REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09)
Identifying and Reporting Suspected Child Abuse
(Resolution 426, A-08)
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. This report reviews the incidence of child abuse, current mandatory reporting requirements, physician compliance with reporting, current medical training on recognizing and reporting suspected child abuse, and common barriers to the reporting process. In addition the report notes solutions which have been proposed to address the current disparity between reporting requirements and compliance.

Data Sources. English-language articles were identified by a Medline search using the terms "child abuse," "child abuse reports," "mandatory reporting," "pediatricians," and "child maltreatment." Additional articles were identified by manual review of the references sited in these publications. The Web sites of the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry also were reviewed. In addition, pediatricians with expertise in child and adolescent trauma at Rush University Medical Center, La Rabida Hospital, Children's Memorial Hospital (all located in Chicago), and the Illinois Department of Children and Family Services were consulted. Finally, a Google search was conducted to further identify possible relevant information or articles on child abuse.

Results. Annually, nearly 3 million cases of suspected child abuse are reported to child protective services. Although physicians are required to report suspected cases of child abuse, several retrospective studies indicate physicians do not report all suspected cases of child abuse. Physicians are more likely to report a case if they perceive the injuries to be inconsistent with the medical history and if the patient was referred for suspected abuse. Variables influencing the decision to report include injury type, severity, and apparent family risk factors.

Several explanations have been advanced for physicians not reporting suspected abuse, including lack of training and clinical experience and gaps exist in medical school curricula and residency training. Other barriers to reporting include uncertainty surrounding HIPAA requirements, lack of clinical support services, and poor communication and collaboration among professionals who evaluate, investigate, and adjudicate child maltreatment.

Conclusions. Mandatory reporting laws do not specify what level of suspicion should trigger a report, only that it be reasonable. Nevertheless, many well-trained physicians are underreporting cases of suspected abuse. Rationales for this behavior include lack of trust in child protective services, concern about breaching the doctor/patient relationship, damaging the physician's relationship with the family, concern that no positive finding may be made, and the possibility of overzealous protective services' workers removing the child from the home when the physician (implicitly) does not believe this is indicated. An ongoing need exists for evidence-based clinical interventions and closer collaboration among all individuals and agencies involved in this process in order to ensure the ultimate victims receive the protections and services they need and deserve

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-09

Subject: Identifying and Reporting Suspected Child Abuse (Resolution 426, A-08)

Presented by: C. Alvin Head, MD, Chair

Referred to: Reference Committee K (Peter C. Amadio, MD, Chair)

Resolution 426, submitted by the Resident and Fellow Section and referred at the 2008 Annual Meeting, asked:

> That our American Medical Association (AMA) support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and
>
> That our AMA support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents.

Current Policy H-515.965 (AMA Policy Database) strongly supports mandatory reporting of suspected or actual child maltreatment and encourages state societies to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states. Furthermore, physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. Policy H-515.965 also notes that our AMA, working with state, county and specialty medical societies, as well as academic medical centers and other appropriate groups, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed.

Given that a significant percentage of physicians do not report child abuse even when they strongly suspect it, this report briefly reviews the incidence of child abuse, current mandatory reporting requirements, physician compliance with reporting, current medical training on recognizing and reporting suspected child abuse, and common barriers to the reporting process. In addition the report notes solutions which have been proposed to address the current disparity between reporting requirements and compliance, and also offers recommendations on how our AMA can advocate for improvements in identifying and reporting suspected child abuse. Although much of the published literature reviewed in this report is from pediatrics, the findings, implications, and recommendations of this report apply to emergency room physicians, family physicians, and other physicians who also may encounter suspected child abuse.

METHODS

English-language articles were identified by a Medline search using the terms “child abuse,” “child abuse reports,” “mandatory reporting,” “pediatricians,” and “child maltreatment.”

Action of the AMA House of Delegates at the 2009 Interim Meeting: Council on Science and Public Health Report 2 Recommendations Adopted as Amended, and Remainder of Report Filed.

Additional articles were identified by manual review of the references cited in these publications. The Web sites of the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry also were reviewed. In addition, pediatricians with expertise in child and adolescent trauma at Rush University Medical Center, La Rabida Hospital, Children's Memorial Hospital (all located in Chicago), and the Illinois Department of Children and Family Services were consulted. Finally, a Google search was conducted to further identify possible relevant information or articles on child abuse.

BACKGROUND

Scope of the Problem.

The National Incidence Study of Child Abuse and Neglect (NIS) gathers information from multiple sources to estimate the number of children who are abused or neglected, providing information about the nature and severity of the maltreatment, and characteristics of the children, perpetrators, and families. Based on the third NIS published more than 15 years ago, only 28% of child abuse or neglect cases were investigated. This study noted that the overall incidence of abuse increased by two-thirds between 1986 and 1993.[1] The fourth NIS is currently underway and will help establish the extent of changes in the incidence or epidemiology of child maltreatment since the third study was completed.

The Department of Health and Human Services in 2005 noted that more than six million children were reported as maltreated. This includes emotional neglect and abuse, physical abuse, sexual abuse, and medical neglect. In 2005, 2.9 million cases of suspected child abuse were reported to child protective services (CPS), even though a lack of consistent physician reporting exists.[2,3] Among these reports, there were 825,000 indicated cases of abuse or neglect. It is estimated that approximately 1,500 children die annually as a result of abuse.[3]

Minorities are substantially overrepresented among those who have been reported; African American children are most frequently reported as victims of abuse. The degree to which racial bias in reporting and actual racial differences in child abuse explain this trend is not clear.[4-7] Children who have caregivers with a history of substance use disorders or alcohol misuse are at increased risk, as are children living in a family with domestic violence occurring.[8]

Attempts have been made to evaluate the impact of child abuse on communities. Wolfe et al. developed a consensus framework involving factors contributing to harm, the role of community institutions such as hospitals, understanding the dimensions of harm, and physicians' concern about (apparent) betrayal of and diminished trust from their patient and the patient's family.[9] A need for further assessment of policy and prevention initiatives exists in order to develop better safeguards in the community and to recognize vulnerabilities and risk factors related to abuse.[9]

MANDATORY REPORTING LAWS

In 1962, Kempe et al. first described the battered child syndrome and focused attention on public policy regarding child maltreatment in the United States.[10] Initially, it was believed that the battered child syndrome likely affected only a few hundred children who were subjected to violent behavior by disturbed parents. However, it was soon recognized that a larger problem existed and to adequately address it would require health professionals to report suspected abuse to public authorities. By 1967, all 50 states had adopted mandatory reporting laws.[11,12]

State eligibility for federal grants requires that they provide immunity to mandated reporters.[13] Every state provides immunity from civil and criminal liability for health care professionals who report suspected child abuse or neglect.[13] Clear statutes exist that must be followed regarding mandatory reporting and immunity, most of which are based on a "reasonable cause to suspect" and "good faith" reporting. These statutes also provide a presumption of "good faith." That is, a person acting in good faith who makes a report, cooperates in an investigation, or assists in any other requirement for reporting child abuse is immune from civil or criminal liability that might otherwise be incurred by that action. A person making a report or assisting in any other requirement of the reporting requirement is presumed to have acted in good faith. In complying with state laws, the physician needs to report to the appropriate authorities and maintain some level of confidentiality. A few states (e.g., California, Tennessee) grant absolute immunity to mandated reporters. Under absolute immunity, a person cannot be held liable for reporting child abuse and for related testimony and communications with authorities.

Most experts on child maltreatment believe mandated reporting is extremely important. Bringing abuse cases to public awareness continues to be in a child's best interest; otherwise these cases remain hidden.[14]

PHYSICIAN COMPLIANCE WITH REPORTING REQUIREMENTS

Several retrospective studies indicate physicians do not report all suspected cases of child abuse.[15-18] The Child Abuse Recognition Experience Study (CARES) gathered prospective data on how primary care providers decided whether injuries they encountered were caused by abuse, and whether they actually reported suspicious injuries to their state child protective services agency.[19] This study involved 1,683 patients for whom primary care physicians (n = 327) had some level of suspicion that the child's injury was caused by child abuse. Only 6% of these cases were reported to the CPS. Physicians did not report 76% of the injuries they thought were possibly a result of abuse, and of even greater concern, did not report 27% of injuries considered "likely or very likely" to have been caused by child abuse.

While physicians are not expected to report every child for whom they have <u>any</u> level of suspicion regarding physical abuse, more than one-quarter of cases in the CARES study were not reported even when the physician had a high degree of suspicion that the injury was caused by abuse. Physicians were more likely to report the case if they perceived the injuries to be inconsistent with the medical history and if the patient was referred to the clinician for suspected abuse. Cases most likely to be reported were those in which the patient: (1) had an injury other than a laceration; (2) had a serious injury; (3) had apparent family risk factors; (4) was black; or (5) was unfamiliar to the clinician.

Mandatory reporting laws do not specify what level of suspicion should trigger a report, only that it be "reasonable." In a follow-up qualitative analysis of the physicians in the CARES study who concluded that the injury was suspicious and actually reported the injury to CPS, four major variables were described that influenced their decision to report: (1) familiarity with the family; (2) elements of the case history; (3) their use of available resources; and (4) their perception of expected outcomes after reporting to CPS.[20] Reporting is a complex issue, and different rationales exist for not reporting (see below). For many physicians, the decision to report is secondary not only to their clinical judgment, but also to their relationship with the family.

Reasons for Not Attributing and Reporting Injuries due to Child Abuse

Several explanations have been advanced for physicians not reporting suspected abuse. Many physicians feel inadequately trained to identify and manage child maltreatment. Although some physicians may knowingly not report suspected abuse, others may fail to identify child maltreatment, either because of insufficient knowledge or clinical experience, or because the case history itself is inadequate. Lack of training and clinical experience contributes to indecision about whether the child has been abused, and uncertainty about what actually must be reported. Even when evaluating sentinel events of physical abuse such as traumatic brain injury or femur fracture, physicians at community hospitals are less likely to report the case than physicians at pediatric specialty hospitals.[21]

Some physicians may not report suspected abuse, in part, because of confusion about the definition of abuse. Physicians have various views on what constitutes medical neglect, emotional neglect, and physical abuse. Research definitions categorizing the severity of abuse include (what may be termed) definitive abuse, likely abuse, questionable abuse vs. questionable unintentional injury, and likely and definitive unintentional injury. Leventhal et al. reviewed specific criteria for clinicians in an attempt to distinguish between abuse and unintentional injuries.[22] Interestingly, definitions regarding sexual abuse are consistent, and this type of abuse also has the highest incidence of reporting.

Physicians' reluctance to report child abuse often reflects a belief that referral to CPS will not result in an effective (or even the "right") intervention.[19,20,23] Distrust between physicians and CPS workers reflects a shared pattern of poor communication, faulty and biased interactions, lack of ongoing collaboration, and misunderstanding about confidentiality requirements. Reluctance to report also includes the possibility of irreparable harm to the doctor/patient/family relationship and undue disruption of the patient's family. Additionally, a belief may exist that the investigating agency will fail to corroborate the findings or, alternatively, may overreact to positive findings resulting in unnecessary transfer of the child to relatives or placement in a foster home. Previous negative experiences with CPS ultimately lead to fewer cases of suspected abuse and neglect being reported by physicians. Generally speaking, physicians believe that mandated reporting is imperfect, results in increased work loads for child protective services, is a potential waste of resources, and most importantly, may be associated with a poor quality of services provided to the children identified in the assessments.[24]

Finally, some physicians may not report suspected child abuse because they are concerned that reporting will lead to involvement in court proceedings. In one study, 16% of physicians considered spending time in court as a negative outcome of reporting.[16] However, in the CARES study, physicians were more likely to report suspected child abuse if they had previous experience in court. [20]

Liability Concerns

As noted above, physician reporters are granted civil and criminal immunity when they comply with state statutes and report child abuse cases in good faith based on a reasonable level of suspicion. The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (Public Law 93-247). This Act has been amended and reauthorized several times, most recently by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). CAPTA directs state programs to identify and report cases of abuse and provides federal funding to states in support of various activities related to child abuse. CAPTA also established the Office on Child Abuse and Neglect and mandates the

National Clearinghouse on Child Abuse and Neglect Information. Although CAPTA does not require states to punish individuals if they fail to report, all 50 states have criminal penalties for failure to report child abuse, and some have civil penalties as well.[12]

The most common cause of liability exposure is a failure of physicians and hospitals to recognize abuse and/or fail to report recognized abuse.[26] Criminal liability also may be incurred for knowingly, or negligently, making a false report.[12,26] Other types of situations such as voluntarily informing third parties (e.g., public officials, attorneys in child custody cases), or relying on third party allegations for decision-making may create incriminating circumstances.[26]

Thus, ramifications exist for physicians who do appropriately comply with mandatory reporting laws for child abuse. Although physicians may believe that they know what is best for the child and family, failure to report is generally not in the best interests of the child who has been abused. Failure to report child abuse or neglect can deny a child the social and protective interventions he or she may need. At present, it is likely that hundreds of thousands of children who are being abused or neglected are not receiving interventions through departments of protective services, in part, because health care professionals are not complying with legal mandates to report suspected child abuse and neglect.[27]

TRAINING ACROSS THE CONTINUUM OF MEDICAL EDUCATION

Medical Schools

Medical school students should be educated to be vigilant for possible child abuse and neglect. The LCME Accreditation Standards state "the curriculum must prepare students for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting and treatment of violence and abuse."[28] Although medical schools are supposed to teach about child maltreatment, many do not. Currently, the educational exposure for medical students on child maltreatment ranges from 0 to 16 hours, with a median of 2 hours. Forty-one schools have preclinical instruction and 49 have instruction during the pediatric clerkship, but 21% of medical schools have no required instruction.[29]

Residents

A 2006 survey of chief residents in pediatric residencies revealed that 25% of accredited pediatric residency programs do not offer rotations in child abuse and neglect and only 41% mandated such clinical experience.[30,31] Nevertheless, a recent survey of pediatric, emergency medicine, and family medicine residents on their level of knowledge, comfort, and training related to the medical management of child abuse found that exposure to child abuse training and abused patients was highest for pediatric residents and lowest for family medicine residents.[32] Overall, findings on residents' knowledge and clinical decision-making support the need for improved education in this sector.[33]

Physicians in Practice

Approaches to improve the training of practicing physicians as mandated reporters include Web-based continuing medical education (CME) programs on recognizing child maltreatment. Online tutorials can potentially help physicians better identify child abuse and understand the process of being a mandated reporter, including reporting to the appropriate department of protective services or other institutions.[34] A specific model program designed to educate physicians,

provide office tools, and promote interaction with child protective services is EPIC-SCAN (Educating Physicians in Their Communities on Suspected Child Abuse and Neglect). This is a statewide community-based CME program developed in Pennsylvania under the auspices of the Pennsylvania chapter of the American Academy of Pediatrics (AAP) and the Pennsylvania Department of Public Welfare.[35]

SOLUTIONS TO LACK OF REPORTING

In response to the ongoing recognition that health care professionals are not adequately reporting suspected cases of child abuse to CPS, barriers to effective reporting and potential solutions were addressed by a multidisciplinary conference hosted by the American Academy of Pediatrics (see Appendix).[36] This conference, entitled Child Abuse, Recognition, Research, and Education Translation Conference (or CARRET) identified five strategies involving confidentiality regulations, development and support of multidisciplinary centers of excellence, regional solutions for sparsely populated areas, education across the continuum of professional development, and better training/collaboration among medical, law enforcement, and CPS professionals.[37] Within the latter domain, changing CPS procedures to require medical consultation for those specific allegations of abuse that include medical assessment, and reducing CPS workload to allow sufficient time for adequate investigation of suspected cases of abuse seem to be a necessary ancillary approach.[23]

Typically, multidisciplinary teams in university-based hospitals are positioned to assess types of suspected abuse and determine the appropriateness of referrals to protective services. For example, in infants who have sustained trauma resulting in bone injuries it is often difficult to determine whether abuse should be suspected. These hospital-based programs can evaluate the complexities of these types of injuries.[38]

In general, when a physician or mandated reporter suspects child abuse, he or she is mandated by law to report the case to CPS. If done appropriately, this is not a HIPAA violation. However, as noted in the CARRET conference, "hospitals have varying interpretation of how HIPAA applies to child abuse cases, which limits hospital-based personnel's ability to discuss cases with CPS. CPS regulations and practices vary according to locality, often preventing them from providing even the most basic feedback to mandated reporters concerning the outcome of their reports." Thus, it remains important to "clarify and expand confidentiality regulation to improve communication and collaboration between CPS workers and other professionals."[37]

The AAP also has advanced the idea of a Child Abuse Research, Education and Service (CARES) Network which is a proposal for federal investment in a national health care infrastructure to reduce the health harms resulting from child abuse and neglect.[39]

Departments of protective services have begun to develop solutions to address lack of reporting. These include the development of centers with areas of expertise on sexual abuse, physical abuse, and medical neglect. Many university-based emergency rooms have access to child abuse teams; physicians who are not certain of maltreatment in particular cases can refer those cases to a child abuse team for evaluation or consult with their local child abuse expert. This approach can foster the doctor/patient relationship and help to bring more objectivity to the process. Most importantly, this approach can provide safe and appropriate interventions for patients.

Child abuse may be easily overlooked within emergency rooms. Because emergency rooms, particularly in urban areas, can be extremely busy, child abuse cases can be missed. Minimally, there should be an abuse-specific checklist. Benger et al. described a 4-point checklist to include

in the medical notes when preschool-aged children present with thermal injuries (a common abuse-related injury). Use of this checklist improved awareness and documentation of intentional injuries, and increased referral rates.[40] In addition, quality improvement programs in community hospitals may be indicated to promote better identification.[21]

The American College of Emergency Physicians "encourages emergency personnel to assess patients for family violence in all its forms, including that directed toward children." Similar to the discussion noted above. ACEP acknowledges the: (1) need for standard education and training; (2) development of best practices for assessment and intervention; (3) use of collaborative interdisciplinary approaches; (4) development of working relationships with agencies that oversee investigation of family violence; and (5) appropriate education of hospital personnel on state legal requirements for reporting suspected cases of abuse and maltreatment.[41]

CONCLUSIONS

Child abuse is endemic. In the United States, focus on the issue began in the early 1960s and by 1967 all 50 states had mandatory reporting requirements. Importantly, physicians must understand that the intent of mandatory reporting is to protect the child. Even though a fellowship with certification in pediatrics for child abuse now exists, some debate continues within the discipline of child welfare on issues related to mandatory reporting, such as the relative role of reporting and investigation, and the overall effects of mandatory reporting on child welfare.[42]

Although a common reason that physicians give for not reporting is uncertainty, the law does not require that they be certain, only that they have "reasonable suspicion to report." Some cases are clearly more straightforward, such as sexual abuse (which physicians report much more consistently). Suspected cases of physical abuse are more complicated based on the age of the patient and the type of trauma observed. Among the more difficult types of cases to assess are medical neglect and certain pathological types of abuse.

At the present time, training in recognizing and reporting child abuse varies among medical schools and residency programs. Nevertheless, many well-trained physicians are underreporting cases of suspected abuse. Rationales for this behavior include lack of trust in child protective services, concern about breaching the doctor/patient relationship, damaging the physician's relationship with the family, concern that no positive finding may be made, and the possibility of overzealous protective services' workers removing the child from the home when the physician (implicitly) does not believe this is indicated.

Finally, there is a need for ongoing evidence-based clinical interventions and closer collaboration among all individuals and agencies involved in this process in order to ensure the ultimate victims receive the protections and services they need and deserve.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 426 (A-08) and that the remainder of this report be filed.

1. That our American Medical Association (AMA) recognize that suspected child abuse is being underreported by physicians. (New HOD Policy)

2. That our AMA support development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention. (New HOD Policy)

3. That our AMA support the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse. (New HOD Policy)

4. That our AMA recognize the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse. (New HOD Policy)

5. That our AMA acknowledge that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust. (New HOD Policy)

6. That our AMA support efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims. (New HOD Policy)

7. That our AMA encourage all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers. (Directive to Take Action)

8. That our AMA reaffirm Policy H-515.965, which strongly supports mandatory reporting of suspected child maltreatment. (Reaffirm HOD Policy)

Fiscal Note: $5,000

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APPENDIX

Barriers that Impede Effective Protection of Children Who May Have Been Abused and Strategies for Addressing these Barriers

1. Barrier**:** Hospitals have varying interpretations of how the Health Insurance Portability and Accountability Act (HIPAA) applies in child abuse cases, which limits hospital-based personnel's ability to discuss cases with CPS. CPS regulations and practices vary according to locality, often preventing them from providing even the most basic feedback to mandated reporters concerning the outcome of their reports.

Solution: Clarify and expand confidentiality regulations to improve communication and collaboration between CPS workers and other professionals.

2. Barrier**:** Research has produced much new knowledge about the identification and management of child maltreatment. The expanding knowledge base has resulted in the development of a new subspecialty: child abuse pediatrics. In addition, because this expertise is needed, some hospitals have developed centers of excellence following guidelines published by the National Association of Children's Hospitals and Related Institutions (NACHRI). The American Academy of Pediatrics (AAP) has developed the Child Abuse Research, Education, and Service (CARES) Network proposal, which would provide federal support for centers of excellence.

Solution: Develop and support multidisciplinary centers of excellence that would provide consultation, referrals to other services in the community, research, surveillance, and training to support and provide resources to reporters.

3. Barrier: Some areas of the country are sparsely populated and cannot effectively utilize a full-time specialized child abuse team.

Solution: Develop more mobile methods and assemble regional service teams for assessment of possible child abuse and neglect.

4. Barrier**:** No standards specify the quantity or quality of education that medical students, pediatric residents, or other physicians should receive about child maltreatment. Many physicians indicate that they feel inadequately trained to identify and manage child maltreatment.

Solution: Develop a comprehensive educational strategy that builds knowledge and experience from medical school and residency through continuing education once a clinician is in practice, including segments that describe prevention, identification, and interaction with the state CPS system. Training should include specific knowledge about CPS policies, services, and outcomes of intervention.

5. Barrier**:** Poor communication and collaboration between the professionals who evaluate, investigate, and adjudicate child maltreatment can lead to ineffective or inappropriate intervention. Poor communication may result from the lack of understanding of the roles of the other professionals. This misunderstanding often includes unrealistic expectations about the power and scope of the other professional's work.

Solution: Clarify the roles of the different professionals who evaluate, investigate, and adjudicate child maltreatment. Encourage and facilitate collaboration between medical, law enforcement, and CPS by including the other professionals in the training to explain their respective roles. One example of how this strategy could be implemented is Pennsylvania's EPIC program. In the EPIC training, CPS workers participate in physician training about child maltreatment.