Parents' Opinion About a Routine Head-to-Toe Examination of Children as a Screening Instrument for Child Abuse and Neglect in Children Visiting the Emergency Department

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Introduction: To improve detection of child abuse and neglect (CAN), many emergency departments use screening methods. Apart from diagnostic accuracy, possible harms of screening methods are important to consider, especially because most children are not abused and do not benefit from screening. We performed a systematic literature review to assess parents' opinions about CAN screening, in which we could only include 7 studies, all reporting that the large majority of participating parents favor screening. Recently, a complete physical examination (called "top–toe" inspection [TTI], a fully undressed inspection of the child) was implemented as a CAN screening method at the emergency department of a teaching hospital in The Netherlands. This study describes parents' opinions about the TTI.

Methods: We used a questionnaire to assess parents' opinions about the TTI of their children when visiting the emergency department. During the study period, 1000 questionnaires were distributed by mail.

Results: In total, 372 questionnaires were returned (37%). A TTI was performed for 194 children (52%). The overall attitude of parents whose children underwent a TTI was positive; 77.3% of the respondents found the TTI acceptable, and 1.5% (N = 3) found it unacceptable. Seventy percent of the respondents agreed with the theorem that all children who visit the emergency department should have a TTI performed, and 7.3% (N = 14) disagreed.

Discussion: Contrary to what is commonly believed, both in our systematic literature review and in our questionnaire study, the majority of participating parents agree with screening for CAN in general and with the TTI specifically. Sharing the results of this study with ED personnel and policy makers could take away prejudices about perceived disagreement of parents, thereby improving implementation of and adherence to CAN screening.

Key words: Child abuse; Physical examination; Emergency department; Screening; Patient satisfaction

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Child abuse and neglect (CAN) is a serious public health problem with severe acute and long-term effects.[1,2] The prevalence of self-reported CAN is much higher than that of CAN that is reported by professionals who work with children, indicating that a substantial amount of CAN remains undetected.[1,3] Early detection of CAN is very important to prevent recurrent abuse and enable treatment in order to prevent short- and long-term adverse consequences of maltreatment.[4–7] Although many abused children do not require acute medical attention, for others, an ED visit may be the first health care contact and can provide the opportunity for the abuse to be detected. It is reported in the literature that 0.03% to 3% of children visit the emergency department because of physical abuse.[8–10] Unfortunately, CAN is underdetected by both physicians and nursing staff.[5,6,11–13]

To improve detection of CAN, many emergency departments use CAN screening methods, such as checklists and protocols.[10,14] General requirements for the implementation of a screening method are that the potential benefits, such as the availability of effective treatment, should outweigh the possible disadvantages, such as potential harm and costs, and that an accurate, acceptable diagnostic test be available.[15] In CAN, these conditions are challenging. Several studies have focused on the diagnostic accuracy of screening methods[10,16,17]; however, harms and costs associated with screening are important considerations as well. Because many screening methods for CAN are aimed at a large group of children, for example, all children presenting at an emergency department, the majority of children involved in the screening are not maltreated and therefore do not benefit from the screening. For these children and their families, it is especially important to keep the burden and possible adverse effects of the screening as low as possible. We believe that the opinion of parents about screening for CAN should be considered in the process of deciding which methods should be implemented. If parents agree with the screening methods, hospital staff might be more inclined to adhere to the screening protocols.

Since 2010, at the emergency department of our hospital, a complete physical examination, named "top–toe inspection" (TTI), was added to the already existing screening method for CAN (involving a checklist). The TTI is aimed at identifying signs of CAN in all children, regardless of the mode of presentation.[18] A TTI gives clinicians an opportunity to detect unexplained injuries and scars, inadequate care and hygiene, failure to thrive, abnormal child behavior, and abnormal parent-child interaction, all of which are potential indicators for CAN. A possible adverse effect of using a TTI to screen for CAN could be that parents experience the TTI negatively—for example, because of feelings of being suspected of CAN, fear or shame, superfluity or waste of time and energy, or insult or discrimination. It could be that the TTI causes anxiety, distress, or pain in the child. In contrast, it is also possible that parents experience the TTI positively, for example, because they feel reassured when their child is thoroughly examined, or they could share the hospital's vision that screening for public child health and safety is important.

At the introduction of the TTI to the already existing screening protocol for CAN at the emergency department of the Academic Medical Center (AMC) in Amsterdam, The Netherlands, all ED personnel received a 2-day training course. Existing barriers to the TTI were discussed. Among the personal barriers mentioned were lack of time and feelings of unease about communicating with parents and children in case of suspected CAN. On the side of the children and parents, the perception of ED personnel was that most parents would have a strong negative attitude toward a TTI. Barriers were mainly expected with older children (teenagers), children known with a chronic illness, and immigrant parents, especially for girls.

First, we systematically searched the literature for evidence on parental acceptability of screening for CAN. Details on search strategy, study selection, data collection, and assessment are provided in Appendix A, available at: http://dx.doi.org/10.1016/j.jen.2015.09.005. In short, we searched 4 databases and various reference lists for studies presenting the opinion of parents about a screening method for CAN. Study selection and appraisal were conducted by 2 authors (AHT and EMHvK) independently. We included 7 studies: 4 cross-sectional surveys,[19–22] 2 cross-sectional qualitative studies,[23,24] and 1 randomized controlled trial.[25] The screening methods for CAN under study were a self-administered questionnaire for parents in 3 studies and an interview with parents in 3 studies. One study was about parental acceptance of the TTI, although it was not used as a screening for CAN.[19–26]

All 6 studies involving questionnaires or interviews showed that the large majority of parents were positive about screening:

1. A qualitative cross-sectional study on the acceptance of a semistructured interview conducted by health visitors showed that women felt comfortable with routine questions on interpersonal violence/abuse, including the negative effects of interpersonal violence on children.[24]

2. A randomized controlled trial was performed in families coming to an inner-city clinic for a child health supervision visit.[25] Their pediatric health care professional was randomized either to receive a specific training and use a screening tool to address psychosocial risk factors, including intimate partner violence and corporal punishment (intervention group), or to no extra training or screening tool use