Psychiatric and Medical Health Care Policies in Juvenile Detention Facilities

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ABSTRACT

Objectives: Many adolescents admitted to detention facilities have serious mental and physical health problems. Little is known about policies for the delivery of mental and physical health care in these settings. Our objective was to describe current health care policies in U.S. detention facilities. **Method:** Telephone interviews were requested from 83 juvenile detention facility administrators across the United States. **Results:** The response rate was 97.6%. Data were collected over 12 months, from 2003–2004. Policies for admission health screening existed in 99% of facilities; 90% included mental health screening. Most sites had policies about psychopharmacotherapy and 92% had crisis services. Continuation of existing psychotropic medication treatment was provided at 96% of facilities. Seventy-three percent of facilities used physicians to manage medications in-house; in 61% of the centers, these physicians were psychiatrists. Medication administration policies most often specified nurses, but 16% of facilities used guards. Provisions for discharge psychotropic medication existed at 84% of sites, but there was wide variation in dispensing policies. **Conclusions:** Detention health care policies for adolescents have significant gaps, particularly for mental health care. Future research should include an epidemiological study of detained youths, evaluating their health needs and the actual care received. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007;46(12):1660–1667. **Key Words:** mental health care policy, health care policy, juvenile detention.

Nearly 2.2 million children and teens were arrested in the United States in 2003 (Synder, 2005). If a youth is not released to parents, then the postarrest disposition is most often a detention facility. Such confinement is intended by the Juvenile Justice and Delinquency Prevention Act to be brief, but often lasts weeks or months (Butts and Adams, 2001; Gamble et al., 2002; Roush, 1996). The number of detention cases increased 41% from 1985 to 2000, the increased caseload comprising mostly crimes against individuals and drug crimes (Puzzanchera et al., 2004).

Unfortunately, antisocial behaviors are not the only problem with which these youths present. High rates of health problems ("health" in this article is used to indicate mental and physical health) in children and adolescents entering detention have been evident since the first juvenile court was established in 1899 (Clapp, 1995; Thomas and Penn, 2002). Although the early juvenile justice system included physical and mental health care, conditions in detention facilities gradually deteriorated. By the 1960s, conditions in many facilities were deemed inhumane, having poor adult supervision, squalid quarters, inadequate food, and little or no medical care (American Academy of Pediatrics, 1973; Litt and Cohen, 1974; National Council on Crime and Delinquency, 1967a, b).

The Juvenile Justice and Delinquency Prevention Act of 1974 (PL 93-415) was passed by Congress in response to these reports. The act mandated reduced confinement times and improvements in conditions of detainment, including provision of appropriate medical

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and psychiatric care (Howell, 1998). Unfortunately, the act did not, and still does not, define appropriate care, mandate accountability, or provide funds for care.

The absence of a monitoring system makes it difficult to determine what health care policies are in place in detention facilities. To date, three surveys about juvenile justice (with separate data for detention facilities) health care policies have been conducted. A 1983 mail survey of all detention facilities in the United States reported that policies for medical screening existed in 61% of the sites, with 50% of them using nonmedical staff. Only 24% of facilities had policies about mental health care (Anno, 1984). The generalizability of this survey was limited by a 29.1% response rate.

Both of the other surveys used detention sites identified in the annual census of juvenile justice facilities conducted for the Office of Juvenile Justice and Delinquency Prevention (OJJDP). A study of the conditions of juvenile confinement in the United States was commissioned by OJJDP in 1991; one goal was to collect data on health care policies. Detention facilities participating in the 1991 census received questionnaires by mail (response rate 80%). Eighty-three percent of detention facilities had a policy to screen for medical problems on admission, 65% provided a full medical exam within 1 week of admission, 76% had policies to provide access to medical care, and 91% had emergency care policies. Seventy-six percent of the detention centers had a policy for some type of mental health care personnel (Parent, 1994).

Goldstrom and colleagues used the OJJDP census data from 1998 to investigate detention facility policies about mental health services (Goldstrom et al., 1998). They found that 71% of facilities had policies to screen for mental health problems, 56% to perform mental health evaluations, 85% had emergency mental health services, 74% provided medication therapy, 27% had a plan for necessary 24-hour mental health care, and 43% provided mental health therapy from a licensed professional.

Data from these surveys suggest that policies for medical care gradually improved from the late 1960s to the mid 1990s; however, these changes may not be adequate. Reports from detention facilities or states indicate that at least 45% of detainees have significant medical problems, including sexually transmitted diseases, dental problems, chronic medical illnesses, asthma, hepatitis B or C, and HIV infections (Alexander-Rodriquez and Vermund, 1987; Bradley and Kalfs, 2003; Centers for Disease Control and Prevention, 1999; Feinstein et al., 1998; Forst et al., 1993; Huerta et al., 1996; Lewis et al., 1982; Litt and Cohen, 1974; Mertz et al., 2002; Mrus et al., 2003; Ogilvie et al., 1999; Shelton, 2000). Up to 65% of youths in detention meet criteria for a psychiatric disorder (Cocozza and Skowyra, 2000; Domalanta et al., 2003; Garland et al., 2001; Otto et al., 1992; Shelton, 2001; Teplin et al., 2002; Timmons-Mitchell et al., 1997; Wasserman et al., 2004). Others may not meet criteria for formal diagnoses, but they are markedly impaired by suicidal ideation, psychotic thinking, reliving trauma, or explosive anger (Cauffman, 2004; Grisso et al., 2001).

Moreover, three recent factors have exacerbated the difficulties in administering health care to this population. First, the composition of the detention population has changed, with larger proportions of younger children, violent youths, and girls (Acoca, 1999; Lederman et al., 2004; Lenssen et al., 2000; Scahill, 2000; Synder, 2003). Second, more youths who have severe psychiatric disorders are admitted. Many of these youths are in detention not for antisocial behavior, but because families have "given them up" to obtain psychiatric care (Cocozza and Skowyra, 2000; Shelton, 2002; U.S. House of Representatives, 2004). Finally, public attitudes toward youths in juvenile justice have reverted to the pre-20th century perspective of children and adolescents as "little adults," including ambivalence about these children and youths' rights to health care.

Recent position statements from the psychiatric and medical communities have expressed concern about these changes and called for better care (American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform, 2005; American Academy of Pediatrics, 2001; American Medical Association, 1990; National Commission on Correctional Health Care, 2003, 2004), as have settlements in legal cases such as *Emily J. v. Lowell P. Weicker* (1997) and *A.M. v. Luzerne County Juvenile Detention Center* (2004).Whether detention facility health care policies are adequate, especially for mental health needs, is thus an unanswered question. Moreover, changes in the juvenile detainee population since the previous survey indicate that updated information is needed. Therefore, the purpose of this study was to characterize the current

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health care policies in U.S. detention facilities, particularly regarding mental health care.

METHOD

Design and Sample

This study was part of the Adolescent Detainees and Medicaid (ADAM) project (Cuellar et al., 2005). ADAM was a supplemental study to the Caring for Children in Welfare (CCW) study (Leslie et al., 2003), a national survey of child welfare policies and practices in the United States. To ensure a nationally representative sample of child welfare agencies, primary sampling units (PSUs) were defined across the nation as areas served by a single child welfare agency (typically, a county). A probability sampling strategy was used to select a nationally representative sample of PSUs. For the ADAM study, we identified the detention facility corresponding to each PSU. Because some PSUs did not have a detention center, our sample consisted of 83 of a total of 92 PSUs. The nine PSUs without detention facilities were located in rural areas with few residents; they shared facilities with PSUs that had them.

Procedures

To identify the key informants, we asked participants in the CCW to provide contact information for local juvenile justice officials. We also performed an Internet search to identify the administrators serving each facility. ADAM study information and an interview summary were then mailed to each informant. Research assistants telephoned informants to confirm that they were appropriate subjects and willing to participate. A reminder telephone call was made on the day before the interview. The center director was asked questions about the detention center characteristics; the health services director answered questions about health care policies. Occasionally, a single person held both positions. The interviewees were asked to answer to the best of their knowledge about current practices in their facilities. We did not ask about whether practice policies were taught or accessible to staff.

Interview

Data were collected between March 2003 and March 2004. Interviews lasted about 30 minutes. Site characteristics were determined from a 33-item semistructured interview. Data on health care policies were collected with a semistructured interview derived from the MacArthur Foundation Mental Health Policy Network's survey on health, Medicaid, and detention in adults (Morrissey et al., 1993; Swanson et al., 1993).

The original MacArthur Foundation interview was reworded slightly to make it appropriate for juveniles and some questions were added about psychotropic drug use. Researchers from the MacArthur Mental Health Policy Network and public agency directors from San Diego County reviewed the draft and the interview was pilot tested in five counties not participating in CCW. The final semistructured interview contained 25 questions on detention facility health care policies in the following domains: screening, history, services, and psychotropic medication usage. (Copies of both interviews are available from the first author.)

Interviewers received 8 hours of classroom training. Following each interview, the project coordinator reviewed the module, and any questions arising from this review were addressed in a follow-up telephone call to the informant. The ADAM study was deemed exempt from human subjects review by the institutional review boards of Columbus Children's Research Institute and San Diego State University because no case-specific data were collected. Informants received no compensation for their participation.

Data Analysis

Descriptive statistics were used to summarize the data (SPSS-PC, version 13.0).

RESULTS

Response Rate

Seventy-nine of 83 (94% response rate) detention facility administrators participated in the detention center characteristics interview. Eighty-one (97.6% response rate) of the health care director/coordinators were interviewed about health care policies. Two nonparticipating practices were urban, two were rural, and one was suburban.

Characteristics of Detention Facilities

Table 1 summarizes the characteristics of the detention facilities. Most sites were administered by counties and received funding from counties or a combination of the state and county. Ten percent of facilities were private institutions caring for youths under a contract with the state or county. Most counties had one detention center; one state had only one facility. Most of the interviewees ran facilities with fewer than 200 beds; units were most commonly organized by sex. Although PL 93-415 clearly states that detention is to be short term, 63% of the facilities had no maximum length of stay and more than 30% allowed at least 1 year.

Health Care Policies in Detention Facilities

Health care policies data are presented in Table 2. Eighty-seven percent of sites reported that they had a facility health director. Admission health screening policies existed in nearly every facility; 90% of these included mental health screening. The majority of centers used detention staff to screen. Policies to collect past medical and/or psychiatric history were present in the majority of facilities. Contact information for previous providers, the dates of previous examinations, or medical/psychiatric/immunization records were obtained in 54% to 78% of the facilities. The most

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frequently used method for collecting this information was a parent/youth history questionnaire.

Ninety-five percent of the detention centers provided nonemergency medical care onsite, with policies specifying the use of contracted providers in 62% or

TABLE 1
Characteristics of Detention Facilities (DF)

Characteristic[a]	*n* (%)	95% Confidence Interval
DF's administration (*N* = 79)		
County probation department/program	12 (15.2%)	7.3–23.1
County juvenile justice, courts, corrections	35 (44.3%)	33.3–55.3
Freestanding, no connection to county	8 (10.1%)	3.5–16.8
Run by state	8 (10.1%)	3.5–16.8
Children's or social services	7 (8.9%)	2.6–15.1
County government	7 (8.9%)	2.6–15.1
Other	2 (2.5%)	0.0–6.0
Sources of funding for DF (*N* = 73)		
1 county	21 (28.8%)	18.4–39.2
>1 county	6 (8.2%)	1.9–14.5
State (department not specified)	11 (15.1%)	6.9–23.2
State juvenile justice department	6 (8.2%)	1.9–14.5
State and county	26 (35.6%)	24.6–46.6
Children's services	1 (1.4%)	0.0–4.0
Other	2 (2.7%)	0.0–6.5
Number of DF in county (*N* = 76)		
0	19 (25%)	15.3–34.7
1	53 (69.8%)	59.4–80.0
2	2 (2.6%)	0.0–6.2
3	2 (2.6%)	0.0–6.2
No. of beds per facility (*N* = 78)		
<200	67 (85.9%)	78.2–93.6
≥200	11 (14.1%)	6.4–21.8
Male beds per facility (*N* = 47)		
<200	40 (85.1%)	74.9–95.3
≥200	7 (14.9%)	4.7–25.1
Female beds per facility (*N* = 47)		
<20	24 (51.1%)	36.8–65.4
20–39	14 (29.8%)	16.7–42.9
40–59	7 (14.9%)	4.7–25.1
≥60	2 (4.2%)	0.0–10.0
Maximum stay at facility (*N* = 74)		
No maximum	47 (63.5%)	52.5–74.5
Case by case	3 (4.1%)	0.0–8.5
<1 y	18 (24.3%)	14.5–34.1
≥1 y	6 (8.1%)	1.9–14.3

[a] Denominators differ because of appropriate skips in questions, respondent refusals, or missing data.

TABLE 2
Health Care Policies in Detention Facilities (DF)

Question[a]	*n* (%) Responding Yes	95% Confidence Interval
DF health director/coordinator (*N* = 79)	69 (87.3%)	80.0–94.7
Admission screening (*N* = 81)	80 (98.8%)	96.4–100
Physical and mental health (MH) screening (*N* = 80)	72 (90%)	83.4–96.6
Screening personnel (*N* = 80)		
DF staff	62 (77.5%)	68.3–86.7
Contract provider	28 (35%)	24.5–45.4
Private provider	3 (3.8%)	0–7.9
Public provider	7 (8.8%)	2.6–14.9
Other	5 (6.3%)	0.9–11.6
Screening site (*N* = 80)		
DF	79 (98.8%)	96.4–100
Court intake	1 (1.2%)	0–3.7
Medical/MH history[b]		
Usual medical provider (*N* = 77)	60 (77.9%)	68.7–87.2
Usual MH provider (*N* = 77)	53 (68.8%)	58.5–79.2
Date last medical examination (*N* = 77)	44 (57.1%)	46.1–68.2
Immunization records (*N* = 78)	42 (53.9%)	42.8–64.9
Youth/parent medical history form (*N* = 78)	66 (84.6%)	76.6–92.6
Physical health services provided by[b] (*N* = 81)		
Detention staff	27 (33.3%)	23.1–43.6
Contract provider	50 (61.7%)	51.1–72.3
Private provider	6 (7.4%)	1.7–13.1
Public provider	8 (9.9%)	3.4–16.4
Other	4 (4.9%)	0.2–9.7
Physical health services site[b] (*N* = 81)		
DF	77 (95.1%)	90.3–99.8
Community location	18 (22.2%)	13.2–31.3
Public health department	6 (7.4%)	1.7–13.1
MH agency	1 (1.2%)	0–3.6
Other	4 (4.9%)	0.2–9.7
MH services provided by[b] (*N* = 81)		
Detention staff	24 (29.6%)	19.7–39.6
Contract provider	43 (53.1%)	42.2–64.0
Private provider	10 (12.4%)	5.2–19.5
Public provider	26 (32.1%)	21.9–42.3
Other	8 (9.9%)	3.4–16.4
MH services sites[b] (*N* = 81)		
DF	71 (87.7%)	80.5–94.8
Public health department	2 (2.5%)	0–5.9
Community location	16 (19.8%)	11.1–28.4
MH agency	19 (23.5%)	14.2–32.7
Other	1 (1.2%)	0–3.6

[a] Denominators differ because of appropriately skipped questions, respondent refusals, or missing data.

[b] Sum of percentages may be >100% because more than one answer was allowed.

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salaried detention staff in 33% of the facilities. Mental health care was also administered mainly within the facility, although 20% to 24% of the centers send their youths to a mental health care agency.

The specific types of health care available varied considerably (these data are not in Table 2). Policies governing general assessment and diagnosis were present in 96% of sites, minor medical procedures in 88% of facilities, and policies to provide outpatient or brief inpatient care for medical problems were present in 67% of sites.

Mental health treatment options consisted primarily of psychotropic medication administration and management. Sixty-eight percent of facilities had policies to provide outpatient psychotherapy and 92% had crisis services available. Day treatment or partial hospitalization services were less common, but mental health case management services were present in 73% of facilities.

Psychotropic Drug Use Policies in Detention Facilities

Nearly all of the facilities (96%) had a policy to continue psychotropic medication following admission (see Table 3). This was most often accomplished by having parents obtain refills or bring medication from home. Most facilities had policies about changing medications during detention, primarily because of dosing or diagnosis issues.

Policies requiring that physicians manage psychotropic medication at the facility (rather than offsite) were reported by 73% of the detention centers; of these, 61% used psychiatrists. Most facilities (70%) used nurses to administer medications, although some used guards (16%) or medical assistants (7%). Discharge medication policies existed in 85% of sites, but for more than half of sites, youths simply received what remained in their DF prescription. Most of the other sites gave the youths 1 to 2 weeks' worth of medication. Only 26% of the detention facilities wrote new prescriptions to continue medication.

TABLE 3
Psychotropic Medication Use Policies in Detention Facilities (DF)

Question[a]	*n* (%) Responding Yes	95% Confidence Interval
Medications continued on admission (*N* = 79)	76 (96.2%)	92.0–100
Former prescription used (*N* = 79)	71 (89.9%)	83.2–96.5
Parents bring former medications (*N* = 72)	42 (58.3%)	46.9–69.7
Parents continue to fill prescription (*N* = 72)	25 (34.7%)	23.7 –45.7
Medications changed on admission[b] (*N* = 77)	61 (79.2%)	70.2–88.3
Not formulary (*N* = 61)	8 (13.1%)	4.6–21.6
Too expensive (*N* = 61)	5 (8.2%)	1.3–15.1
Dose change needed (*N* = 61)	54 (88.5%)	80.5–96.5
Diagnosis changed (*N* = 61)	45 (73.8%)	62.7–84.8
Medication management provided by		
Physician (*N* = 78)	57 (73.1%)	63.2–82.9
Psychiatrist (*N* = 57)	35 (61.4%)	48.8–74.0
Medication administered by[b] (*N* = 77)		
Physician	2 (2.6%)	0– 6.2
Nurse practitioner	2 (2.6%)	0– 6.2
Nurse	54 (70.1%)	60.0–80.4
Medical assistant	5 (6.5%)	1.0–12.0
Guard/detention staff	12 (15.6%)	7.5–23.7
Medication administration supervised (*N* = 77)	76 (98.7%)	96.2–100
Discharge medications[b]		
Youths given medication supply (*N* = 77)	65 (84.4%)	76.3–92.5
No. of days of medications (*N* = 64)		
Remainder of DF prescription	44 (54.3%)	42.1–66.5
1- to 7-day supply	15 (18.5%)	9.0–28.0
8- to 14-day supply	4 (4.9%)	0–10.2
>14-day supply	1 (1.2%)	0–3.9
Youths given new prescription (*N* = 77)	20 (26.0%)	16.2–35.8

[a] Denominators differ because of appropriately skipped questions, respondent refusals, or missing data.
[b] Sum of percentages may be >100% because more than one answer was allowed.

DISCUSSION

Our study of health care policies in a sample of U.S. juvenile detention facilities improved on earlier surveys by using semistructured telephone interviews, obtaining more detail about mental health care, and achieving a high response rate. The characteristics of our sample were similar to the contemporaneous OJJDP facility census data (Sickmund, 2004). For example, 80% of the facilities in the census were run by the state or county, compared with 79% of our sample. Nineteen percent were run by a social services agency or freestanding organization in the census, as were 19% in our sample.

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Comparing our data with previous surveys, there have been significant improvements in medical and mental health care policies. The 1983 survey reported that policies for medical screening existed in only 61% of the detention facilities, the rate was 83% in 1994, and nearly 100% of facilities had such a policy in our data. Similarly, the proportion of facilities having policies for regular access to medical care has increased, with 95% of our sample providing care onsite with licensed providers. Whether improvements have been made in mental health care policies is less clear. We asked more questions than previous studies, but we also asked different ones. However, questions that were similar indicated a positive change. For example, nearly all of the facilities now screen for mental health problems.

Although screening rates have improved, our data raise concerns about the types of mental health care provided and by whom. The American Academy for Child and Adolescent Psychiatry and the American Academy of Pediatrics recommend that a range of mental health services—including crisis management, psychotherapy, and psychopharmacologic treatment—be available in detention facilities, and that this care be administered by licensed providers.

We found that more than 90% of facilities had policies requiring crisis management services, significantly higher than earlier surveys. However, only 68% of facilities provide outpatient psychotherapy, with lower percentages reporting provision of other types of mental health services. Moreover, despite the recommendation that licensed mental health care specialists be used to administer treatment, our data show that nonmental health care staff performed all such care at many sites.

Limitations

There are several important limitations to our study. Like the earlier surveys, we collected data on health care policies as reported by administrators. Such data may overestimate the quality and quantity of health care provided. In addition, our sample was derived from a national sample of child welfare agency catchment areas, not a sample of detention facilities. The comparability of our facility characteristics to the facility data from the 2004 OJJDP census supported the validity of our sampling method, but we cannot use our data to calculate national proportions for detention centers.

Clinical and Policy Implications

The clinical implications of our results are disquieting, particularly for psychopharmacologic treatment. Administration of psychotropic medication by personnel such as detention staff or guards could easily lead to errors, missed side effects, or overdoses. Youths taking more than one drug may be particularly vulnerable to such adverse consequences. Similarly, policies for discharge psychotropic medication fall short of accepted standards of clinical care. Current policies are likely to result in abrupt cessation of medications, causing discontinuation syndromes or relapses. Both can mimic antisocial behavior (e.g., violent outbursts), leading to detention readmission. The absence of appropriate postdischarge mental health care is important, especially in light of data suggesting that mental health care can reduce or prevent antisocial behavior in adolescents (Foster et al., 2004; Lyons et al., 2003; Pullmann et al., 2006; Trupin et al., 2004).

Our data also suggest two important areas for future research. First, we need nationally representative data about the health care needs of the youths and the services actually received. Obtaining data on mental health, expanding the work done on Chicago's juvenile detention population by Teplin and colleagues (Teplin et al., 2002), is particularly important. Second, we must identify the barriers to providing better detention facility health care. For example, state officials and facility directors frequently report that cost is the single biggest obstacle to providing good care (Cuellar et al., 2005; Hartney et al., 2002, 2003; Murray et al., 1998; National Council on Crime and Delinquency, 2001; Office of the Child Advocate, 2004). Youths covered by Medicaid are routinely disenrolled upon entering detention, thus shifting health care costs to the facility. A facility can incur enormous cost in caring for a psychiatrically ill detained youth, who may require intense supervision and several medications. Creative solutions are now appearing in the literature (e.g., setting up programs for benefit retention or "fast-track" re-enrollment programs that ameliorate the fiscal consequences of Medicaid disenrollments), but more work is needed (Gupta et al., 2005; Hartney et al., 2002; Office of the Child Advocate, 2004).

No research can make a long-term impact on care without a system that requires accountability from the detention facilities. As providers or researchers interested in the health care of children and adolescents, we

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must advocate for these youths, working to create changes in the system that would result in accountability. Because the juvenile justice system is not centralized at the federal or the state level, a monitoring system created by the federal government is likely to fail. However, states and facilities could create their own monitoring systems using guidelines such as those developed by OJJDP (Roush, 1996). Alternatively, requiring accreditation either through the American Correctional Association or the National Commission on Correctional Healthcare may improve the quality of care.

Summary

Our study of detention facility health care policies has demonstrated that important improvements have been made since earlier survey data were collected. Significant policy gaps remain, however, particularly in mental health care. Because a policy evaluation represents the best possible view of the system, these gaps are likely to translate to major problems in the actual care received by detained youths. We recommend that future research focus on a national health needs assessment of the youths in detention and on the identification of barriers to providing good health care. It is also crucial that we use our professional organizations to lobby for accountability in the psychiatric and medical health administered by detention facilities.

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Rights Moli Paul

This article provides an overview of different types of rights to aid consideration of, and debate about, children and young people's rights in the context of paediatrics and child health. It demonstrates how children's rights may or may not differ from adult rights and the implications for practice. It shows that applying a children's rights framework can be more helpful in pursuing a public child health agenda than in reducing ethical or legal conflicts when interacting with child patients and their families. **Arch Dis Child** 2007;92:720–725.

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