Barriers and Facilitators to Detecting Child Abuse and Neglect in General Emergency Departments

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Study objective: Child abuse and neglect is common in the United States, and victims often present to emergency departments (EDs) for care. Most US children who seek care in EDs are treated in general EDs without specialized pediatric services. We aim to explore general ED providers' experiences with screening and reporting of child abuse and neglect to identify barriers and facilitators to detection of child abuse and neglect in the ED setting.

Methods: We conducted 29 semistructured interviews with medical providers at 3 general EDs, exploring experiences with child abuse and neglect. Consistent with grounded theory, researchers coded transcripts and then collectively refined codes and identified themes. Data collection and analysis continued until theoretical saturation was achieved.

Results: Barriers to recognizing child abuse and neglect included providers' desire to believe the caregiver, failure to recognize that a child's presentation could be due to child abuse and neglect, challenges innate to working in an ED such as lack of ongoing contact with a family and provider biases. Barriers to reporting child abuse and neglect included factors associated with the reporting process, lack of follow-up of reported cases, and negative consequences of reporting such as testifying in court. Reported facilitators included real-time case discussion with peers or supervisors and the belief that it was better for the patient to report in the setting of suspicion. Finally, providers requested case-based education and child abuse and neglect consultation for unclear cases.

Conclusion: Our interviews identified several approaches to improving detection of child abuse and neglect by general ED providers. These included providing education through case review, improving follow-up by Child Protective Services agencies, and increasing real-time assistance with patient care decisions. [Ann Emerg Med. 2015;66:447-454.]

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INTRODUCTION

Child maltreatment is common in the United States. In 2011, an estimated 1,570 children died from child abuse and neglect, and 676,579 (9.1 per 1,000 children) were victims of child abuse and neglect.[1] However, this estimate likely underrepresents the true extent of child abuse and neglect in the United States.[2-5]

Federal and local laws mandate that medical providers report cases of suspected child abuse and neglect to a Child Protective Services agency. Despite this mandate, health care providers often fail to recognize child abuse and neglect and, even when they do, also fail to report it. For example, a national study of primary care physicians in the United States identified several reasons for these clinicians to fail to report cases of child abuse and neglect, including familiarity with families, perceived lack of benefit to the family from Child Protective Services involvement, and use of an alternative management strategy such as close follow-up with the family.[6,7] In another study, pediatric nurses identified reporting of suspected child abuse and neglect as a priority, but they struggled with cases that lacked objective and clear evidence of abuse.[8] A study of Dutch emergency department (ED) providers identified limited time, fear of unjustified suspicions, insufficient communication skills, and turnover of an ED staff as barriers to reporting child abuse and neglect.[9]

The acute nature of the injury or lack of access to a primary care physician may lead child abuse and neglect victims to the ED for care, which may be additionally convenient because of its proximity and long hours of operation. Thus, ED personnel are often the first or only medical contact and opportunity for child abuse and neglect victims to be recognized. Rates of child abuse and neglect in children presenting to EDs have been

Editor's Capsule Summary

What is already known about this topic

Child abuse and neglect is underrecognized and underreported in emergency departments (EDs), but the reasons have not been thoroughly studied.

What question this study addressed

What are the barriers and facilitators to recognition and reporting of child abuse and neglect in the ED?

What this study adds to our knowledge

Focused interviews of 29 ED providers in 3 Connecticut EDs revealed that barriers to recognition include skill gaps, the desire to believe caregivers, and personal biases. Barriers to reporting include cumbersome processes, lack of follow-up, and concern about erroneous reporting. Facilitators include opportunities to discuss child abuse and neglect cases with colleagues and experts and additional education.

How this is relevant to clinical practice

Although not directly relevant to clinical practice, understanding the causes of underreporting of child abuse and neglect is a requisite step in improving recognition.

reported at 0.1% to 2% in recent studies, some of which calculate rates within a subset of children with injuries,[10-14] whereas older studies involving young children presenting with injuries report rates as high as 10%.[15,16] Additionally, there is evidence that 20% to 30% of children who died from child abuse and neglect had been previously evaluated by health care providers, including ED providers, for unrecognized abusive injuries.[17-19]

The majority of children in the United States who seek care in EDs are treated in general EDs that lack access to specialized pediatric services.[20,21] One study that examined delays in the identification of fractures in young children showed that presentation to a general versus pediatric ED setting was an independent predictor of missed diagnosis of abuse.[22] Another study examined the variation in the diagnosis of child abuse in severely injured infants (those with femur fractures or traumatic brain injury) and found that 29% of these cases were diagnosed as abuse at children's hospitals versus 13% at general hospitals.[23] To our knowledge, no previous study has examined barriers to the appropriate recognition of child abuse and neglect and reporting to Child Protective Services agencies by medical providers in general EDs in the United States, in which a large population of children are evaluated, but where access to pediatric emergency medicine and child abuse and neglect expertise is minimal.

The purpose of this qualitative study was to explore general ED providers' experiences with evaluation, detection, and reporting of child abuse and neglect and identify barriers and facilitators to recognizing and reporting it. Additionally, we aimed to identify preferences in regard to education about child abuse and neglect to inform future interventions to improve recognition and reporting of it in the general ED setting.

MATERIALS AND METHODS

We used a qualitative research design with one-on-one interviews to understand general ED providers' experiences with child abuse and neglect. We conducted 29 semistructured interviews of nurses, physicians, and physician assistants of various levels of seniority and with various clinical roles at 3 general EDs in Connecticut with different models of pediatric care and in different regions of the state. Each ED has established transfer relationships with a tertiary care children's hospital. ED 1 has 50,000 annual visits, with 7,500 pediatric visits, and has 8 hours of pediatric emergency physician availability per day; ED 2 has 36,000 annual visits, with 8,000 pediatric visits; and ED 3 has 55,000 annual visits, with 5,000 pediatric visits. Neither of the latter 2 EDs has pediatric emergency medicine availability. The same group of physicians staff EDs 1 and 2. Any child requiring hospitalization in ED 3 and most children requiring hospitalization in EDs 1 and 2 are transferred to a tertiary care children's hospital. None of the 3 general EDs has full-time, on-site social work or child abuse expert support.

To recruit participants for interview, we used both purposeful sampling (identifying participants who had recently evaluated and treated patients with child abuse and neglect, had various levels of experience and roles in the ED setting [eg, junior and senior attending physicians, nurses playing various roles in the clinical setting], and would be willing to discuss their experiences with the research team) and snowball sampling (in which existing participants then recruited future participants from among their colleagues).[24] In ED 1, physician and nurse leaders were asked to identify providers with the above characteristics and to let the providers know that they would be solicited for an interview. A lead nurse at ED 2 provided a time during which coverage for clinical duties was offered for nurses to participate in our interviews. Providers at ED 3 were identified by the senior physician assistant in the ED, also according to the above qualifications.

We recruited a total of 13 physicians, 18 nurses, and 9 physician assistants. The majority was recruited through e-mail contact; however, providers at ED 2 were approached in person because clinical coverage was provided for their