2011-07-15

Nurse Practitioner Barriers to Reporting Child Maltreatment

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Advanced Practice Nurse Barriers to Reporting Child Maltreatment

by

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A thesis submitted to the faculty of

Brigham Young University

In partial fulfillment of the requirements for the degree of

Master of Science

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August 2011

ABSTRACT

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Each year approximately 1,000,000 child become the victims of abuse or neglect. The detrimental effects of child maltreatment (CM) have been well documented and create significant problems for the survivors and for society as well. All fifty states have enacted mandatory reporting laws to combat the CM epidemic. As mandated reporters, nurse practitioners and nurse midwives (APRNs) have the opportunity and responsibilities to identify and refer potential victims of CM, in this study a significant percentage choose not to report their suspicions. Respondents to the study survey identified several potential barriers to APRN reporting such as lack of education and training about CM, negative perceptions of child protective services and lack of physical evidence indicating CM occurred.

Keywords: abuse, barriers, child, maltreatment, reporting, nurse practitioner

ACKNOWLEDGMENTS

The author would like to express his gratitude and appreciation to the committee members Dr. Donna Freeborn, Dr. Beth Cole, and Dr. Mary Williams as well as Dr. Judi Berry for their direction, insight and encouragement. Also a special thanks to Dr. Renea Beckstrand for her time and invaluable help.

Kimber, you remain as ever “All the things I’ve got to remember”.

Introduction

The abuse and neglect of children is not a new phenomenon. History is replete with accounts of heinous acts perpetrated against the innocent. Healthcare providers have also taken note of child maltreatment (CM) with writings appearing as early as 900 A.D. In his text *Practica Puerorum,* the Arabic physician Rhazes stated that intentional injury may be a cause of some hernias in children (Labbé, 2005). In 1860 the French physician and child-welfare advocate Ambrois Tardeiu published details of 32 cases of CM in an attempt to raise social awareness about the "singular insanity" of child abuse and neglect (Labbé, 2005; Roche, Fortin, Labbé, Brown, & Chadwick, 2005). Tardieu's efforts to raise social awareness were met with resistance (Al-Holou, O'Hara, Cohen-Gadol, & Maher, 2009; Jenny, 2008) and it would take more than one-hundred years for healthcare to rediscover CM. Similarly to Tardieu, Kempe also encountered resistance and disbelief (Jenny, 2008; Kempe, Silverman, Steele, Droegomueller, & Silver, 1962; Leventhal, 2003). Kempe and associates' publication of *The Battered-Child Syndrome* in 1962 transformed CM from a social phenomenon to a recognized detriment to childhood health and well-being. For nearly a half-century CM has been researched extensively. Entire journals are dedicated to the subject, yet the fight against CM is still in its infancy. Nevertheless, the consequences and costs of CM make it imperative that healthcare providers protect and advocate for the most vulnerable populations.

The importance of identifying and reporting cases of suspected maltreatment is due in part to the prevalence of CM. National data idicates 1.2% of the United States (U.S.) child population, nearly 1 million children, were either abused or neglected (Centers for Disease Control and Prevention, 2008). This number has remained stable over the past decade (Sedlak et al., 2010). The U.S. Department of Health and Human Services (HHS) estimates that only one-third of abused and neglected children come to the attention of Child Protective Services (CPS).

They further concluded in the National Incidence Survey-4 (Sedlak et al., 2010) that not all reported cases meeting the criteria established by HHS are investigated by CPS. In a national survey of children and youth, Finkelhor, Turner, Ormond, and Hamby (2009) found the incidence of CM to be 10-fold greater than the number of CM cases substantiated by CPS, while a study conducted in North and South Carolina reported an incidence of CM greater than 40 times the official reported cases (Theodore et al., 2005). Many other studies verify that CM is a greater problem than official statistics disclose (Dube, Felitti, Dong, Giles, & Anda, 2003; Hussey, Chang, & Kotch, 2006; Swahn et al., 2006).

The consequences of CM are pervasive and long-lasting; potentially affecting survivors of CM for their entire life and have been linked with increased incidence of mental health issues such as depression, anxiety, post-traumatic stress disorder, and suicide (Dube et al., 2003). Abused and neglected persons also suffer poorer physical wellness and score lower on both subjective and objective measures of health. Sachs-Ericsson, Blazer, Plant, and Arnow (2005) found that persons who had been physically abused as children were more than twice as likely to suffer from a major physical illness compared to their non-abused counterparts. Individuals of advanced age with a history of CM were one and one-half times more likely to have three or more serious medical diagnoses (Draper et al., 2008). Heart disease, liver disease, and obesity occur at higher rates in people who were abused or neglected in childhood (Aaron & Hughes, 2007; Dong, Dube, Felitti, Giles, & Anda, 2003; Draper et al., 2008; Sachs-Ericsson, Blazer, Plant, & Arnow, 2005). Exposure to CM predisposes victims to engaging in high-risk health behaviors such as drug, alcohol, or tobacco use, early sexual debut, prostitution, a higher number of lifetime sexual partners, and lack of condom use. There is also a link between CM and behavioral issues with victims experiencing increased rates of juvenile delinquency, violent

behavior, and adult criminality. Wang and Holten (2007) estimated the annual cost of CM to be $103.8 billion. This however is a conservative number. While this estimate incorporates direct and indirect costs of the maltreated individual, it does not include some of the secondary costs incurred across the lifetime of the victim.

The adverse effects of CM are cumulative (Bifulco, Bernazzani, Moran, & Jacobs, 2005; Dube et al., 2003; Flaherty et al., 2006; Flaherty et al., 2009; Teicher, Samson, Polcari, & McGreenery, 2006; Wiersma et al., 2009). Each episode of abuse or neglect a child experiences increases the probability of suffering serious or lasting harm. It is imperative to identify and intervene at the earliest opportunity in order to minimize the negative effects of maltreatment. Yet there is no point in the timeline of maltreatment that intervention is fruitless. To that end, all fifty states have established mandatory reporting laws that require CPS to be notified when a reasonable suspicion of abuse or neglect exists. Research indicates that clinicians do not report all suspicious cases for CM even when the probability of maltreatment suspected by the clinician is high (Berkowitz, 2008; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty et al., 2006; Flaherty et al., 2008; Flaherty & Sege, 2005; Gunn, Hickson, & Cooper, 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Lundquist, 1997; Russell, Lazenbatt, Freeman, & Marcenes, 2004; Schweitzer, Buckley, Harnett, & Loxton, 2006).

Several studies have examined the decision-making processes and factors that inform and influence a clinician's reporting behavior. The research has primarily focused on physicians and any inclusion of nurse practitioners or certified nurse midwives (hereafter identified as advanced practice nurses or APRNs) appears incidental. As mandated reporters, APRNs have the opportunity and responsibility to identify and refer potential victims of CM. Advanced practice nurses play an increasingly large role in the delivery of healthcare (Allen & Viens, 2006; Brown,

Hart, & Burman, 2009), it is important to understand their reporting behaviors and experiences. The purpose of this study is to determine what barriers APRNs perceive in fulfilling their mandate to report suspected CM.

Review of the Literature

A comprehensive search of the literature was conducted in the MEDLINE, CINAHL, and PsychInfo databases using the search terms: child, abuse, neglect, maltreatment, reporting, mandatory reporting, and barriers. Initially, the literature was searched from 2000 to the present which returned only a moderate number of articles. The search was then expanded to include the years 1960 through the present in order to discover any insights into barriers that may have existed at the creation of mandatory reporting statues. Additionally, expanding the timeline provided an opportunity to gain an understanding of any changes in the identified barriers to reporting that have occurred across time.

Barriers to Reporting Child Maltreatment

Literature from the past several decades revealed barriers to reporting CM perceived by providers are consistent over time. These barriers can be divided into two categories: failure to recognize CM and anticipated consequences of reporting CM (Sege & Flaherty, 2008).

Failure to recognize child maltreatment. A child who has been abused or neglected is not a common clinical presentation (Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). Some providers reported having never treated a child who had been abused (Flaherty et al., 2006). Based on the vast under substantiation of CM, it is more likely that CM goes unrecognized in the clinical setting. Lack of training is a commonly reported barrier which causes clinicians to lack a sense of competence in recognizing CM (Flaherty et al., 2006; Flaherty, Jones, & Sege, 2004; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006; Leder,

Emans, Hafler, & Rappaport, 1999). Studies indicate clinicians who have received education regarding CM are more likely to report their suspicions, (Flaherty et al., 2000; Fraser, Mathews, Walsh, Chen, & Dunne, 2010) yet education remains sparse. Most emergency medicine residents and family practice residents receive less than 7 hours of didactic education on CM (Starling, Heisler, Paulson, & Youmans, 2009). McCarthy (2008) reports the median time spent educating about CM in medical schools is two hours. Furthermore, the CM education providers receive varies greatly between specialties leading to differing levels of competence and comfort among providers (Lawrence & Brannen, 2000; Starling et al., 2009). Participants in one focus group described their training regarding CM as "haphazard and infrequent" (Flaherty et al., 2004). No state medical board requires specific CM education for licensure renewal (American Medical Association, 2010) and Iowa is the only state that requires APRNs who routinely treat children to receive regular training on CM identification and reporting (Medscape, 2009; State of Iowa, 2007).

Anticipated consequences of reporting child maltreatment. The decision not to report suspected CM appears to involve a complex decision-making process and previous research has identified many barriers that inhibit reporting. Some have indicated that the reality of CM is too psychologically challenging for the provider to accept (Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999). Denial that an injury or behavior is the result of CM is not an unusual occurrence. Reports of sexual abuse have in the past been explained away as child fantasies or some other psychological dysfunction (Labbé, 2005). As participants of one study stated, "Do we really want to know this information and then [have to] deal with it?" (Leder et al., 1999).

A recurring barrier theme is the impact the CPS system has on clinicians' decision as to report. Negative interactions with CPS staff and perceptions that CPS interventions are either

inadequate or may potentially harm the family or child, discourage reporting (Flaherty et al., 2000; Flaherty et al., 2004; Gunn et al., 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Leder et al., 1999; Van Haeringen, Dadds, & Armstrong, 1998; Vulliamy & Sullivan, 2000). In some instances, clinicians have felt their management of CM would be adequate or superior to CPS involvement (Flaherty et al., 2006; Jones et al., 2008; Van Haeringen et al., 1998).

The legal environment in which clinicians practice appears to create a barrier to reporting CM. State laws often require mandatory reporting when a reasonable suspicion of abuse or neglect is evident (Child Welfare Information Gateway, 2008). This mandate is problematic in that there is no uniform definition of what constitutes reasonable suspicion. Levi and Loeben (2004) have extensively explored the concept of reasonable suspicion from both legal and cognitive perspectives and concluded that the term creates ambiguity. This lack of a clearly established threshold for suspicion leads to inconsistent reporting even among child abuse experts (Flaherty et al., 2006; Levi & Brown, 2005; Levi & Loeben, 2004; Levi, Brown, & Erb, 2006; Lindberg, Lindsell, & Shapiro, 2008).

Many healthcare providers choose not to report in order to avoid the legal system (Flaherty et al., 2006; Vulliamy & Sullivan, 2000). Those who have provided depositions or testified are less likely to report their suspicions again (Gunn et al., 2005); furthermore fear of litigation or having been previously sued decreases the likelihood of reporting CM (Flaherty et al., 2006; Gunn et al., 2005; Lazenbatt & Freeman, 2006).

As with the previous issues, the relationship between the clinician and the family also effects the decision to report. Unlike the prior mentioned barriers, the clinician/family relationship may impede or support reporting behaviors. Lack of familiarity with the child or family appears to encourage reporting (Flaherty et al., 2008), while a closer relationship with the

family deters reporting (Flaherty et al., 2006; Flaherty et al., 2004; Jones et al., 2008). In some instances, however, a close relationship with the family supports reporting. Provider knowledge of previous or current CPS involvement or an awareness of risk factors for abuse in the family positively effects reporting behavior (Flaherty et al., 2004; Jones et al., 2008).

Method

Design

This was a descriptive study examining the perceived barriers to CM reporting experienced by nurse practitioners and nurse midwives in an intermountain state to determine if these barriers are similar to the barriers perceived by physicians.

Sample

A search for APRNs in the State's Department of Professional Licensure's (DOPL) database provided a potential sample size of 1223 nurse practitioners and nurse midwives. Using a random number table, 400 names were selected to participate in the study. Participants met inclusion criteria if they were actively licensed in the state as a Family Nurse Practitioner (FNP), Pediatric Nurse Practitioner (PNP), or Certified Nurse Midwife (CNM), who treated children under the age of 18 years and could read and speak English. Nurses licensed as a nurse anesthetist or clinical nurse specialist, or who had not provided care to a child within the past five years or had not been concerned about the possibility of abuse or neglect for any child in the past five years were excluded from the study.

Procedures

Institutional Review Board approval was obtained. A cover letter explained the general purpose of the study. Participants were informed that returning the survey constituted their consent to participate in the study.

The survey instrument was mailed to individual addresses obtained through the DOPL search. A participation incentive of one dollar was included in the mailing. A self-addressed stamped envelope was also included to encourage the participants to return the survey.

Anonymity was maintained through the following means: the survey was entirely anonymous, the mailing list and returned surveys were kept in a locked file. At the conclusion of the study, all identifiable documentation and the surveys were destroyed.

Instrument

A 25-question survey entitled "Child Maltreatment Survey" (appendix) was used to determine barriers to reporting CM that was developed by Gunn, Hickson, and Cooper (2005). The survey was divided into three sections and contained a variety of question formats including: yes/no, Likert scale, and free response. Section I posed questions to determine respondent's familiarity with reporting laws and processes and also asked about any previous experience reporting abuse or neglect. Section II used a Likert scale to elicit the perceived barriers to reporting experienced by APRNs. Section III was composed of three clinical vignettes in which a child presented for evaluation of an injury. After reading each case presentation, the participant was asked if they would report the situation as suspicious for abuse or neglect, and if so, to whom. Additionally, participants were asked to rate their level of suspicion using a visual analog scale to assess the level of suspicion that prompts the APRN to file a report of suspected CM. Demographic information was also obtained as part of the survey and included gender, race, and age, number of years in practice, practice area, practice type, and degree type.

Data Analysis

The data collected were analyzed using SPSS® (SPSS Inc., Chicago IL). Descriptive statistics were used to define the sample characteristics. Likert items, which measure level of

perceived barriers, were analyzed using descriptive statistics including means and standard deviations. Additionally, correlational statistics were conducted to determine relationships between demographic data and perceived barriers. According to the level of data collected, the appropriate correlational statistic was identified and used. The vignettes, which assessed the provider's level of suspicion that prompts reporting, were analyzed using the appropriate correlational statistics. Qualitative questions were analyzed according to themes and patterns (Lincoln & Guba, 1985) and the yes/no questions were analyzed using frequencies. An experienced qualitative researcher reviewed the responses to the qualitative questions to establish the trustworthiness of the data.

Results

Quantitative Analysis

Of the 400 APRNs in the original sample twenty-six surveys were returned undeliverable. Of the remaining 374 possible participants, 182 (48.6%) returned surveys. Ninety-three indicated they had, in the past five years either not treated a child under the age of 18 years or not treated a child under 18 whom they suspected had been abused or neglected. Of the eighty-nine eligible respondents eighty-eight completed the survey and one returned the survey refusing to answer.

Respondent demographics, practice setting, specialty certification and prior CM reporting experience are listed in table 2. The study sample is similar to the demographic trends for APRNs within the United States (Allen & Viens, 2006). The mean age of all respondents was 45.5 years (range: 26 – 65 years) with standard deviation of 10.3 years (range: less than 12 months – 36 years) of practice experience in the nurse practitioner role. Family nurse practitioners made up nearly two-thirds (64.6% n=51) of the sample while 12.7% (n=10) and

8.9% (n=7) identified themselves as pediatric nurse practitioners or certified nurse midwives respectively. The majority of respondents identified themselves as female (88.6%) and Caucasian (98.9%).

Nearly all of those responding to the survey (85.2%) had reported at least one case of possible CM with a mean of 5.3 reports. However, most of the respondents (76.1%) had filed a total of five or fewer reports with the median number of CM reports filed being two. In response to the question “Have you ever considered reporting suspected child abuse or neglect, but chose not to do so?” 31% (n=27) of participants indicated that at some time they suspected a child to be a victim of CM but declined to report their suspicions.

When comparing those providers that had not reported cases suspicious for CM to those who had always reported their suspicions no statistically significant differences were discovered. While no differences were found between the groups of APRNs included in this study the survey did identify some beliefs that may negatively affect reporting. At least half of all respondents expressed frustration with CPS during the reporting process and that CPS provided no follow-up with the reporter. While a significant number of respondents expressed negativity toward CPS most agreed CPS involvement is necessary to provide adequate assistance to resolve the CM issue. Other potential barriers that were identified were the beliefs that reporting suspected CM may harm the child or negatively impact the family. Interestingly, while nearly half (45.3%) of respondents agreed or strongly agreed that reporting may result in harming the child victim, three-fourths (75.6%) disagreed with the statement “Reporting suspicions of child abuse or neglect does not improve the outcome for the child victim”.

Qualitative Analysis

The APRNs who declined to report suspected CM were asked to list the factors which influenced their decision. The most common reason for not reporting was lack of evidence CM had occurred. From the remaining responses, lack of certainty that CM had occurred and the lack of physical evidence were overwhelmingly cited as the reason for not reporting. Out of the total responses provided only two stated that additional patient history or the physical exam lead the APRN to exclude CM as a reasonable diagnosis. Table 3 lists themes of the responses for declining to report.

All survey participants were asked to list reasons why a health care provider might decide not to report possible CM. Ten distinct themes emerged during the analysis of these perceived barriers. The most significant barrier was fear of being wrong about the diagnosis of CM. The next two most significant presumed barriers were “Fear reporting may harm the provider personally, professionally or legally” and “Lack of time”. Provider confidence in CPS was also identified as a barrier to reporting. One participant stated, “It seems a child needs to be dead or permanently injured to be removed from the home”. Lack of knowledge about CM or the reporting process was another barrier identified; half of the respondents disagreed with the statement “I feel adequately trained to recognize abuse or neglect”.

Discussion

This study demonstrates that the perceived barriers reported by APRNs are similar to those previously reported by physicians. The primary obstacle to reporting identified by the participants was uncertainty that CM occurred. This manifested as clinicians citing a lack of evidence or expressing fear of CM being an incorrect diagnosis. These misgivings and resultant inaction may be the result of inadequate CM training or little exposure to CM in the clinical setting (Flaherty et al., 2004; McCarthy, 2008; Starling, et al., 2009). Lack of training about CM

or feelings of being unqualified to render a definitive opinion about whether or not CM occurred is a barrier that is recurrent in the literature about reporting behavior (Flaherty et al., 2004; Gunn et al., 2005; Lane & Dubowitz, 2009; Lazenblatt & Freeman, 2006; Leder et al., 1999). Participants of this study indicated that CM was infrequently seen by clinicians. These results are congruent with other studies that indicate CM is an uncommon presentation or CM is dramatically under recognized in the clinical setting (Flaherty et al., 2006; Lane & Dubowitz, 2009; Lazenbatt & Freeman, 2006). This paucity of experience reinforces the feelings of inadequacy in the identification of CM.

Implications for Practice

Findings from this study indicate a significant barrier to reporting CM is a lack of competency in recognizing CM. Educating providers about CM has been shown to increase rates of reporting (Flaherty et al., 2000; Fraser et al., 2010). In light of this, states should consider implementing mandatory CM education as part of the licensure renewal process in order to increase awareness of CM and consequently reporting. However, it has been demonstrated that experience with CPS via the reporting process negatively impacts reporting behavior (Flaherty et al, 2000; Flaherty et al., 2004; Gunn et al., 2005). Merely educating the clinician may not be enough to sustain lasting and meaningful behavior change. What may be necessary is to change the reporting process altogether. An option is for the clinician to refer the child to an abuse expert. Lane and Dubowitz (2009) in their study of pediatricians found strong support for the use of referrals to CM specialists. A referral allows for the child victim to be screened by a health care provider with CM expertise who can determine the need for CPS involvement, thus mitigating some of the perceived barriers by removing the APRN from the reporting process. Furthermore, such a process provides an opportunity for the expert to provide the referring

clinician validation or education regarding the appropriateness of their suspicions, increasing the clinician's sense of competency. Another option is to increase the number of clinical sites that provide social services interventions via an on site licensed clinical social worker (LCSW). This provides an opportunity to develop a collegial relationship with individuals who by virtual of their education and training may have more positive and effective interactions with CPS staff.

Limitations

Although the return rate for the survey was good (48.6%) the low incidence of recognized CM in the clinical setting resulted in a usable sample size (23.5% of all possible participants) that may have not been large enough to adequately determine if any actual differences are present between APRNs that always report CM and those who have declined reporting. This may mean the results are not representative of APRNs. Mailing a reminder card two to three weeks after the initial mailing of the survey may have helped to increase the return rate and subsequently the number of usable surveys.

Recommendations for Further Research

It is important to accurately determine the reporting barriers APRNs experience in order to implement effective interventions to overcome them. Research comparing reporting rates between states that have mandatory CM training and those which do not may be of value in determining the effectiveness of such training. Next, focus groups to determine why APRNs require such a high degree of certainty prior to intervening in cases of suspected CM have the potential to be of great benefit. Finally, research is needed to determine what processes must be changed or implemented in order to increase the collaboration between clinicians and CPS workers. Such research should focus on determining healthcare providers' knowledge of the CPS system and its mandate, as well as, understanding the qualifications of CPS staff; their case loads

and how they proceed with a report of suspected CM. Focus groups of CPS staff would facilitate understanding their perceived barriers about working with healthcare providers.

Conclusion

This study demonstrates the non-reporting rates among APRNs are similar to physician rates of non-reporting and that the perceived barriers were similar (Gunn et al., 2005; Lane & Dubowitz, 2009; Schweitzer et al., 2006; Van Haeringen et al., 1998). Lack of evidence or certainty CM occurred was the most common reason given for failing to report. Also, CPS may exert an important influence regarding the clinician's decision to report.

Ironically, mandatory reporting laws are written to empower the clinician to refer suspected victims of CM to experts, specifically CPS. Unfortunately, negative interactions between CPS and health care providers, the lack of follow-up and the perception that CPS interventions are inadequate or harmful may be directly responsible for a provider's need for a greater level of certainty prior to intervening than with other clinical presentations (Jones et al., 2008; Leder et al., 1999; VanHaeringen, 1998). Referring to CM experts within the health care field may be one option for overcoming this barrier but unless current laws are changed it would not remove the legal responsibility of reporting to CPS nor would it guarantee that the family would follow-up with the referral. Ultimately, APRNs as a growing force in primary care must remain open to the possibility that any child they treat may be the victim of CM and should appropriately include CM in their differential diagnosis. Acknowledging the possibility of CM promotes caution and awareness when gathering history and performing the physical assessment and may help to overcome the failure to recognize CM in the clinical setting. The next critical step is reporting to the appropriate agency. Although the CPS system is far from perfect it is what currently exists to intervene in cases of abuse and neglect and merely avoiding its use will

not improve it. Increased interaction between clinicians and CPS workers has the potential to aid in the identification of and the improvement in the reporting/response process.

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Tables

Table 1

Summary of Studies

Author(s)	Purpose	Study Design	Population	Major Findings
Adams, B. L. (2005)	To study the frequency of assessing and documenting risk factors for child abuse and neglect by APRNs	Quantitative questionnaire	APRNs in a single Midwestern state n= 87	The surveyed APRNs demonstrated a lack of knowledge regarding the significance of identifying key risk factors for child abuse and neglect
Flaherty *et al*. (2008)	Examine decision-making of clinicians regarding the reporting or non-reporting of child abuse	Prospective observational study	National sample of pediatric clinicians n= 434 Majority of sample population were physicians (88%)	Data collected on 15,003 child injury visits revealed 1683 (11.2%) cases that generated some degree of suspicion for CM. Clinicians did not report 27% of injuries considered likely or very likely to have been caused by abuse and did not report 76% of injuries they considered possibly caused by CM. Eight factors were identified that influenced the decision to report 1. An inconsistent history, 2. If the patient was referred to the clinician for suspected abuse, 3. An injury with >1 identified family risk factors, 4. The degree of injury severity, 5. Race, 6. Lack of familiarity with the patient, 7. Clinicians who had previously not reported all suspicious injuries, 8. Prior loss of patients as a result of reporting
Flaherty, E. G., Jones, R. & Sege, R. (2004)	Learn about primary care physicians' experiences in identifying and reporting injuries caused by physical abuse	Qualitative design: focus group	Chicago-area physicians n= 6	Themes 1. Previous experience with identifying and reporting strongly influenced the participants 2. The physicians felt a heavy responsibility to accurately identify child abuse during the brief time allotted for an office visit. Identified barriers to reporting: 1. Lack of knowledge and training 2. The relationship between the physician and victim's family 3. Negative experiences with CPS when reporting 4. Lack of time 5. Lack of in-office diagnostic testing.
Flaherty, E. G, Sege, R., Binns, H. J., Mattson, C. L., & Christoffel, K. K. (2000)	Identify primary care providers' experiences with identifying and reporting CM and determining factors that affect reporting decisions	Mixed design	Primary care providers affiliated with Pediatric Practice Research Group n=85 Majority of the sample were physicians (89%)	8% of providers declined to report cases of suspected abuse. Reasons for not reporting: Lack of certainty that abuse occurred, 2. Provider had a prior negative experience with CPS, 3. Providers felt capable of solving problem with family without outside intervention.
Flaherty, E. G., Sege, R., Mattson, C. L., & Binns, H. J. (2002)	Describe the primary care practitioner's assessment of the likelihood an injury was caused by abuse	Prospective cross-sectional study	Primary care providers affiliated with Pediatric Practice Research Group n=85 Majority of the sample were physicians (89%)	Of 659 injuries treated during the 4 week study period 20% were identified as arousing some level of suspicion for abuse and 1% as moderately suspicious for abuse. Characteristics that increased the practitioner's level of suspicion: 1. Hispanic or African-American ethnicity, 2. Severity of injury, 3. If the child's age is less than 6 years, 4. If the mother did not have a college education, 5. If the family received Medicaid or is self-pay for health care, 6. Identified family risk factors, 7. Recent practitioner education about CM.

Flaherty, E. G., Sege, R., Price, L. L., Christoffel, K. K., Norton, D. P. & O'Connor, K. G. (2006)	Describe pediatricians experience, confidence, and attitudes identifying and managing child abuse. Describe the effects of reporting.	Mixed design questionnaire	Random sample of non-retired members of the American Academy of Pediatrics n= 851	3% of responding pediatricians had not reported all cases of suspected abuse. Reasons given for not reporting: 1. Desire to work with family without involving an outside agency (CPS), 2. Uncertain abuse had occurred, 3. Socially acquainted with the family, 4. Did not wish to become involved with the legal system. A negative opinion of CPS services acted as a barrier to reporting. 40% of participants who had reported experienced some negative outcome including: 1. Loss of the family as patients 2. Lawsuits
Gunn, V. G., Hickson, G. B. & Cooper, W. O. (2005)	Identify factors associated with the decision not to report suspected CM	Mixed design	Pediatricians in one southeastern state who had treated an injury suspicious for child abuse in the past 5 years n= 195	28% of respondents had at some point not reported a case of suspected CM. Identified themes for declining to report: 1. Concern about the potential consequences of reporting for the provider or child, 2. Hassle and time involved in reporting, 3. Fear of being wrong or wrongly accusing a family, 4. Lack of certainty that maltreatment had occurred, 5. Denial that CM could occur. Identified barriers to reporting: 1. Gender of the physician, 2. More years in practice, 3. Previous reporting of CM, 4. Having been deposed or having testified, 5. Having been threatened with a lawsuit, 6. Prior negative experience with CPS, 7. Lack of knowledge of the reporting law and process
Jones *et al*. (2008)	Describe the decision-making process, alternative management strategies, and explanations when not reporting suspected maltreatment	Qualitative design: phone interview	Pediatric primary care clinicians who participated in the Child Abuse Reporting Experience Study (CARES) n= 81	Themes of factors influencing the decision whether or not to report: 1. Familiarity with the family 2. Specific elements of the case history such as an inconsistent history, the injury pattern, multiple injuries etc. 3. Clinical resources such as consultation and collaboration and radiographic findings 4. Expected outcomes of CPS involvement
Lane, W. G. & Dubowitz, H. (2009)	Assess the experience, comfort, and competence of primary care pediatricians in evaluating and managing child abuse	Quantitative questionnaire	Random sample of members of the American Academy of Pediatrics n= 520	Physicians did not report 28% of cases suspicious for physical abuse, 23% of cases suspicious for sexual abuse, and 50% of cases suspicious for neglect. 94% of participants *usually* report abuse while fewer (84%) report neglect. 16% only report suspected CM when certain abuse had occurred. Most PCPs had little experience with child abuse. Most study participants felt competent to perform an examination for physical abuse and neglect, less than half (47.6%) felt able to evaluate sexual abuse. They did not feel competent to provide a definite opinion or testify, especially in cases of alleged sexual abuse
Lazenblatt, A. & Freeman, R. (2006)	Describe the ability of physician, nurses, and dentists to recognize and respond to abuse	Self-report survey	A stratified random sample of physicians, community nurses, and dentists in Northern Ireland n= 419	Clinicians did not report 13% of cases suspicious for CM. Of the three professional groups participating community nurses were the most likely to recognize and report suspicions of CM. Identified barriers: 1. Fear of misidentification and its consequences 2. Uncertainty when reporting 3. Challenges of reporting i.e. 'red tape and hierarchy'. Clinicians also identified a need for additional education.
Leder, M. R., Emans, S. J., Hafler, J. P., & Rappaport, L. A. (1999)	Describe factors that generate suspicion of sexual abuse and barriers to inquiry	Qualitative interviews: focus group	Pediatric primary care discussion group members n=65	Identified themes of barriers to inquiry: 1. Lack of training, 2. Lack of time, 3. Loss of alliance with family, 4. discomfort with discussing issues of sexuality, 5. fear/uncertainty, 6. Lack of appropriate referral services, 7. Belief that CPS are inadequate or counterproductive, 8. Concern regarding false accusations.

Levi, B. H. & Brown, G. (2005)	Identify pediatrician understanding of what constitutes reasonable suspicion for mandated reporters	Quantitative questionnaire	Members of the AAP Pennsylvania Chapter n= 1249	The utilization of 'reasonable suspicion' as a threshold for reporting CM may be of little value as the concept of reasonable suspicion varies greatly between and even within individuals. 85% of participants demonstrated an internal inconsistency when using different reporting scales. This uncertainty of what constitutes a reasonable suspicion creates a barrier to reporting.
Linberg, D. M., Lindsell, C. J., & Shapiro, R. A. (2008)	Assess the inter-rater reliability of child abuse experts in determining the likelihood of CM	Quantitative design using video recorded case vignettes and 4 rating scales	Physician members of the Helfer Society n=22	Broad variability in ratings for likelihood of CM was found for most cases reviewed. The least variability was found for the cases which generated the highest concern for abuse. Single expert opinion should be interpreted with caution regarding likelihood for CM.
Starling, S.P., Heisler, K. W., Paulson, J. P., & Youmans, E. (2009)	Determine the level of knowledge, comfort, and training related to the medical management of child abuse among pediatrics, emergency medicine, and family medicine residents	Quantitative questionnaire	Residency-program directors (n=53) and third-year residents (n=462). Survey sites were solicited from child abuse physicians practicing at institutions with residency programs.	46% of pediatric residents, 80% of emergency medicine residents and 88% of family medicine residents received less than 7 hours of didactic instruction in CM. Pediatric residents received the greatest amount of training for and exposure to CM and family medicine residents the least. Family medicine resident were less comfortable with managing CM cases.
Saulsbury, F. T., & Campbell, R. E. (1985)	Evaluate the CM reporting practices of physicians	Mixed design	Pediatric, family practice, and emergency medicine physicians practicing in the State of Virginia n=1962	26% of respondents reported treating no child they had suspected of being abused or neglected in the previous year, 90% treated $\leq$5 cases of abuse or neglect. Most physicians reported all cases of diagnosed physical and sexual abuse were reported, 91% and 92% respectively. 58% reported all cases of neglect, 45% reported emotional abuse and 43% medical neglect. Most common reasons for not reporting: 1. Lack of certainty, 2. Belief the physician could solve the issue without outside agency assistance.
Schweitzer, R. D., Buckley, L., Harnett, P., & Loxton, L. J. (2006)	Evaluate the reporting behaviors of medical practitioners and barriers to reporting CM they experience	Quantitative questionnaire	General practitioners in Queensland, Australia n=91	26% of participants had at some point suspected CM but not filed a report. 69% had filed at least one report during the course of their career and 21% had reported in the past year. Most significant predictor of non-reporting behavior: if the practitioner believes the CM is a one-time only occurrence. More male practitioners declined to report than their female colleagues 28% vs. 18% $p > 0.05$.
Van Haeringen, A., Dadds, M., & Armstrong, K. (1998)	Assess the responsiveness and attitudes of medical practitioners to the reporting of suspected child abuse or neglect. Determine is variances exists between specialties	Mixed design questionnaire	Pediatricians, general practice physicians and hospitalists n =224	43% of respondents had declined to report at least one case of suspected CM. More years in practice is associated with a decreased likelihood of reporting. Reasons given for not reporting: 1. Reasonable explanation of the injury, 2. Other personnel or agencies already involved, 3. Confidence in family dynamics (denial of possibility of abuse), 4. Difficulty in proving emotional abuse or neglect, 4. Desire to manage problem without outside agency (CPS) involvement, 5. Concern about potential detrimental effects of reporting for the provider or family. GPs are more cautious about reporting CM than pediatricians. Identified factors influencing the decision to report: 1. Explanation of the injury, 2. Nature of the injury, 3. Age of the victim.

Vulliamy, A. P., & Sullivan, R. (2000)	Explore reasons for pediatricians' failure to report suspected CM	Mixed design questionnaire	Pediatricians with admitting privileges to British Columbia Children's Hospital n=26	Themes of factors that discourage reporting: 1. Problems with CPS, 2. Physician's loyalty to parents, 3. Court problems. Main reasons why physicians may decline to report: 1. Negative view of CPS social workers, 2. Physician's loyalty to parents, 3. Negative view of the court system, 4. Definitional or diagnostic confusion, 5. Confidentiality, 6. Ignorance of reporting laws or procedures, 7. Not willing to get involved, 8. Family will not seek help if the doctor reports. An increased level of comfort in reporting perceived as social worker professionalism, ease of reporting, and the reporter being treated in a professional manner increased the incidence of reporting.
Willis, S. E., & Horner, R. D. (1987)	Examine the experience of family physicians with child sexual abuse and identify barriers to suspicion and reporting	Quantitative survey; pilot study	All physician faculty, residents, and clinical preceptors of the Department of Family Medicine at the East Carolina University School of Medicine n=181	57% of participants suspected sexual abuse in the past year, yet only 39% reported 1 or more cases. Barriers to suspicion and reporting: 1. More years in practice, 2. Lack of confidence in social service agencies to effectively respond, 3. Concern that reporting will adversely affect the physician, child, or family, 4. Desire to avoid the legal system.
Wright, R. J., & Wright, R. O. (1999)	Determine pediatric emergency fellows' level of preparedness to respond to suspected child abuse, and to assess barriers to effective response	Self-reported written survey	Pediatric emergency Fellows in the United States and Canada n=162	70.1% of respondents received less than 10 hours of child abuse training during fellowship. Only 32.7% had a required child abuse training rotation. 50% of Fellows who were provided an elective child protection/abuse rotation were unlikely to participate. Most frequently identified barriers: 1. Lack of formal training, 2. Lack of experience handling cases of CM, 3. Personal discomfort, 4. Perceived lack of response by CPS and law enforcement.

Table 2

Respondent Demographics

	Female	Male	Age	Race	APRN experience	Specialty
Reporters	90.2% (n=55)	9.8% (n=6)	45.6 yrs	Caucasian 98.4%(n=60) Hispanic 1.6% (n=1)	10.5 yrs	FNP 70.7% (n=41) PNP 12.1% (n=7) CNM 5.2% (n=3) Other 12.1% (n=7)
Non-reporters	85.2% (n=23)	14.8% (n=4)	45.5 yrs	Caucasian 100% (n=27)	10.3 yrs	FNP 47.6% (n=10) PNP 14.3% (n=3) CNM 19% (n=4) Other 19% (n=4)

	Practice setting	Number of CM cases reported
Reporters	Primary care 44.3% (n=27) Hospital based 24.6% (n=15) Emergency dept 8.2% (n=5) Other 22.9% (n=14)	Mean = 6.3 Median = 2
Non-reporters	Primary care 33.3% (n=9) Hospital based 40.7% (n=11) Emergency dept 3.7% (n=1) Other 22.2% (n=6)	Mean = 5.6 Median = 3

Table 3

Themes for Non-Reporting Behavior

Reasons for declining to report (actual) – 24 responses

Reason	n=	%
Not enough evidence or unsure abuse occurred	17	70.8
Lack of knowledge about abuse or reporting	2	8.3
Assumed someone else would report	2	8.3
Influenced not to report by others	1	4.2
Concerned report would harm the victim	1	4.2
Lack of confidence in the child protection system	1	4.2

Why would others be reluctant to report (hypothetical) – 170 responses

Reason	n=	%
Afraid of being wrong about CM diagnosis	51	30
Fear report may harm the provider personally, professionally or legally	40	23.5
Lack of time	25	14.7
Lack of confidence in the child protection system	13	7.6
Do not want to become involved in the reporting/legal process	10	5.9
Lack of knowledge about abuse or reporting	9	5.3
Fear report would harm the victim	7	4.1
Fear report would harm the family	6	3.5
Relationship with the family	5	2.9
Assumed someone else will report	4	2.4

Appendix

Child Maltreatment Survey

This is a short survey about child maltreatment. You were selected to participate because your job brings you into contact with children, and your responses are very important to us. Participation is completely voluntary and your responses will be kept strictly confidential. Please try to answer all of the questions, but if you come to a question you do not want to answer, just skip it, and move to the next question. The survey should take about 15 minutes.

1. During the PAST 5 YEARS, have you provided medical care to children under the age of 18 years? 1. □ Yes □ No

2. In the course of your work, have you ENCOUNTERED any child where you were concerned about the possibility of child abuse or neglect? 2. □ Yes □ No

IF YOU ANSWERED "No" TO EITHER OF THESE QUESTIONS, PLEASE STOP HERE, YOU HAVE COMPLETED THE SURVEY. Please return the survey in the self-addressed, stamped envelope. Thank you for your time.

3. Does your state have a LAW regarding child abuse or neglect reporting?

3. □ Yes

□ No

□ Don't Know

a. *If yes*, who is required to report?

3a. □ Don't Know

_____

_____

b. To whom are reports made?

3b. (check all that apply)

□ Child protection agencies

(i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

4. Does your state have an "IMMUNITY" provision that protects persons that report from

4. □ Yes

□ No

lawsuits?

□ Don't Know

a. If there is an immunity provision, do you know who is covered by the provision?

4a. □ Don't know

□ Anyone who reports

□ Medical professionals

□ Law enforcement

□ Teachers

□ Citizens

5. Does your **primary practice location** have GUIDELINES for reporting suspected child abuse or neglect?

5. □ Yes

□ No

□ Don't Know

a. *If yes*, to whom are reports made?

5a. (check all that apply)

□ Don't Know

□ Child protection agencies

(i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

6. Have you ***ever*** REPORTED suspected child abuse or neglect?

6. □ Yes □ No

a. *If yes*, to whom have you reported (i.e., a social worker, Child Protective Services, police)?

6a. (check all that apply)

□ Child protection agencies

(i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

b. *If yes*, approximately HOW MANY TIMES since completing your training have you **ever reported or been involved in reporting**

6b. _____

suspected abuse or neglect?

7. Have you ever CONSIDERED reporting suspected child abuse or neglect, but chose ***not to*** do so?

7. □ Yes □ No

a. If you chose ***not to report***, what were all the considerations you had in deciding not to report?

7a. _____

_____

_____

_____

8. Have you ***ever been asked*** to GIVE A DEPOSITION regarding a case of child abuse or neglect?

8. □ Yes □ No

a. *If yes*, have you ***ever agreed*** to GIVE A DEPOSITION?

8a. □ Yes □ No

□ Does Not Apply

b. *If yes*, approximately <u>how many hours</u> did your ***most recent*** deposition take?

8b. □ <2 hrs □ 2-5 hrs

□ 6-8 hrs □ >8 hrs

□ Does Not Apply

9. Have you ***ever*** had to TESTIFY in a case of child abuse or neglect?

9. □ Yes □ No

a. If yes, approximately <u>how many hours</u> did your ***most recent*** experience take? (Including: reviewing files, travel, speaking with attorneys)

9a. □ <2 hrs □ 2-5 hrs
□ 6-8 hrs □ >8 hrs
□ Does Not Apply

10. Have you ever been PERSONALLY named in a civil lawsuit as a result of YOUR involvement in reporting suspected child abuse or neglect?

10. □ Yes □ No

11. Have you ever been THREATENED with a civil lawsuit as a result of YOUR involvement in reporting suspected child abuse or neglect?

11. □ Yes □ No

12. Please list <u>as many reasons as possible</u> why you think ***other*** medical providers may be RELUCTANT TO REPORT suspected child abuse or neglect.

12. _____

_____

_____

_____

Please indicate to what extent you agree or disagree with the each of the following:

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Does not apply to me
13a. Reporting suspicions of child abuse or neglect does not improve the outcome for the child victim						
13b. I am concerned that the child may come to harm as a result of my reporting suspicions of abuse or neglect						
13c. I am not certain what legally constitutes child abuse						
13d. I am not certain what legally constitutes neglect						

13e. The last time I reported suspected abuse or neglect, I did not get any follow-up						
13f. I do not believe that anyone would harm a child						
13g. I believe that I can sometimes provide the necessary assistance to the child and family without involving a child protection agency						
13h. I am concerned about being sued for reporting suspected abuse or neglect						

13i. I am frustrated by the response from Child Protective Services when I report						
13j. I am reluctant to report suspected child abuse or neglect because I have been sued for reporting						
13k. If I got feedback from the social service agency, I would be more willing to report						
13l. I am concerned that reporting will alter my relationship with the child's family						
13m. I do not report until I am <u>certain</u> that the child has been abused or neglected						
13n. I am concerned about having to testify						

13o. I am concerned about the impact of reporting on the family's relationship with the community						
13p. I am reluctant to report abuse or neglect because I know colleagues who have been sued for reporting						
13q. I am reluctant to report because of the time that it takes						
13r. I am concerned about incorrectly "labeling" a family as suspicious for abuse or neglect						
13s. I feel adequately trained to recognize abuse or						

neglect						

Please read the following three cases and answer the corresponding questions to the best of your ability. We recognize that the information we provided is very limited. There are **no "right" answers** to these questions.

14. Child A is brought to the emergency department by her mother on a Sunday evening after having spent the weekend with her father. The mother reports that her 13-month-old has been abused by her ex-husband. She angrily states that when she went to pick her daughter up, she noted several bruises on the child's legs and one on her forehead, and insists that the child's father has "beaten" her. She says that her ex-husband is "a strict disciplinarian" and "probably wouldn't think twice" about hitting their daughter. On exam, the child appears to be clean, happy and well nourished, and she is busily exploring the exam room. Her exam is unremarkable except for a 2x3 cm contusion midline on her forehead, and several 1- and 2-cm bruises of different colors on her knees and anterior tibial surfaces.

a. Would you report this as suspicious for abuse or neglect? 14a. □ Yes □ No

a1. ***If yes***, to whom would you report?

14a1.

□ Child protection agencies

(i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

b. Given the information in this case, how suspicious are you of abuse or neglect?

|----------|----------|----------|----------|

0% 50% 100%

(Not at all suspicious) (Certain of abuse/neglect)

15. Child B is a 22-month-old Caucasian male who is brought to your office for a sick visit. Both of his parents have accompanied him on this visit, and appear concerned. They report that he has been fussy and refusing to walk for the past 18 hours. The day before, the child had been playing outside while his mother attended to her 2-month-old twins. She reported hearing the child cry, and found him sitting on the deck among his toys. Initially, the parents thought that his clinginess was due to "jealousy" of the attention his siblings received, but became concerned when he continued to refuse to walk this morning. Neither parent witnessed any trauma, nor did they notice fever, redness or swelling. On exam, you note mild swelling and tenderness of the right distal femur and obtain an x-ray, which reveals a non-displaced spiral fracture of the distal femur.

a. Would you report this as suspicious for abuse or neglect? 15a. □ Yes □ No

a1. ***If yes***, to whom would you report? 15a1.

□ Child protection agencies (i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

b. Given the information in this case, how suspicious are you of abuse or neglect?

|----------|----------|----------|----------|

0% 50% 100%

(Not at all suspicious) (Certain of abuse/neglect)

16. Child C is a 7-year-old boy who is sent to your office from school after having been unexpectedly absent from school for several weeks. He is emaciated and apathetic, and he does not make eye contact or respond to your attempts at engagement. His shorts and t-shirt are soiled and malodorous. He will not respond when you ask him why he has not been in school.

a. Would you report this as suspicious for abuse or neglect?

16a. □ Yes □ No

a1. ***If yes***, to whom would you report?

16a1.

□ Child protection agencies (i.e., CPS, DCS, DYS)

□ Police/law enforcement

□ Office/practice social worker

□ Other (please specify):

_____

b. Given the information in this case, how suspicious are you of abuse or neglect?

|----------|----------|----------|----------|

0% 50% 100%

(Not at all suspicious) (Certain of abuse/neglect)

17. What describes the AREA in which your **primary practice** is located?

17. □ Urban
□ Suburban
□ Rural

18. What TITLE best describes your TRAINING?

18. □ MS/MSN
□ PhD
□ DAPRN
□ FAPRN
□ PAPRN
□ CNM
□ Other
(please specify):
_____

19. Do you have children of your own?

19. □ Yes □ No

20. On an **AVERAGE DAY** (independent of season):	**None**	**1-10**	**11-20**	**>20**
20a. How many children 0-3 years old do you provide care for?				

20b. How many children 4-7 years old do you provide care for?				
20c. How many children 8-11 years old do you provide care for?				
20d. How many children 12-15 years old do you provide care for?				
20e. How many children 16-17 years old do you provide care for?				

21. What year (after completing your professional training) did you ***first*** START PRACTICING?

21. _____

22. Please indicate your GENDER.

22. □ Female □ Male

23. In WHAT YEAR were you born?

23. _____

24. What best describes your RACE?

24. □ Caucasian, non Hispanic

□ Black, non Hispanic

□ Hispanic or Latino

□ Asian

□ Native American

□ Other (please specify):

_____

25. Please select the best descriptor of your PRACTICE TYPE.

25. □ Primary care

□ Hospital-based

□ Emergency Department

□ Child abuse consultant

□ School clinic

□ Public health

□ Other (please specify):

_____

26. Is there anything else that you would like to tell us about your experience?

_____
_____
_____
_____

Thank you for your participation! Please return the survey in the enclosed, self-addressed, stamped envelope.