PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Translating Child Abuse Research Into Action

Emalee G. Flaherty, Robert D. Sege and Tammy Piazza Hurley

Pediatrics 2008;122;S1; originally published online August 1, 2008;
DOI: 10.1542/peds.2008-0715c

SUPPLEMENT ARTICLE

Translating Child Abuse Research Into Action

Emalee G. Flaherty, MD[a], Robert D. Sege, MD, PhD[b], Tammy Piazza Hurley, BS[c]

[a]Department of General Pediatrics, Children's Memorial Hospital, Feinberg School of Medicine, Northwestern University, Chicago, Illinois; [b]Division of Ambulatory Pediatrics, Boston Medical Center, Boston, Massachusetts; [c]Division of Safety and Health Promotion, American Academy of Pediatrics, Elk Grove Village, Illinois

The authors have indicated they have no financial relationships relevant to this article to disclose.

ABSTRACT

The Child Abuse Recognition Experience Study revealed that primary care clinicians did not always follow the legal mandate to report suspected child abuse to child protective services. National child abuse experts representing different disciplines met in a 2-day conference in January 2007 to discuss and develop new strategies that would address the barriers to reporting suspected child abuse and improve the protection of children. This article describes the rationale, structure, and goals of the conference. *Pediatrics* 2008;122:S1–S5

www.pediatrics.org/cgi/doi/10.1542/peds.2008-0715

doi:10.1542/peds.2008-0715c

Key Words
child abuse, decision making, primary care physicians, research translation

Abbreviations
CPS— child protective services
CARES—Child Abuse Recognition Experience Study
AAP—American Academy of Pediatrics

Accepted for publication May 28, 2008

Address correspondence to Emalee G. Flaherty, MD. 2300 N. Children's Plz, #16, Chicago, IL 60614-3363. E-mail: e-flaherty@northwestern.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

BETWEEN 1963 AND 1967, all 50 states passed laws mandating that suspected child abuse be reported.[1] Although significant strides have been made in the identification and protection of children since that time, child abuse continues to affect the lives of many children and families. The mortality and morbidity rates seem unchanged. Each year ~1500 children die as a result of maltreatment, and many more suffer serious, permanent physical and emotional trauma. Sometimes the diagnosis of child abuse is delayed because child abuse is not recognized. Jenny et al[2] found that approximately one third of children with abusive head trauma had been seen by a physician before their diagnosis because of symptoms caused by their head trauma, and the opportunity to intervene and prevent further abuse had been missed. These children had been evaluated by a physician for signs and symptoms related to their abuse an average of 2.8 times (range: 2–9) and an average of 7 days (range: 0–189 days) before the diagnosis of maltreatment was made.

Sometimes physicians recognize that a child may have been abused and do not report the suspected abuse to child protective services (CPS). In a number of retrospective studies that researched physician response to suspected abuse, physicians have said that they do not report all suspected abuse.[3–6] Physicians in these studies provided a variety of reasons for not reporting. Lack of certainty that the child had been abused and a previous negative experience with reporting were the 2 most common reasons for not reporting.

The Child Abuse Recognition Experience Study (CARES) demonstrated the extent to which clinicians do not report suspected abuse.[7] CARES was a national study conducted through the American Academy of Pediatrics (AAP) Pediatric Research in Office Settings (PROS) Network and the National Medical Association Pediatric Research Network (NMAPedsNet). The study prospectively examined primary care clinician decision-making around 15 003 childhood injuries they cared for in the office. The participants indicated their level of suspicion that an injury was caused by child abuse on a 5-point Likert scale and whether they reported the child to CPS.

CARES participants reported only 24% of injuries that they indicated were possibly caused by abuse.[7] They seemed to need to consider that the child's injury was likely or very likely to have been caused by abuse before reporting to their state's CPS. Even when they were quite suspicious of abuse, clinicians participating in this study did not always report: they decided not to report 27% of the injuries that they indicated were likely or very likely to have been caused by abuse.[7] Patient- and incident-related factors primarily influenced the clinicians to report suspected child abuse, and factors associated with the CPS system were often cited for choosing not to report.[7]

CARES participants were most likely to report a suspicious injury if the injury was not consistent with the history provided or if someone else had suspected abuse and referred the child to them for an evaluation. Patients who had other injuries or who had had injuries in the past, patients with more serious injuries, and patients with injuries other than a laceration (eg, bruises and fractures) were more likely to be reported. If the parent had delayed seeking care for the child or if the clinician knew of certain parental risk factors such as interpersonal violence or drug or alcohol abuse or if the parent had been the subject of previous reports to CPS, the clinicians were more likely to report the suspected abuse. If the clinician was unfamiliar with the family or if the child was black, the clinicians were also more likely to report.

When a subsample of these clinicians was interviewed, further analysis of their decision-making showed the extent to which they were influenced by their knowledge of the patient and the patient's family.[8] The clinicians were

more likely to report patients they did not know well. Occasionally, however, familiarity with a family seemed to be a double-edged sword: when the clinician had had previous concerns about the family, they were more likely to report suspected abuse, but if they were unaware of any risk factors, they were less likely to report suspicious injuries.

In contrast, in deciding not to report suspected abuse, clinicians were influenced by their perception of CPS. Clinicians sometimes decided not to report because they expected that CPS would do nothing or would not intervene effectively. Previously, clinicians had expressed distrust about the effectiveness of CPS intervention.[4,5,9] In general, clinicians perceive that CPS fails to protect significant numbers of children from further abuse, and they lack confidence that CPS activation will improve patient outcomes. Because the clinicians also reported that they frequently do not receive feedback from CPS,[4,9] they may assume that CPS has not intervened simply because they have received no feedback.

The evidence is mixed as to whether continuing medical education improves clinician decision-making and supports their reporting suspicious injuries. In 1 study, clinicians who had received some continuing education about child abuse were 10 times more likely to report all suspicious injuries.[4] On the other hand, previous education about child abuse did not show any effect on reporting in the CARES.[5,7] Pediatricians who had received some continuing education indicated that they felt more confident to identify and manage child abuse,[5] although 23% of the pediatricians who said they had received some education about child abuse in the past 5 years reported that they did not feel adequately trained.

These studies described significant barriers to health care provider identification and reporting of suspected child abuse. They demonstrated a need to refine and find new strategies to improve the protection of children. To meet that need, we convened a conference of national experts and professionals; this supplemental issue of *Pediatrics* provides a summary of the conference and its recommendations.

In January 2007, influential policy makers representing a broad range of the different disciplines that evaluate, investigate, treat, and provide care for maltreated children participated in a 2-day conference to discuss the CARES findings. They were invited to share their own perspectives of the problems involved and reach joint recommendations for solutions to improve the identification and protection of maltreated children. The conference had 3 goals:

1. Understand current roles and relationships between health care professionals, investigative agencies, and the legal system.
2. Develop strategies for enhancing physicians' capabilities and confidence in reporting suspected child abuse and neglect, including improving interactions with investigative agencies and the legal system.
3. Enhance working relationships among multidisciplinary participants who will work toward implementation of the strategies developed during this conference, including dissemination of the results of the conference to a broad group of interested professionals from a variety of related disciplines.

PARTICIPANTS

The 26 professionals who participated in the conference are nationally recognized experts in their field. Medical representation included those in general pediatrics, child abuse pediatrics, family practice, and child psychiatry as well as nurse practitioners. Child welfare and CPS were represented at both the social worker and administrator levels. State and federal agency officials and other professional associations that advocate on behalf of children also participated.

CONFERENCE DESIGN

The conference moved participants through a series of information exchanges and exercises to arrive at a common agenda for change in the distinct areas described below. The conference used multiple facilitation formats to maximize interdisciplinary understanding and allow the group to identify areas of agreement and avenues for change.

A facilitator began the conference by asking the participants to develop a vision of the 3 characteristics of an effective system that would allow health care providers and other professionals to work together to ensure the best outcome for children who have been maltreated. The participants concluded that an effective system would:

- establish clear roles for everyone involved;
- not be punitive;
- be sensitive to perceptions and expectations;
- provide opportunities for relationship building;
- be child and family centric;
- facilitate good communication that is multidisciplinary, unbiased, and integrated;
- have adequate resources; and
- include primary prevention.

The results of the CARES and other studies about physician decision-making around child abuse were presented as background and as the rationale for the conference.

The remaining part of the conference was designed around a series of topically focused panel discussions that each involved 3 professionals who served as lead speakers and panelists. The lead speakers were chosen on the basis of their expertise in the field they represented and their ability to provide a thorough perspective. Speakers were asked to write an article with their perspective and experience on the following topics:

Understanding Roles and Improving Reporting and Response Relationships Across Professional Boundaries

Health care providers have reported that they are influenced by their previous experience with CPS.[3–6,10,11] Ap-

proximately half of the health care providers participating in the 1998 Pediatric Primary Care Research Group (PPRG) study, a Chicago, Illinois, pediatric practice–based network, said that their previous experience with CPS made them less willing to report future suspicions of child abuse.[4] Some of them were concerned that CPS would not respond promptly if they reported suspected abuse.[10] Furthermore, 63% of these providers believed that the children who were reported had not benefited from CPS intervention, and 47% said that the family had not benefited. Providers indicated that they considered the likely outcome of a report to CPS before making a report. If they did not believe that the child or family would benefit, they might not report suspected abuse.[8]

In addition, health care providers often complained that they had not received feedback from CPS about the results and disposition of their investigation.[4,9] The providers indicated that the lack of CPS feedback might make them less likely to report suspected abuse in the future.[9]

Mandated reporters from all professions have described how inadequate law enforcement investigations, ill-prepared prosecution efforts, and inappropriate legal decisions leave children exposed and vulnerable to further maltreatment. Health care providers perceive that CPS fails to protect significant numbers of children from further abuse. The pediatricians responding to the 55th AAP Periodic Survey of Fellows (Pediatricians Views on the Treatment and Prevention of Violent Injuries to Children) and the providers in the CARES reported instances in which a child they had reported previously to CPS had suffered further abuse because CPS had not responded appropriately (20% and 21%, respectively).[5,7]

On the other hand, it is critical to recognize the challenges that CPS agencies face. First, pediatricians' expectations of the system may not be accurate. Some of the participants in the CARES did not seem to understand the role of CPS and expected them to intervene in cases that did not involve child maltreatment (unpublished data). Second, communication difficulties are bilateral. CPS workers and law enforcement officials attempting to contact physicians who had cared for children who were reported to CPS frequently encountered difficulty in contacting them. On the other hand, these physicians may not have the expertise in child abuse needed to provide CPS with the medical support they need to make a decision.

Third, evidence suggests that health care practitioners' reports of abuse may differ according to race. One study of toddlers hospitalized for fractures indicated that health care professionals were more likely to request skeletal surveys for minority (black or Hispanic) versus white children and were more likely to report minority children for suspected child abuse.[12] The CARES also found that black children were more likely to be reported than nonblack children whom the provider suspected had been abused.[7]

Finally, state CPS agencies frequently do not have adequate resources to complete their responsibilities to the best of their abilities. They are often underfunded, which results in significantly overburdened caseloads for workers who are charged with investigating reported cases.

John Goad, former Illinois Department of Children and Family Services Deputy Director, responded to these concerns and challenges, and proposed strategies for addressing the specific issues of improving understanding of roles, enhancing feedback to pediatricians who report suspected abuse, and enhancing trust between health care and CPS agency professionals in the first of the series of articles in this supplement.[13]

Supports/Resources That Could Help Reporters Best Respond to the Mandate to Report Suspected Maltreatment

Child abuse pediatrics has become much more complex as research has contributed much new information about the root causes of child abuse, the mechanisms of specific injuries, and the consequences of maltreatment on the children's physical and emotional health. As a result, the American Board of Pediatrics has approved child abuse pediatrics for a Certificate of Special Qualification, which is the first step toward achieving subspecialty status.[14] The complexity of child abuse pediatrics presents a stumbling block for both health care providers and the investigators and judges who must determine the disposition for children who are reported to CPS. Health care providers have described a reluctance to report suspected abuse unless they are certain that the child has been abused.[3,4] CPS and law enforcement professionals who investigate allegations of abuse often turn to health care providers with little expertise in child abuse pediatrics for their opinion about the cause of a child's condition. Self-appointed experts with little training and knowledge of child abuse pediatrics may provide expert medical opinions in court. These failures demonstrate the need for all child professionals who make decisions about the disposition of abused children to have access to the expertise of child abuse pediatric subspecialists.

Most of the primary care providers who participated in the CARES or the AAP Periodic Survey of Fellows said they had resources available to help them determine if a child's injury had been caused by abuse.[8] The majority said that they had mental health professionals, hospital-based child abuse medical teams or experts, and pediatric emergency departments available to help them determine if an injury was caused by child abuse. Only 2% of the CARES health care providers said that they had no available resources. A notable finding of the CARES was that health care providers said they had consulted others when they made a report to CPS, but those providers who did not report injuries they suspected were caused by abuse did not consult others in their decision-making process. When the participants of the focus group were asked about resources that would help them identify and report child abuse, they indicated that both child abuse experts and pediatric emergency departments were helpful resources.[9] When asked to describe a resource that would be helpful, they suggested that a telephone clearinghouse that was immediately available and functioned like a

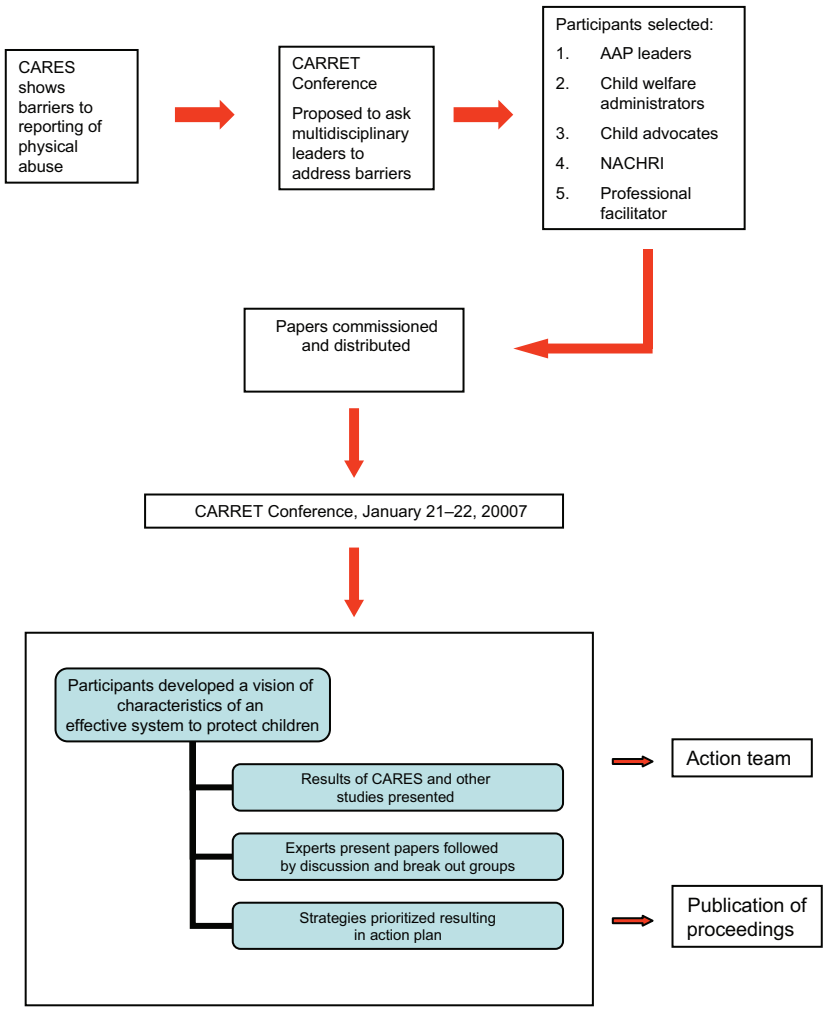

FIGURE 1
Child Abuse Recognition, Research, and Education Translation (CARRET) Conference design.

poison control line be made available to assist any practitioner who had questions about identifying or reporting child maltreatment to CPS.

In the second article of this supplement,[15] Carol Berkowitz, MD, past-president of the AAP and executive vice chair at the Department of Pediatrics at Harbor-UCLA Medical Center, responded to these results and suggested strategies to educate practitioners to more effectively use resources to make better decisions.

Professional Education for Partnership

Although the Residency Review Committee requires all pediatric residency programs to include education about child abuse in their training curriculum, they do not specify the amount of that training or how that training will be delivered.[16] Few pediatric programs schedule a mandatory block of child abuse education for their trainees.

In addition, current education about child abuse focuses only on identification of abuse. Although most health care providers have some experience identifying and reporting child abuse, these experiences seem to be infrequent. The pediatricians in the focus group described how these rare experiences became "sentinel events" that influenced their future attitudes and responses to the management of suspicions of abuse.[9] These results suggest that education needs also to address reporting and management of suspected child abuse. Because most primary health care providers have limited experience with reporting suspected child abuse, education should help to present these providers with a more accurate perspective about the outcomes and consequences of reporting.

Cindy Christian, MD, chair of the Child Abuse Special Interest Group of the Ambulatory Pediatrics Association and co-director of Safe Place: The Center for Child Protection and Health, addressed these findings and made specific recommendations for pediatric residency education and for continuing medical education after residency.[17]

After each presentation, 2 panelists representing different disciplines or expertise responded to the presentation by providing their unique perspectives. These presentations and panel discussions laid the foundation for the consensus-building discussion that followed and led to agreement on 5 strategies for improving recognition and reporting of child abuse and ultimately saving the lives of many children. Information about this consensus

building and the resulting strategies have been summarized in the article "Strategies for Saving and Improving Children's Lives."[18] We conclude this supplement with a commentary from general pediatrician Claire McCarthy reacting to the articles and sharing her struggles with reporting child abuse.[19] Figure 1 shows the conference design that brought us to this point.

REFERENCES

1. Myers JEB. *Legal Issues in Child Abuse and Neglect*. Newbury Park, CA: Sage Publications; 1992
2. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma [published correction appears in *JAMA*. 1999;282(1):29]. *JAMA.* 1999;281(7): 621–626
3. Saulsbury FT, Campbell RE. Evaluation of child abuse reporting by physicians. *Am J Dis Child.* 1985;139(4):393–395
4. Flaherty EG, Sege R, Binns HJ, Mattson CL, Christoffel KK. Health care providers' experience reporting child abuse in the primary care setting. Pediatric Practice Research Group. *Arch Pediatr Adolesc Med.* 2000;154(5):489–493
5. Flaherty EG, Sege R, Price LL, Christoffel KK, Norton DP, O'Connor KG. Pediatrician characteristics associated with child abuse identification and reporting: results from a national survey of pediatricians. *Child Maltreat.* 2006;11(4):361–369
6. Gunn VL, Hickson GB, Cooper WO. Factors affecting pediatricians' reporting of suspected child maltreatment. *Ambul Pediatr.* 2005;5(2):96–101
7. Flaherty EG, Sege RD, Griffith JL, et al. From suspicion to report: primary care clinician decision-making. The Child Abuse Recognition Experience Study Research Group. *Pediatrics.* 2008;122(3):611–619
8. Jones R, Flaherty EG, Binns HJ, et al. Clinicians' description of factors influencing their reporting of suspected child abuse: report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics.* 2008;122(2):259–266
9. Flaherty EG, Jones R, Sege R; Child Abuse Recognition Experience Study Research Group. Telling their stories: primary care practitioners' experience evaluating and reporting injuries caused by child abuse. *Child Abuse Negl.* 2004;28(9): 939–945
10. Badger LW. Reporting of child abuse: influence of characteristics of physician, practice, and community. *South Med J.* 1989; 82(3):281–286
11. Borres MP, Hägg A. Child abuse study among Swedish physicians and medical students. *Pediatr Int.* 2007;49(2):177–182
12. Lane WG, Rubin DM, Monteith R, Christian CW. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA.* 2002;288(13):1603–1609
13. Goad J. Understanding roles and improving reporting and response relationships across professional boundaries. *Pediatrics.* 2008;122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/S6
14. Block RW, Palusci VJ. Child abuse pediatrics: a new pediatric subspecialty. *J Pediatr.* 2006;148(6):711–712
15. Berkowitz CD. Child abuse recognition and reporting: supports and resources for changing the paradigm. *Pediatrics.* 2008; 122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/S10
16. Accreditation Council for Graduate Medical Education. Program requirements for graduate medical education in pediatrics. www.acgme.org/acWebsite/downloads/RRC_progReq/320pediatrics07012007.pdf. Accessed February 26, 2008
17. Christian CW. Professional education in child abuse and neglect. *Pediatrics.* 2008;122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/S13
18. Flaherty EG, Sege RD, Piazza Hurley T, Baker A. Strategies for saving and improving children's lives. *Pediatrics.* 2008;122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/S18
19. McCarthy C. Doing the right thing: a primary care pediatrician's perspective on child abuse reporting. *Pediatrics.* 2008; 122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/S21