Saudi Journal of Medicine and Public Health

https://saudijmph.com/index.php/pub

https://doi.org/10.64483/202412486

The Social Emergency: A Narrative Review of the Interdisciplinary Management of Pediatric Failure to Thrive and Neglect from Crisis to Recovery

Ali Ahmed Mohammed Hobani [(1)] , Hussain Mohammed Abdullah Matabi , Khalid Mohammed Marshod Alabsi [(2)] , Nourah Abdullah Ali Alslole [(3)] , Ahmed Nasser Alqahtani [(4)] , Fahad Mousa Wasili [(5)] , Waleed Ali Ahmed Maghfuri [(6)] , Adel Ali Abdu Harbi [(7)] , Rwaidh Ali Barnawi [(8)] , Fatimah Hadi Haddadi [(9)] , Bayan Suliman Mohammed Haddad [(10)] , Rawabi Hamdan Muklif Alshammari [(11)]

(1) Crisis and Disaster Center at Jazan Health Cluster,Ministry of Health, Saudi Arabia,
(2) Farsan General Hospital,Ministry of Health, Saudi Arabia,
(3) King Khaled hospital -Al Kharj, Ministry of Health, Saudi Arabia,
(4) Alrain Jeneral Hospital, Ministry of Health, Saudi Arabia,
(5) King Fahad Hospital, Ministry of Health, Saudi Arabia,
(6) King Abdullah Hospital in Bisha (Bisha), Ministry of Health, Saudi Arabia,
(7) Eradah Mental Health Hospital, Ministry of Health, Saudi Arabia,
(8) King Salman Medical City – Maternity and Children Hospital, Ministry of Health, Saudi Arabia,
(9) Primary Healthcare – Community Health, Nursing Department, Ministry of Health, Saudi Arabia,
(10) King Fahad Central Hospital, Ministry of Health, Saudi Arabia,
(11) Women and Children Hospital, Hafr Al-Batin, Ministry of Health, Saudi Arabia

Abstract

Background: Pediatric Failure to Thrive (FTT), characterized by inadequate growth, is a common presentation of child neglect and a medical emergency with profound developmental implications. Its management necessitates a coordinated response across acute, primary, and community care sectors. **Aim:** This narrative review investigates the multi-agency, interdisciplinary response to pediatric FTT as a potential sentinel event for neglect, mapping the pathway from emergency medical intervention through to community-based recovery and support. **Methods:** A comprehensive search of PubMed, CINAHL, PsycINFO, and Social Work Abstracts (2010-2024) was conducted, integrating literature from pediatrics, emergency services, nursing, laboratory medicine, social work, and public health. **Results:** Effective management requires seamless transitions between distinct phases: EMS for safe transport, hospital-based teams (NICU nurses, laboratory) for medical stabilization and diagnostic clarification, and community-based teams (Family Medicine, Home Care, Community Health Workers) for longitudinal monitoring and in-home family support. Communication breakdowns and fragmented systems between these sectors are significant barriers to child safety and family preservation. **Conclusion:** Pediatric FTT demands a unified, child-centered, and family-focused interdisciplinary model. Success hinges on integrating medical diagnostics with social support through robust communication systems and shared care plans that prioritize safe, therapeutic intervention over punitive approaches.

Keywords: failure to thrive; child neglect; interdisciplinary teams; child protective services; home visitation

Introduction

Pediatric Failure to Thrive (FTT) is a complex, multifactorial diagnosis defined by a child's failure to achieve expected weight and growth, often with accompanying developmental delays (Votto et al., 2023). It represents one of medicine's most potent intersections of biology and environment, where inadequate caloric intake, absorption, or utilization frequently signals profound disruptions in the caregiving environment, including neglect (Cole & Lanham, 2011). While organic medical conditions (e.g., cystic fibrosis, congenital heart disease, metabolic disorders) can cause FTT, a significant proportion, especially in high-income countries, is attributed to non-organic or psychosocial causes, wherein environmental, behavioral, and relational factors are primary (Golembiewski, 2023). In these cases, FTT operates as a social emergency—a visible, measurable biomarker of family crisis, parental mental health struggles, poverty, food insecurity, or outright caregiving failure (Yousef et al., 2022).

The presentation of a severely malnourished, hypotonic infant or toddler is a sentinel event that triggers a cascade of interventions spanning the entire

*Corresponding author e-mail: alhobani@moh.gov.sa (Ali Ahmed Mohammed Hobani).
Receive Date: 19 December 2024, Revise Date: 30 December 2024, Accept Date: 31 December 2024

healthcare and social service spectrum (Agrawal et al., 2023). This journey often begins with a crisis: an Emergency Medical Services (EMS) team transporting a lethargic, dehydrated child from a chaotic home to the Emergency Department (ED). It proceeds through the acute diagnostic phase in a hospital, frequently involving a Neonatal Intensive Care Unit (NICU) or pediatric ward, where medical stabilization occurs alongside a forensic-like search for cause, heavily reliant on Medical Laboratory investigations (Shiha et al., 2023). Crucially, the child's ultimate safety and developmental trajectory depend not on the hospital admission alone, but on what follows: the transition to longitudinal monitoring in a medical home (often Family Medicine) and the implementation of intensive, therapeutic support within the family environment, delivered by Home Care nurses and Community Health Workers (CHWs) (Ahmad et al., 2022). Figure 1 illustrats the management of pediatric failure to thrive (FTT) associated with neglect across the continuum of care.

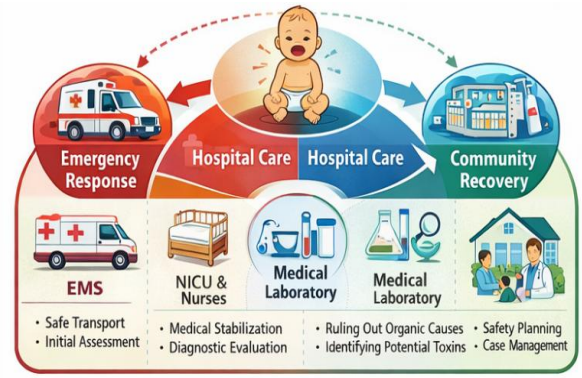

Figure 1. Interdisciplinary Care Pathway for Pediatric Failure to Thrive (FTT) Due to Neglect: From Crisis to Community Recovery

This narrative review aims to synthesize the literature from 2010 to 2024 to map and critically analyze this interdisciplinary pathway for managing pediatric FTT with suspected neglect. It will examine the distinct but interdependent roles of: EMS as first clinical observers of the home environment; NICU and pediatric nurses as acute caregivers and assessors of parent-child interaction; the Medical Laboratory in ruling out organic disease and sometimes revealing toxicological evidence of neglect; Family Medicine as the anchor for long-term growth surveillance and family advocacy; and Home Care and Community Health professionals as the frontline agents of in-home intervention and family preservation. By viewing FTT management as a continuum, this review seeks to identify best practices for interdisciplinary collaboration, highlight systemic gaps that allow children to fall through the cracks, and advocate for models that prioritize safe, supportive family rehabilitation over purely punitive child removal, whenever possible.

Methodology

This interdisciplinary narrative review employed a systematic search strategy across clinical, social science, and public health databases. PubMed, CINAHL, PsycINFO, and Social Work Abstracts were queried for English-language articles published between January 2010 and December 2024. The search strategy combined MeSH terms and keywords organized into conceptual clusters: (1) Clinical Problem: "Failure to Thrive," "Child Nutrition Disorders," "Child Abuse," "Neglect"; (2) Professional Roles & Settings: "Emergency Medical Services," "Intensive Care Units, Neonatal," "Nurses," "Community Health Workers," "Family Practice," "Home Care Services"; (3) Diagnostic Processes: "Diagnosis, Differential," "Clinical Laboratory Techniques," "Toxicology"; (4) Interventions & Systems: "Patient Care Team," "Continuity of Patient Care," "Child Protective Services," "Home Visitation." Boolean operators (AND, OR) were used to combine clusters iteratively.

Inclusion criteria were: peer-reviewed articles (empirical studies, reviews, systematic reviews) focusing on the identification, diagnosis, management, or interdisciplinary care of pediatric FTT, particularly with a psychosocial component; studies involving the roles of specified professions (EMS, nursing, laboratory, etc.) in this context; or analyses of child welfare/medical collaboration. Exclusion criteria included: articles focusing solely on organic FTT without discussion of psychosocial aspects, opinion pieces without empirical basis, and studies not involving at least two of the specified professional groups in a collaborative context. The initial search yielded 518 articles. After deduplication and title/abstract screening, 87 full-text articles were assessed, with 42 selected for in-depth synthesis. Data were extracted and organized thematically around the phases of care (crisis, diagnosis, transition, recovery) and the roles of specific disciplines.

Crisis and Acute Presentation – EMS as the First Clinical Observer

The pathway for a child with severe FTT often originates outside the healthcare system, in a home where crises have accumulated. The activation of Emergency Medical Services (EMS) typically follows a call for a "unresponsive child," "lethargic baby," or "not feeding" (Gausche-Hill et al., 2014). The EMS team's role in this social emergency is dual: life-saving medical stabilization and forensic observation. Paramedics and emergency medical technicians (EMTs) are trained to assess and manage pediatric emergencies, including hypoglycemia, dehydration, and hypothermia common in severe malnutrition (Lammers et al., 2022). However, their unique contribution lies in being the only healthcare professionals to witness the index home environment in its unrehearsed state.

Observations documented by EMS—the presence of adequate food/formula, safe sleeping

conditions, general home hygiene, parental affect and interaction with the child, and the presence of other vulnerable individuals—become critical, objective data points for subsequent medical and child protective services (CPS) investigations (Alphonso et al., 2017). Their patient care report is not just a medical record but a social snapshot that can corroborate or contradict parental history. Effective management requires EMS personnel to be trained in recognizing subtle signs of neglect beyond acute illness and to understand the importance of meticulous, non-judgmental documentation, as their observations may be subpoenaed in court proceedings (Sawyer et al., 2023).

Hospital Stabilization and Diagnostic Clarification – The NICU and Laboratory Nexus

Upon arrival at the hospital, critically ill infants with FTT are often admitted to a NICU or pediatric intensive care unit (PICU) for stabilization of metabolic and hemodynamic instability (Fleming et al., 2017). Here, the NICU nurse assumes a pivotal role that extends beyond medical tasks. They are the constant observers of parent-child interaction during feeding, comforting, and care routines. Nurses document feeding refusal, parental disengagement, anxiety, or inappropriate feeding practices (e.g., improper formula dilution) with a detail that is invaluable for the diagnostic team (Denker et al., 2023). Their longitudinal, shift-based perspective provides a rich narrative of the caregiving dynamic that complements the physician's episodic assessments.

Concurrently, the Medical Laboratory is central to the diagnostic triage essential for distinguishing organic from non-organic FTT (Vienni Baptista et al., 2020). A systematic laboratory work-up is initiated to rule out malabsorption, endocrine dysfunction, renal disease, and inborn errors of metabolism. This typically includes a complete blood count, comprehensive metabolic panel (assessing electrolytes, liver and kidney function), thyroid studies, celiac serology, and urinalysis (Neuhauser et al., 2020). A critical and often revealing component is toxicology screening. The detection of illicit drugs (e.g., cannabis, opioids) or non-prescribed medications in an infant's urine is a definitive marker of exposure and neglect, shifting the diagnostic probability and legal implications dramatically (Howell et al., 2019). The laboratory thus provides the objective biochemical evidence that either uncovers a medical disease or strengthens the case for a psychosocial etiology, guiding both treatment and reporting mandates (Table 1). Figure 2 highlights coordinated roles of EMS, hospital teams, family medicine, community health services, and child protective services in ensuring child safety, medical stabilization, and family-centered recovery.

Table 1: The Interdisciplinary Pathway in Pediatric FTT Management: Roles and Responsibilities

Phase of Care	Key Disciplines	Primary Roles & Actions	Critical Information for Handoff
1. Crisis & Transport	Emergency Medical Services (EMS)	Medical stabilization (airway, glucose, hydration); Observation/documentation of home environment & parent-child interaction; Safe transport.	Patient care report with vital signs, clinical findings, AND descriptive observations of home safety, available food, parental behavior.
2. Acute Hospitalization	NICU/Pediatric Nurses, Medical Laboratory, Hospital Social Work, Pediatricians	**Nurse:** Continuous monitoring, observing/documenting feeding interactions, providing parental education. **Lab:** Conducting diagnostic work-up (CBC, CMP, toxicology) to rule out organic disease. **SW:** Initial psychosocial assessment, CPS liaison.	Discharge summary with final diagnosis (organic vs. non-organic), detailed feeding/growth plan, results of CPS investigation, and clear follow-up requirements.
3. Transition & Longitudinal Medical Home	Family Medicine, Pediatric Primary Care	Assuming longitudinal care; precise growth monitoring (using WHO charts); ongoing developmental surveillance; coordinating with community supports; serving as family advocate & CPS reporter if backsliding occurs.	A shared, accessible care plan outlining weight gain goals, feeding schedule, community support contacts, and clear "red flag" criteria for re-referral.
4. In-Home Intervention & Recovery	Home Care Nursing, Community Health Workers (CHWs)	**Home Care Nurse:** Direct, supervised feedings; teaching proper formula preparation; assessing home safety; monitoring weight gain. **CHW:** Addressing social determinants (food security, transportation, parenting skills, maternal depression); providing	Regular progress reports to the Family Medicine provider and CPS caseworker; documentation of caregiver compliance, home environment changes, and child's response.

culturally congruent support & mentorship.

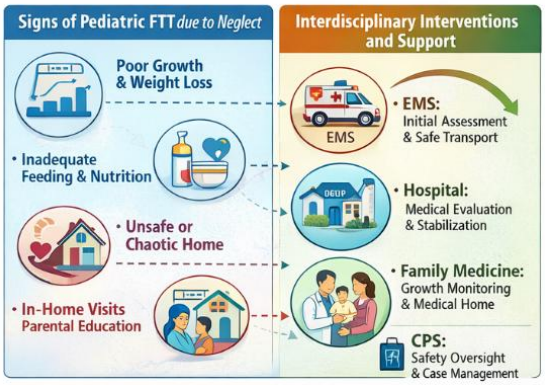

Figure 2. Clinical Indicators and Interdisciplinary Interventions in Pediatric Failure to Thrive Related to Neglect

Transition to the Medical Home – Family Medicine as the Longitudinal Anchor

Following medical stabilization and completion of the inpatient diagnostic work-up, the child is discharged. For cases of non-organic FTT, discharge is not an endpoint but the beginning of the most challenging phase: sustained recovery in the home (David et al., 2022). The Family Medicine physician or pediatrician becomes the longitudinal anchor in this process, operating as the designated "medical home." Their role is multifaceted: meticulous serial growth plotting on standardized World Health Organization (WHO) growth charts, ongoing developmental screening, and vigilant monitoring for signs of recurrent neglect (Homan, 2016).

Crucially, the family physician acts as the central communicator and integrator. They receive the hospital discharge summary, interpret laboratory trend data, and maintain contact with the assigned Child Protective Services (CPS) caseworker. They must balance a therapeutic alliance with the family—building trust to encourage engagement—with a mandated reporter's duty to alert CPS of any concerning backsliding (Dubowitz, 2014). This dual role requires exceptional communication skills and a deep understanding of both medical and social service systems. The physician's office becomes the neutral ground where weight checks are not punitive but objective measures of a family's progress, and where successes can be celebrated to reinforce positive change (Engström et al., 2022).

In-Home Intervention and Recovery – Home Care and Community Health as Agents of Change

The success or failure of the entire intervention often rests on the work done in the home. Home Care nursing and Community Health Workers are the professionals who translate medical plans into lived reality (Henwood et al., 2020). The Home Care nurse provides hands-on, supervised therapeutic feedings, directly observes and corrects formula preparation, verifies the presence of adequate food supplies, and performs weekly or biweekly weight checks, providing immediate, objective feedback (Molloy et al., 2020). This demystifies the medical plan for caregivers and provides concrete evidence of progress (or lack thereof).

The Community Health Worker (CHW), often a trusted member of the community, addresses the underlying social determinants that contributed to the FTT. Their work is more holistic and longitudinal (Ibrahim et al., 2022). They may connect the family to food pantries or WIC (Women, Infants, and Children) programs, assist with transportation to medical appointments, provide parenting education using non-judgmental, strength-based approaches, screen for and provide support for maternal depression, and serve as a cultural broker between the family and formal systems (Olds et al., 2014). The CHW's relationship-based model builds parental capacity and self-efficacy, which is fundamental for sustainable change (Robling et al., 2022). Together, the nurse and CHW form a powerful therapeutic dyad, with the nurse ensuring the child's immediate nutritional needs are met and the CHW working to transform the family's capacity to meet those needs independently (McConnell et al., 2022).

Systems Integration, Communication, and Ethical Challenges

The effectiveness of this interdisciplinary model is wholly dependent on the quality of systems integration and communication. Persistent information silos between hospital EHRs, primary care records, CPS databases, and home care agency notes create dangerous blind spots (Flaherty et al., 2013). A standardized, shared care plan—accessible to all authorized providers and the family itself—is essential but rarely implemented. Regular interdisciplinary case conferences involving the family physician, home care nurse, CHW, CPS worker, and a hospital liaison are the gold standard for coordination but are resource-intensive (Lévesque et al., 2023).

Significant ethical tensions permeate this work. The primary tension is between the therapeutic imperative (supporting family rehabilitation) and the protective imperative (removing the child from danger) (Webb, 2022). Professionals must constantly assess whether in-home support is sufficient to ensure safety or if foster care placement is necessary. This decision is fraught with racial, ethnic, and socioeconomic biases that can disproportionately affect marginalized families (Dettlaff et al., 2020). Furthermore, the act of reporting to CPS, while legally mandated, can irreparably damage the therapeutic relationship between healthcare providers and the family, making subsequent support more difficult (Table 2).

Saudi Journal of Medicine and Public Health

https://doi.org/10.64483/202413486

Table 2: Evidence and Challenges in Interdisciplinary FTT Management

Domain	Supporting Evidence for Interdisciplinary Approach	Persistent Systemic Challenges	Recommendations for Improved Practice
Early Identification & Transport	EMS documentation of home conditions improves diagnostic accuracy for neglect (Alphonso et al., 2017).	Lack of specific training for EMS in subtle neglect recognition; poor information sharing between EMS reports and hospital/CPS systems.	Integrate pediatric neglect recognition into EMS continuing education; develop digital platforms for secure EMS-to-ED report transmission.
Hospital-Based Diagnosis	Systematic lab work-ups reduce missed organic diagnoses (Neuhauser et al., 2020). Standardized nursing assessments of parent-child interaction are reliable (Denker et al., 2023).	Over-reliance on lab testing without equal investment in psychosocial assessment; toxicology results can be delayed, slowing CPS response.	Implement structured nursing observation tools; advocate for rapid-turnaround toxicology screens for child protection cases.
Transition to Primary Care	A consistent medical home improves growth outcomes and reduces hospitalization (Homan, 2016).	Incomplete or delayed hospital discharge summaries; lack of warm handoffs between inpatient team and primary care physician.	Mandate discharge summaries within 24 hours; create formal transition protocols with direct provider-to-provider communication.
In-Home Intervention Efficacy	Nurse-home visitation programs significantly improve weight gain and reduce recurrent neglect (Molloy et al., 2020). CHW interventions improve parental mental health and connection to resources (Olds et al., 2014).	Funding instability for home visiting programs; high turnover of CHWs; poor reimbursement for non-clinical, preventative support.	Advocate for sustainable public funding of evidence-based home visiting; create career ladders and fair wages for CHWs.
Interagency Collaboration	Co-located health/CPS services and shared care plans improve child safety outcomes (Lévesque et al., 2023).	Privacy laws (HIPAA, FERPA) misinterpreted as barriers to information sharing; lack of trust and differing goals between medical and child welfare professionals.	Develop cross-system confidentiality agreements and shared consent forms; establish regular, structured interdisciplinary team meetings.

Conclusion and Future Directions

Pediatric Failure to Thrive as a manifestation of neglect is a profound social emergency that demands an equally profound, coordinated response. This review has charted the essential journey from crisis to recovery, highlighting the indispensable, yet often fragmented, roles of EMS, hospital-based nurses and laboratories, family physicians, and home-based support teams. The child's recovery is not a medical outcome alone but a family systems outcome, dependent on the careful integration of diagnostic precision with compassionate, capacity-building support.

Future directions must focus on braiding systems rather than merely bridging them. This requires: 1) Policy and Financing: Creating blended funding streams that support integrated health and social service models, ensuring CHWs and home care

*Corresponding author e-mail: alhobani@moh.gov.sa (Ali Ahmed Mohammed Hobani).

Receive Date: 19 December 2024, Revise Date: 30 December 2024, Accept Date: 31 December 2024

nurses are valued and sustained; 2) Technology for Integration: Developing secure, interoperable information platforms that allow for real-time sharing of key data (growth parameters, care plan updates, CPS status) among the authorized care team; 3) Cross-Disciplinary Education: Implementing joint training for EMS, medical, nursing, and social work students on collaborative assessment and management of FTT and neglect; and 4) Trauma-Informed Care: Embedding principles of trauma-informed care across all disciplines to recognize that parents who neglect may themselves be trauma survivors, requiring a therapeutic, not solely punitive, response (Bartlett et al., 2014).

Ultimately, managing the social emergency of FTT is the ultimate test of our collective commitment to child well-being. By forging a truly unified, interdisciplinary continuum of care—one that holds the tension between protection and support, and sees the family as a unit for healing—we can move beyond merely identifying crises to fostering resilient recoveries.

References

1. Agrawal, A., Janjua, D., Zeyada, A. A. A. A., & Elsheikh, A. T. (2023). Heart failure in children and adolescents: an update on diagnostic approaches and management. *Clinical and Experimental Pediatrics*, *67*(4), 178. https://doi.org/10.3345/cep.2023.00528
2. Ahmad, H., Yacob, D., Halleran, D. R., Gasior, A. C., Di Lorenzo, C., Wood, R. J., ... & Levitt, M. A. (2022, April). Evaluation and treatment of the post pull-through Hirschsprung patient who is not doing well; update for 2022. In *Seminars in pediatric surgery* (Vol. 31, No. 2, p. 151164). WB Saunders. https://doi.org/10.1016/j.sempedsurg.2022.151164
3. Alphonso, A., Auerbach, M., Bechtel, K., Bilodeau, K., Gawel, M., Koziel, J., ... & Tiyyagura, G. K. (2017). Development of a child abuse checklist to evaluate prehospital provider performance. *Prehospital emergency care*, *21*(2), 222-232. https://doi.org/10.1080/10903127.2016.1229824
4. Bartlett, J. D., Raskin, M., Kotake, C., Nearing, K. D., & Easterbrooks, M. A. (2014). An ecological analysis of infant neglect by adolescent mothers. *Child abuse & neglect*, *38*(4), 723-734. https://doi.org/10.1016/j.chiabu.2013.11.011
5. Cole, S. Z., & Lanham, J. S. (2011). Failure to thrive: an update. *American family physician*, *83*(7), 829-834.
6. David, J. G., Kiely, J. R., Kersten, H. B., & Bennett, D. S. (2022). The Development of an Adherence Measure for Pediatric Failure to Thrive/Faltering Growth. *Clinical Practice in Pediatric Psychology*, *10*(4), 362-371. https://doi.org/10.1037/cpp0000466
7. Denker, K., Dean, M., Chapman, D., & Sump, C. (2023). Using a centralized nursing team to implement multi-specialty pediatric remote patient monitoring programs. *Journal of Pediatric Nursing*, *69*, 10-17. https://doi.org/10.1016/j.pedn.2022.12.028
8. Dettlaff, A. J., Weber, K., Pendleton, M., Boyd, R., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare*, *14*(5), 500-517. https://doi.org/10.1080/15548732.2020.1814542
9. Dubowitz, H. (2014). The Safe Environment for Every Kid (SEEK) Model: helping promote children's health, development, and safety: SEEK offers a practical model for enhancing pediatric primary care. *Child Abuse & Neglect*. https://psycnet.apa.org/doi/10.1016/j.chiabu.2014.07.011
10. Engström, M., Randell, E., & Lucas, S. (2022). Child health nurses' experiences of using the Safe Environment for Every Kid (SEEK) model or current standard practice in the Swedish child health services to address psychosocial risk factors in families with young children–A mixed-methods study. *Child abuse & neglect*, *132*, 105820. https://doi.org/10.1016/j.chiabu.2022.105820
11. Flaherty, E. G., Schwartz, K., Jones, R. D., & Sege, R. D. (2013). Child abuse physicians: Coping with challenges. *Evaluation & the health professions*, *36*(2), 163-173. https://doi.org/10.1177/0163278712459196
12. Fleming, L., Knafl, K., Knafl, G., & Van Riper, M. (2017). Parental management of adrenal crisis in children with congenital adrenal hyperplasia. *Journal for Specialists in Pediatric Nursing*, *22*(4), e12190. https://doi.org/10.1111/jspn.12190
13. Gausche-Hill, M., Eckstein, M., Horeczko, T., McGrath, N., Kurobe, A., Ullum, L., ... & Lewis, R. J. (2014). Paramedics accurately apply the pediatric assessment triangle to drive management. *Prehospital Emergency Care*, *18*(4), 520-530. https://doi.org/10.3109/10903127.2014.912706
14. Golembiewski, J. A. (2023). Using ecological theory to manage behaviour and symptoms in people living with dementia: a transdisciplinary approach to design. *Architectural Science Review*, *66*(5), 406-415. https://doi.org/10.1080/00038628.2023.2232349
15. Henwood, T., Channon, S., Penny, H., Robling, M., & Waters, C. S. (2020). Do home visiting programmes improve children's language development? A systematic review. *International journal of nursing studies*, *109*, 103610. https://doi.org/10.1016/j.ijnurstu.2020.103610

16. Homan, G. J. (2016). Failure to thrive: a practical guide. *American family physician*, *94*(4), 295-299.
17. Howell, S., Bailey, L., & Coffman, J. (2019). Evaluation of drug-endangered children: The yield of toxicology and skeletal survey screening. *Child Abuse & Neglect*, *96*, 104081. https://doi.org/10.1016/j.chiabu.2019.104081
18. Ibrahim, B. B., Tuttle, M., Fritz, A. H., Interrante, J. D., & Kozhimannil, K. B. (2022, July). *Racial inequities in the availability of evidence-based supports for maternal and infant health in 93 rural US counties with hospital-based obstetric care (Policy Brief). University of Minnesota Rural Health Research Center*.
19. Lammers, R. L., Willoughby-Byrwa, M. J., Vos, D. G., & Fales, W. D. (2022). Comparison of four methods of paramedic continuing education in the management of pediatric emergencies. *Prehospital emergency care*, *26*(4), 463-475. https://doi.org/10.1080/10903127.2021.1916140
20. Lévesque, S., Julien, D., Joubert, K., Clément, M. É., Lessard, G., & Flores, J. (2023). Exposure to intimate partner violence in children aged 6 months to 8 years: factors associated with mothers' awareness of children's exposure to this violence. *Violence and gender*, *10*(2), 73-84. https://doi.org/10.1089/vio.2020.0083
21. McConnell, M. A., Rokicki, S., Ayers, S., Allouch, F., Perreault, N., Gourevitch, R. A., ... & Baicker, K. (2022). Effect of an intensive nurse home visiting program on adverse birth outcomes in a Medicaid-eligible population: a randomized clinical trial. *Jama*, *328*(1), 27-37. doi:10.1001/jama.2022.9703
22. Molloy, C., Beatson, R., Harrop, C., Perini, N., & Goldfeld, S. (2021). Systematic review: Effects of sustained nurse home visiting programs for disadvantaged mothers and children. *Journal of Advanced Nursing*, *77*(1), 147-161. https://doi.org/10.1111/jan.14576
23. Neuhauser, L., Brettler, T., & Boyle, D. (2020). Re-thinking failure: Using design science theory and methods, including design-thinking, for successful transdisciplinary health and social interventions. In *Interdisciplinary and Transdisciplinary Failures* (pp. 21-42). Routledge.
24. Olds, D. L., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow-up of a randomized clinical trial. *JAMA pediatrics*, *168*(9), 800-806.doi:10.1001/jamapediatrics.2014.472
25. Robling, M., Lugg-Widger, F. V., Cannings-John, R., Angel, L., Channon, S., Fitzsimmons, D., ... & Slater, T. (2022). Nurse-led home-visitation programme for first-time mothers in reducing maltreatment and improving child health and development (BB: 2-6): longer-term outcomes from a randomised cohort using data linkage. *BMJ open*, *12*(2), e049960. https://doi.org/10.1136/bmjopen-2021-049960
26. Sawyer, S., Cahill, A., Bartlett, S., Smith, K., & Higgins, D. (2023). Do Australian paramedics understand their professional and legal obligations regarding child abuse and neglect?. *International journal on child maltreatment: research, policy and practice*, *6*(1), 59-77. https://doi.org/10.1007/s42448-022-00144-7
27. Shiha, M. G., Zammit, S. C., Elli, L., Sanders, D. S., & Sidhu, R. (2023). Updates in the diagnosis and management of coeliac disease. *Best Practice & Research Clinical Gastroenterology*, *64*, 101843. https://doi.org/10.1016/j.bpg.2023.101843
28. Vienni Baptista, B., Fletcher, I., Maryl, M., Wciślik, P., Buchner, A., Lyall, C., ... & Pohl, C. E. (2020). *Final report on understandings of interdisciplinary and transdisciplinary research and factors of success and failure*. ETH Zurich. https://doi.org/10.3929/ethz-b-000516065
29. Votto, M., De Filippo, M., Caimmi, S., Indolfi, C., Raffaele, A., Tosca, M. A., ... & Licari, A. (2023). A practical update on pediatric eosinophilic esophagitis. *Children*, *10*(10), 1620. https://doi.org/10.3390/children10101620
30. Webb, M. R. (2022). Building a Guaranteed Income to End the" Child Welfare" System. *Colum. J. Race & L.*, *12*, 668.
31. Yousef, E., Korotkaya, Y., & Simpson, A. B. (2022, January). Eosinophilic esophagitis in children: updates and practical aspects of management for allergists in a non–tertiary care private practice setup. In *Allergy and Asthma Proceedings* (Vol. 43, No. 1, p. 5). https://doi.org/10.2500/aap.2022.43.210084