauma hospitalizations in United States children. *Child Abuse & Neglect*, 36, 142–148
Wood, J. N., Hall, M., Schilling, S., Keren, R., Mitra, N., Rubin, D.M. (2010). Disparities in the evaluation and diagnosis of abuse among infants with traumatic brain injury. *Pediatrics*, 126, 408-14.

Drug Exposed Infants and Injuries

- More mothers and babies are tested for drugs of abuse based on their race during labor and the newborn period, despite clinical guidelines. (Ellsworth et al. 2010).
- Laskey and colleagues (2012) surveyed 5000 pediatricians using clinical vignettes with varying race (Black/White) and status (high SES/low SES), concluding that *physicians had greater willingness to consider abuse as a potential cause of injury in low SES children but not Black children.*

Definitions

- Race: A social construct based on phenotypic qualities
- Racism: A "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities…"
- Ethnicity: Belonging to a social group that has a common national or cultural tradition.

- Jones CP, Truman BI, Elam-Evans LD, et al. Using "socially assigned race" to probe white advantages in health status. *Ethn Dis*. 2008;18(4):496–504.
- Collins FS. What we do and don't know about 'race', 'ethnicity', genetics and health at the dawn of the genome era. Nat Genet. 2004;36(suppl 11):S13–S15
- Trent AAP et al. 2019

Additional Definitions

- Health Equity:

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Robert Wood Johnson Foundation:
https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

Additional Definitions

- Health Disparity: Differences in health outcomes of populations, commonly associated with race, ethnicity, gender, gender identity, age, disability and other
- Disproportionality: Usually refers to over- or under-representation of a population receiving services
- Bias
  - **Implicit** – attitudes or beliefs at an unconscious level
  - **Explicit** – attitudes or beliefs at a conscious level

https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Unconscious/Implicit Bias

Unconscious Bias & Why It Matters

Unconscious Bias = Assumptions and expectations we have that we are not even aware of

Biases affect us and our decision-making processes in a number of ways:

- Our Perception — how we see people and perceive reality
- Our Attitude — how we react towards certain people (including emotions)
- Our Behaviors — how receptive/friendly we are towards certain people
- Our Attention — which aspects of a person we pay attention to
- Our Listening Skills — how much we actively listen to what certain people say
- Our Micro-Affirmations — how much or how little we comfort certain people in certain situations

Where is Bias in Child Abuse?

- Reporters
- Investigators
- Medical examiners
- Treatment
- Legal system
- Mental health providers
- Families and patients
- All!

Parenting Skills vs. Abuse

- A 16 year old mom brings in her 14 month old who had chewed on some liquid dishwasher pods she found under the sink.
- The same 16 year old returns to the ED two weeks later because the daughter drank Tide.
- What if the mom is 32 years old and a pediatrician?

Abusive Unwise Acceptable Ideal

*Spectrum adapted from James Garbarino, PhD, researcher and author of *Parents Under Siege*

Relevant Types of Bias

Bias	Definition
Recency effect	Recent events easier to remember
In-group preference	Categorize people into groups and then attribute positive attributes to their own group
Availability bias	Making decisions based on immediate information that comes to mind
Confirmation bias	Paying more attention to information that reinforces previously held beliefs and ignoring evidence to the contrary
Anchoring bias	First piece of information becomes baseline for comparison or subsequent decisions
Halo effect	Assumptions based on attribution of good or bad to "all" aspects

Diagnosis and Reporting

- Most, if not all, clinical decision-makers are at risk of *error* due to biases.
- These errors may be further compounded when the diagnosis and reporting of suspected child abuse is being considered (emotional effect) and the clinician is under added stress.
- Not all potentially biased decisions are incorrect.
- It is important for physicians to report suspicions of child abuse.

Diagnostic Errors

- influenced by knowledge gaps, communication skills, and access to resources as well as cognitive and implicit biases. (Singh, 2017; Zwaan,2015)
- Clinical reasoning is "the cognitive process that is necessary to evaluate and manage a patient's medical problems," with a dual process(IOM Report, NAS, 2015)
  - **Non-analytical – *Systems I thinking***
  - **Analytical -- *Systems II thinking***

Framework for Cognitive Bias Applied to Child Abuse

- **Systems I Thinking:** "Intuitive," automatic, impulsive; lacks conscious control; based on pattern recognition; uses associations (rules of thumb, mental short cuts); driven to reduce ambiguity; emotionally driven; imposes causal thinking; does not draw upon reasoning process.
- **Systems II Thinking:** Uses metacognition; deliberate, analytical; hypothetical/deductive reasoning; inferential reasoning; uses logic, checks conclusions; reasoning leads logically from premise to conclusions.

Skellern C. Thinking fast and slow… *J Paediatrics Child Health*. 2020 https:onlinelibrary.wiley.com/doi/full/10.1111/jpc.15084

What is this finding?

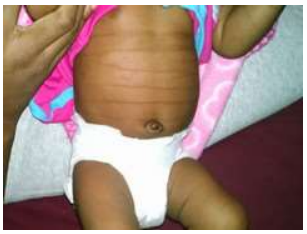


Figure 82. A report to child protective services was made when the linear marks were noted on the body of the baby in this image. They are transient pigmentary lines of the newborn and are in the flexural creases of the skin. Courtesy of Lori Fraser, MD.
AAP Visual Diagnosis of Child Abuse 4th Edition

Patient has "Ligature Marks"

Ligature marks would be abusive when a child is restrained with a rope or cord being tied around a body part, most commonly an extremity. There are marks that might mimic ligature marks, such as the elastic at the top of socks. In the baby in this image, a report was made to child protective services when the marks on the lower legs were felt to be ligature marks. Careful assessment demonstrated the similarity of the marks to the texture of the knit pattern of the socks. Courtesy of Jamie Hoffman-Rosenfeld, MD.
AAP Visual Diagnosis of Child Abuse 4th Edition

Bias Over the Years

- Missed AHT, more likely in very young White children from White, intact families. (Jenny, 1999)
- Wood and colleagues (2010) noted fewer skeletal surveys done among White infants evaluated for traumatic brain injury.
- Significant race/ethnicity-based disparities in AHT evaluation and reporting were observed almost exclusively in lower risk non-White patients. (Hymel, 2018)

A Story About Bias

What do you see?

- Race/Ethnicity/Culture
- Education
- Profession
- Poverty
- Age
- Appearance
- Family structure
- Other

Case Discussion

- An 18-year-old male presents to the police station with his mother after being missing for 24 hours.
- He had gone to a friend's house and remembers drinking something.
- The next thing he remembers is awakening in a drowsy state, his clothes were off, and he was in a strange home/bedroom.
- He dressed himself, left the house, and walked home.

What Else Would You Like to Know?

- What additional information might change the next steps for this teenager?
- Do you think being male would influence his investigation?
- As a non-white male, he may face additional biases, how can these be addressed?

Culture

- Many cultures use "non-traditional" methods to treat illness and conditions
- We have learned to recognize cutaneous findings associated with specific therapies
- Have we learned to understand these practices?
- Moxibustion, coining, cupping, others
  http://champprogram.com/question/22a.shtml#answer

Five R's of Cultural Humility

Society of Hospital Medicine Practice Management Committee
https://www.hospitalmedicine.org/practice-management/the-5-rs-of-cultural-humility/
Slide adapted from presentation by Drs. Amy Caruso Brown and Nayla Khoury

Suspicions:

We recommend considering the following questions to help differentiate Systems I from Systems II thinking:

- **Why** *do I suspect (not-suspect) maltreatment? If my "gut" is telling me to report (or not), why is that?*
- ***What*** *objective evidence exists?*
- ***Who*** *is this family? If the family does not look like me, share my values, or lives on the "other" side of town, is that affecting my thinking?*

Next Steps

- Ongoing education regarding indicators for all types of child maltreatment; racial disproportionality; systemic and implicit biases
- Develop structural changes that minimize bias, such as use of an EMR based trigger system to identify reportable concerns (Rumball-Smith J. et al.)
- Strong multidisciplinary teams that incorporate diverse cultural and racial perspectives –take a moment to review for potential biases
- Review institutional protocols for potential bias
- Recognize (and reflect on) personal biases

AAP 2019: Adapted for Child Abuse

1. Create a culturally safe clinical environment.
2. Use strategies to provide support for youth and families including countering or replacing those messages and experiences with something positive.
3. Train staff in culturally competent care.
4. Assess patients for stressors and social determinants of health often associated with racism (bullying on the basis of race, neighborhood safety, poverty, housing inequity, and academic access) and connect families to resources.

Trent M, Dooley DG, Dougé J, AAP SECTION ON ADOLESCENT HEALTH, AAP COUNCIL ON COMMUNITY PEDIATRICS, AAP COMMITTEE ON ADOLESCENCE.

AAP 2019: Adapted for Child Abuse

5. Assess patients who report experiencing racism for mental health conditions.
6. Identify strengths and assess youth and families for protective factors ~ supportive extended family network that can help mitigate exposure to racist behaviors.
7. Advocate for policies and programs that diversify the pediatric workforce and provide ongoing professional education for pediatricians in practice as a strategy to reduce implicit biases and improve safety and quality in the health care delivery system.

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Summary

- We (child abuse professionals) are part of a much larger society in which we see racism.
- We can more accurately diagnose and support our patients best by recognizing our own potential biases.
- Understanding Systems I vs. Systems II thinking can help us to avoid missing or overcalling abuse.
- We don't have all the answers, nor all the questions, but what is important is to understand the issues and to reflect upon our role in the process.

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- For additional information: Palusci, V. J., Botash, A. S. Bias and Racism in Child Maltreatment Diagnosis and Reporting. Pediatrics 2021: (in press).

Thank You! Questions?

Ann S. Botash, M.D.
Botasha@.upstate.edu

Vincent J. Palusci, M.D., M.S., F.A.A.P.
Vincent.palusci@nyulangone.org

References

- Baetzel AE, Holman A, Dobija N, Reynolds PI, Nafiu OO. Racial Disparities in Pediatric Anesthesia. Anesthesiol Clin. 2020 Jun;38(2):327-39. PMID: 32336387.
- Baird J, Ashland M, Rosenbluth G. Interprofessional teams: Current trends and future directions. Pediatr Clin North Am. 2019 Aug;66(4):739-50. doi:10.1016/j.pcl.2019.03.003.
- Baker AJL, LeBlanc S, Adebayo T, Mathews B. Training for mandated reporters of child abuse and neglect: Content analysis of state-sponsored curricula. Child Abuse Negl 2021;113:104932. doi: 10.1016/j.chiabu.2021.104932.
- Barth RP, Jonson-Reid M, Greeson JKP, Drake B, Berrick JD, Garcia AR, Shaw TV, Gyourko JR. Outcomes following child welfare services: what are they and do they differ for black children? Journal of Public Child Welfare 2020;14:5, 477-499. https://doi.org/10.1080/15548732.2020.1814541
- Boatswain-Kyte, A., Esposito, T., Trocmé, N. (2020). A longitudinal jurisdictional study of Black children reported to child protection services in Quebec, Canada. Children and Youth Services Review, 116, 105219
- Child Welfare Information Gateway. Racial disproportionality and disparity in child welfare. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau, 2016. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/
- Children's Aid Society of Toronto (2015). Addressing disproportionality, disparity and discrimination in child welfare: Data on services provided to Black African Caribbean Canadian families and children. Children's Aid. Society of Toronto.
- Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U. S. Department of Health and Human Services (2021). National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2019 [Dataset]. National Data Archive on Child Abuse and Neglect.

References

- Children's Bureau, Administration on Children, Youth and Families. How to report child abuse and neglect. US Department of Health and Human Services, 2020. https://www.childwelfare.gov/topics/responding/reporting/how/
- Doubeni CA, Simon M, Krist AH. Addressing systemic racism through clinical preventive service recommendations from the US Preventive Services Task Force. JAMA. 2021;325(7):627-628. doi:10.1001/jama.2020.26188.
- Drake B, Jolley JM, Lanier P, Fluke J, Barth RP, Jonson-Reid M. Racial bias in child protection? A comparison of competing explanations using national data. Pediatrics. 2011 Mar;127(3):471-8. doi: 10.1542/peds.2010-1710. Epub 2011 Feb 7. PMID: 21300678.
- Drake B, Jonson-Reid M, Kim H, Chiang C-J, Davalishvili D, Chapter 9: Disproportionate need as a factor explaining racial disproportionality in the CW system. In: Dettlaff AJ, ed. Racial Disproportionality and Disparities in the Child Welfare System. (Child Maltreatment: Contemporary Issues in Research and Policy, vol 11). Springer, Cham; 2021:159-76.
- Ellsworth MA, Stevens TP, D'Angio CT. Infant race affects application of clinical guidelines when screening for drugs of abuse in newborns. Pediatrics. 2010;125:e1379–85. doi: 10.1542/peds.2008-3525.
- Goyal MK, Kuppermann N, Cleary SD, Teach SJ, Chamberlain JM. Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments. JAMA Pediatr 2015 Nov;169(11):996-1002. PMID: 26366984
- Greiner MV, Palusci VJ, Keeshin BR, Kearns SC, Sinal SH. A preliminary screening instrument for early detection of medical child abuse. Hosp Pediatr. 2013 Jan;3(1):39-44. doi: 10.1542/hpeds.2012-0044.
- Haider, A. H., Weygandt, P. L., Bentley, J. M., Monn, M. F. M., Rehman, K. A., Zarzaur, B. L., Crandall, M. L., Cornwell, E. E., Cooper, L.A. (2010). Disparities in trauma care and outcomes in the United States: A systematic review and meta-analysis. Journal of Trauma and Acute Care Surgery, 74(5), 1195–205.

References

- Hampton RL, Newberger EH. Child abuse incidence and reporting by hospitals: Significance of severity, class, and race. Am J Public Health. 1985; 75:56-60. doi: 10.2105/ajph.75.1.56.
- Harris MS. Chapter 8: Racial bias as an explanatory factor for racial disproportionality and disparities in child welfare. In: Dettlaff AJ, ed. Racial Disproportionality and Disparities in the Child Welfare System. (Child Maltreatment Contemporary Issues in Research and Policy, vol 11). Springer, Cham; 2021:141-58.
- Herbert JL, Bromfield L. Evidence for the efficacy of the Child Advocacy Center model: A systematic review. Trauma Violence Abuse. 2016 Jul;17(3):341-57. doi: 10.1177/1524838015585319.\
- Hymel, K. P., Laskey, A. L., Crowell, K. R., Wang, M., Armijo-Garcia, V., Frazier, T. N., et al. (2018). Racial and ethnic disparities and bias in the evaluation and reporting of abusive head trauma. Journal of Pediatrics, 198, 137-43.
- Janson S. Can we trust our gut feeling when we suspect child abuse? Acta Paediatrica. 2021;110(6):1713-1714. doi: 10.1111/apa.15783
- Jenny C, Hymel, KP, Ritzen, A., Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. JAMA. 1999;281(7):621-6. doi: 10.1001/jama.281.7.621.
- Johnson JC. A report from the Special Advisor on Equal Justice in the New York State Courts, October 1, 2020. Available from https://www.nycourts.gov/whatsnew/pdf/SpecialAdviserEqualJusticeReport.pdf

References

- Kerker BD, Horwitz SM, Leventhal JM. Patients' characteristics and providers' attitudes: Predictors of screening pregnant women for illicit substance abuse. Child Abuse Negl. 2004;28(2):209–23. doi: 10.1016/j.chiabu.2003.07.004.
- Kim H, Drake B, Jonson-Reid M. An examination of class-based visibility bias in national child maltreatment reporting. Children and Youth Services Review 2018;85:165-173. https://doi.org/10.1016/j.childyouth.2017.12.019
- Kokaliari ED, Roy AW, Taylor J. African American perspectives on racial disparities in child removals. Child Abuse Negl. 019;90:139-48. doi: 10.1016/j.chiabu.2018.12.023.
- Lane WG, Rubin DM, Monteith R, Christian, CW. Racial differences in the evaluation of pediatric fractures for physical abuse. JAMA. 2002; 288(13):1603-9. doi: 10.1001/jama.288.13.1603
- Lane, W. G., Dubowitz, H., Langenberg, P., & Dischinger, P. (2012). Epidemiology of abusive abdominal trauma hospitalizations in United States children. Child Abuse & Neglect, 36, 142–8
- Lanier P, Maguire-Jack K, Walsh T, Drake B, Hubel G. Race and ethnic differences in early childhood maltreatment in the United States. J Dev Behav Pediatr. 2014 Sep;35(7):419-26. doi: 10.1097/DBP.0000000000000083. PMID: 25180892.
- Laskey AL, Stump TE, Perkins SM, Zimet GD, Sherman SJ, Downs SM. Influence of race and socioeconomic status on the diagnosis of child abuse: A randomized study. J Pediatr. 2012;160(6):1003–8. doi: 10.1016/j.jpeds.2011.11.042.

References

- Look KM, Look RM. Skin scraping, cupping and moxibustion that may mimic physical abuse. Journal of Forensic Sciences. 1996;42(1):103-5. doi: 10.1520/JFS14075J.
- Maguire-Jack, K., Lanier, P., Motoyama, M. J., Welch, H., Dineen, M. (2015). Geographic variation in racial disparities in child maltreatment: The influence of county poverty and population density. Child Abuse & Neglect, 47, 1–13.
- Marco M, Maguire-Jack K, Gracia E, López-Quílez A. Disadvantaged neighborhoods and the spatial overlap of substantiated and unsubstantiated child maltreatment referrals. Child Abuse Negl. 2020 Jun;104:104477. doi: 10.1016/j.chiabu.2020.104477. Epub 2020 Apr 19.
- Najdowski CJ, Bernstein KM, Race, social class, and child abuse: Content and strength of medical professionals' stereotypes, Child Abuse & Neglect, 86, 2018, 217-222.
- National Academies of Sciences, Engineering, and Medicine 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/21794.
- O'Sullivan, ED, Schofield SJ. Cognitive bias in clinical medicine. J Royal Coll Physicians Edinburgh. 2018;48:225–32. doi: 10.4997/JRCPE.2018.306.
- Palusci, V. J., Botash, A. S. Bias and Racism in Child Maltreatment Diagnosis and Reporting. Pediatrics 2021;148(1):e2020049625 (in press).
- Palusci VJ, Hicks RA, Vandervort FE. "You are hereby commanded to appear": pediatrician subpoena and court appearance in child maltreatment. Pediatrics. 2001 Jun;107(6):1427-30. doi: 10.1542/peds.107.6.1427.

References

- Palusci VJ, Rosman I, Shami MR, Sklenar D. Hospital experience using cultural interpreters with the orthodox Jewish community. Int J Child Health Human Dev. 2020;13(4):415-423.
- Roberts DE. Child protection as surveillance of African American families. J Soc Welfare Fam Law. 2015;36(4):426-37. doi: 10.1080/09649069.2014.967991.
- Rumball-Smith J, Fromkin J, Rosenthal B, Shane D, Skrbin J, Bimber T, Berger RP. Implementation of routine electronic health record-based child abuse screening in General Emergency Departments. Child Abuse Negl. 2018;85(11):58-67. doi: 10.1016/j.chiabu.2018.08.008.
- Sabin JA, Rivara FP, Greenwald AG. Physician implicit attitudes and stereotypes about race and quality of medical care. Med Care. 2008 Jul;46(7):678-85.
- Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress, Executive Summary. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.
- Singh H, Schiff GD, Graber ML, Onakpoya I, Thompson MJ. The global burden of diagnostic errors in primary care. BMJ Qual Saf. 2017 Jun;26(6):484-494. doi:10.1136/bmjqs-2016-005401.
- Skellern C. Thinking fast and slow in the evaluation of injury plausibility in child protection. J Paediatr Child Health. 2020;56(9):1330-4. doi: 10.1111/jpc.15084.

References

- Stolper E, van de Wiel M, Kooijman S, Feron F. How child healthcare physicians struggle from gut feelings to managing suspicions of child abuse. Acta Paediatrica. 2021;110(6):1847–1854. doi: 10.1111/apa.15736.
- Trent M, Dooley DG, Dougé J, AAP Section on Adolescent Health, AAP Council on Community Pediatrics, AAP Committee on Adolescence. The impact of racism on child and adolescent health. Pediatrics. 2019;144(2):e20191765. doi: 10.1542/peds.2019-1765.
- U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021). Child Maltreatment 2019. Available from https://www.acf.hhs.gov/cb/research-data-technology /statistics-research/child-maltreatment.
- Weed K, Nicholson JS. Differential social evaluation of pregnant teens, teen mothers and teen fathers by university students. Int J Adolesc Youth. 2015 Jan 2;20(1): 1–16. doi: 10.1080/02673843.2014.963630.
- Wood JN, Hall M, Schilling S, Keren R, Mitra N, Rubin DM. Disparities in the evaluation and diagnosis of abuse among infants with traumatic brain injury. Pediatrics. 2010; 126: 408-14. doi: 10.1542/peds.2010-0031.
- Zwaan L, Monteiro S, Sherbino J, et al. Is bias in the eye of the beholder? A vignette study to assess recognition of cognitive biases in clinical case workups. BMJ Qual Saf. 2017;26:104–110. doi:10.1136/bmjqs-2015-005014.