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Commitment, confidence, and concerns: Assessing health care professionals' child maltreatment reporting attitudes

Rebecca H. Foster[a,b], Denyse Olson-Dorff[c,*], Hannah M. Reiland[d], Ann Budzak-Garza[e]

[a] Department of Psychology, St. Louis Children's Hospital, One Children's Place (3N-14), St. Louis, MO, 63110, USA
[b] Department of Pediatrics, Washington University School of Medicine, One Brookings Drive, St. Louis, MO, 63130, USA
[c] Behavioral Health Department, Gundersen Health System, 1900 South Ave., La Crosse, WI, 54601, USA
[d] College of Osteopathic Medicine, Des Moines University, 3200 Grand Ave., Des Moines, IA, 50312, USA
[e] Pediatrics Department, Gundersen Health System, 1900 South Ave., La Crosse, WI, 54601, USA

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ABSTRACT

Given that childhood maltreatment is a significant international public health problem contributing to all major morbidity and mortality determinants, there is need to explore current practices and readiness of health care professionals (HCPs) to assess maltreatment, identify maltreatment risk factors, and complete mandated reporting. HCPs ($N = 114$) completed a child maltreatment mandated reporting measure to assess level of comfort with mandated reporting, commitment to the reporting role, and confidence in the child protection system to take action as needed. Additional questions explored comfort discussing maltreatment and risk factors for maltreatment in a medical setting and knowledge of community resources. Results indicated that HCPs were committed to their mandated reporting role and did not perceive substantial potential negative consequences of reporting. However, there were concerns regarding lack of confidence in the system's ability to respond sufficiently to reports. Despite commitment to the reporting role, results showed that large proportions of HCPs do not routinely screen for maltreatment, feel uncomfortable discussing maltreatment history, and lack knowledge about community resources. Additional training efforts must be prioritized in health care systems to improve short- and long-term health outcomes.

1. Introduction

Child maltreatment is the act or omission by a caregiver, regardless of intent, that results in the threat of harm, potential harm, or actual harm to a child (Gilbert et al., 2009b). Internationally it is estimated that 40 million children experience abuse annually, with nearly 25% of adults reporting physical abuse, 20% of women and 5–10% of men reporting sexual abuse, 36.3% reporting emotional abuse, and 16.3% experiencing physical neglect at some point during their childhoods (World Health Organization, 2014). Although local, national, and international child protection laws and enforcement of laws vary widely, by 1967, all 50 United States (U.S.) states, where this study was conducted, passed laws mandating reporting of child

* Corresponding author.
E-mail addresses: rebecca.foster@bjc.org (R.H. Foster), dgolsond@gundersenhealth.org (D. Olson-Dorff), Hannah.M.Reiland@dmu.edu (H.M. Reiland), AEBudzak@gundersenhealth.org (A. Budzak-Garza).

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maltreatment; states also pledged to provide child welfare services by 1975 (Myers, 2008). Mandatory reporting laws were designed to allow professionals who had the most contact with children to intervene on behalf of individuals experiencing maltreatment, with the goal of ameliorating and preventing long-term negative health and developmental outcomes. Despite reporting laws and other primary and tertiary efforts, an estimated 1500 U.S. children and 57,000 children worldwide die annually from child maltreatment (Flaherty, Sege, & Hurley, 2008; Jenny & Isaac, 2006). In addition, a study published in 2003 reported that only 5.1% of survivors of physical abuse and only 8.7% of survivors of sexual abuse had contact with child protective services (MacMillan, Jamieson, & Walsh, 2003). It is widely believed that child maltreatment is not only underreported and underestimated but acts as a major social determinant of health.

To date, mandated child maltreatment reporting has been minimally assessed among health care professionals (HCPs). A study published in 2000 found that 53% of physicians and 58% of physician assistants did not report all cases of suspected abuse (Delaronde, King, Bendel, & Reece, 2000). In another study (Gunn, Hickson, & Cooper, 2005), 28% of physicians suspected maltreatment and considered reporting but chose not to report. Reasons for not reporting included anticipated consequences for the parent or child, fear for personal safety, the possibility of lawsuits, fear of being wrong, the time required, and inadequate training (Flaherty, Jones, & Sege, 2004; Gunn, Hickson, & Cooper, 2005).

More than a decade of research indicates that child abuse reporting behavior of professionals is influenced by negative and positive attitudes toward making a report (O'Toole, Webster, O'Toole, & Lucal, 1999). Negative attitudes act as barriers to reporting, whereas positive attitudes facilitate making a report. While there are no validated measures of HCPs' attitudes toward mandated reporting, initial assessment tools have been created and validated for utilization in other settings. The Teachers' Reporting Attitude Scale for Child Sexual Abuse (TRAS-CSA) was originally developed by Walsh and colleagues (2010, 2012) as an easily distributed tool for relatively quick assessment of teachers' attitudes toward reporting child sexual abuse. Importantly, the tool is grounded in Ajzen's Theory of Planned Behavior (TPB), with items reflecting the cognitive, behavioral, and affective components of the model (Ajzen, 2005). According to the TPB, a person's behavioral attitudes, perceptions of control, and subjective norms relate to intention to engage in a certain behavior. In turn, intention to engage in a behavior predicts behavioral outcomes. Applying this theory to reporting child maltreatment, the individual's attitudes toward reporting, the opinions of their colleagues and supervisors, and perceptions of control over reporting may predict intentions to report suspected maltreatment. All of these components then relate to whether or not a report is made.

The attitudes of HCPs toward reporting suspected child abuse remains relatively unexplored despite mandated reporting laws, and, as stated, there are no published validated measurement tools for assessing this in health care settings. Studies of attitudes toward reporting child abuse are needed to design medically-oriented education and training programs. The need for cumulative and ongoing collaborative efforts by all members of a child's care team, including the importance of trust and rapport with patients and families, also cannot be underestimated. Therefore, this study sought to investigate HCPs' attitudes making a child maltreatment report in a moderately-sized, multi-specialty health system. To do this, the TRAS-CSA (Walsh et al., 2010, 2012) was modified slightly for use in a health care setting, and the internal reliability of the previously identified factor structure was assessed. Following this, we explored univariate and multivariate demographic and professional factors associated with commitment to the child maltreatment reporting role, concerns related to reporting, and confidence that appropriate action will be taken once a report is made. It was hypothesized that attitudes toward reporting would vary as a function of several factors, including professional background (e.g., physician, psychologist), years in practice, involvement in adult versus pediatric care, practice in primary versus specialty care, and whether specialized training was received.

2. Methods

2.1. Participants

HCPs ($N = 114$, $M_{age} = 48.55$ years, $SD = 10.79$, 64.90% female) completed study questionnaires. This represents 14.77% of possible medical and associate staff participants within our hospital. The majority of participants were members of the medical staff (59.60%) and held a doctoral or medical degree (59.60%). Most participants were physicians (51.30%), nurse practitioners (17.70%), or psychologists/psychotherapists (13.30%). The majority had worked in a medical setting (69.90%) and were licensed (62.30%) for more than 15 years. There was a relatively equivalent split between HCPs working in primary care (41.50%) versus specialty care (49.50%) with an additional minority working in surgery (9.00%). Among HCPs, 25.90% worked with pediatric populations only, 31.20% worked with adults only, and 42.90% worked with all age groups. Additional demographics are shown in Table 1.

2.2. Research setting, design, and informed consent

Study participants included associate and medical staff at a moderately-sized, free standing hospital system. Associate staff included non-doctoral or non-medical degree level providers such as non-doctoral level nurse practitioners or physician assistants; medical staff included doctoral and medical degree level providers such as physicians and psychologists. To be eligible for participation in the survey, HCPs were 1) at least 18 years of age, 2) a member of the associate or medical staff, and 3) able to read and write in English. All associate and medical staff were sent an introductory email via the associate and medical staff listserves. This email described the study's purpose and provided the Internet link to the online survey. Although a traditional consent process was waived for the anonymous online questionnaire, participants were provided with