

This document reflects some of the most recent studies, statistics, and discussions with relevant persons in the community pertaining to the topic of child abuse and neglect reporting and training issues.

Recent Law Changes

In April, 2007 Karly's Law was presented to the Oregon House and was passed. The law proposed to modify procedures in child abuse investigations to include a prompt medical assessment, including photo documentation, of a child with suspicious injuries from a professional trained to detect abuse.

Three sections of the act are especially relevant to medical professionals in concert with CA/N training. Section three of the law specifies that members of the multi-disciplinary team conducting the child abuse investigation must have: training in risk assessment, dynamics of child abuse, child sexual abuse and rape of children and legally sound, and age appropriate interview and investigatory techniques.

Section nine specifies that the physician designated by the team must have received training in how to conduct child abuse medical assessments, and who is (or can designate another physician who is) regularly available to conduct the medical assessment. The third relevant section is section twelve. If the team is not able to identify a medical professional with the necessary training they must develop a plan for recruitment and training to make a medical professional available to the children of the county.

Implication: Medical professionals who have not received training in the area of CA/N cannot act as effective resources for their county. A lot of areas are trying to catch up to the law that was put into effect immediately when it was passed, and get medical professionals trained.

Under Reporting

An article from The Oregonian (Green, 2007) cited a study from the year 2000 that found that **53% of doctors do not report all cases of abuse.**

In a 2007 study from Sweden, Borres and Hägg examined physicians' responses to vignettes of cases of child abuse and neglect. Results from this study showed that **two thirds of the physicians suspected abuse after reading vignettes but did not report it.**

A recent article from Lazenbatt and Freeman (2006) surveyed medical professionals in Northern Ireland and found that **60%** of respondents (various types of medical professionals) stated that they **had seen at least one case where there was suspicion of CA/N**, though **only 47% of respondents had reported a suspicious case.** In the previous six months 42 out of 44 respondents who stated they had identified a potential case of abuse reported it.

Barriers to Reporting

Borres and Hägg (2007) identified that a major reason given for not reporting child abuse, or suspicion of child abuse in practice was a **lack of confidence in social services organizations.**

Lazenbatt and Freeman (2006) found that respondent's general fears in regards to reporting child abuse were: **the fear of misidentification, an unwillingness to confront**

a family about abuse, a lack of clear guidelines and protocols for reporting, workload pressures, and lack of sensitivity and support from social services and colleagues.

In a 2006 survey of licensed physicians from Kentucky, views and experiences relevant to child abuse and neglect were examined. It was found that when asked, physicians report most often that there is **no standard office protocol used in their practice to identify and/or report child abuse and neglect (35.5%)**. Twenty-eight percent of physicians report that there is a protocol in place for reporting. When asked to identify all standardized forms used in their practices for identifying and/or documenting child abuse or neglect **the majority (62.4%) report using no standardized forms** while 25.3% identify using standardized forms.

Barriers to reporting most often cited by respondents in the Kentucky study (2006) were: **an uncertainty that reporting would help the child, fear that reporting will make it worse for the child, a loss of relationship with the family, inconsistent response (by the system) to previous reports, unfamiliarity with social workers, and risk of medical malpractice.**

The barriers to reporting CA/N articulated by local sources are: **a fear of attorneys/court/malpractice/family retribution, a lack of confidence in the system response, the time it takes to fill out a report when they have back to back medical appointments.**

Curricula

Education in the area of CA/N is not mandatory to become a physician, and most medical schools do not require training in the area.

Narayan, Socolar, and St. Claire (2006) used a questionnaire sent out to chief residents of all accredited pediatric residency programs in the United States from 2004-2005 to assess the CA/N curricula in these programs and to identify the level of preparedness of residents to address issues of child abuse and neglect upon graduation. They found that **41% of programs required mandatory clinical rotations in CA/N, 57% offered elective rotations, and 25% offered no rotations**. Respondents rated the **level of preparedness** of graduating residents to address issues of CA/N as: **very well (12%), well (54%), somewhat well (28%), or not well (6%)**.

In a Canadian study similar to the Narayan et al (2006) study, Ward, Bennett, Plint, King, Jabbour, and Gaboury (2004) found through a survey of child protection program directors, pediatric program directors, and pediatric residents that **only 20% of the 15 programs nationwide had mandatory clinical rotations in CA/N, 60% offered clinical electives, and 47% did not offer any specific clinical experience in CA/N**. Residents and program directors in rating training in CA/N most often rated it as "somewhat adequate, needs improvement". **A large percentage (92%) of residents felt that they needed further training in CA/N, graduating residents also mirrored this need (82%)**.

Training

There is no specific percentage requirement for continuing education units (CEUs) in the area of CA/N.

In 1993 the Oregon State Legislature created the Child Abuse Multidisciplinary Intervention account (CAMI) to support and develop community-based child abuse intervention centers (CAICs). CAICs have since been created in most counties within the state of Oregon. The aim of the centers is to minimize trauma to child victims of abuse by coordinating medical assessment, investigation, and intervention services in each community. In 1997 the legislature allocated funds to CAMI to establish regional centers and to expand child abuse assessment services.

In Oregon three Regional Child Abuse Training and Consultation Centers (RTCCs) were established and charged with providing professional consultation, education, training, technical assistance, and referral services to the administrators, child interviewers/investigators, and medical staff affiliated with CAICs and county multidisciplinary teams (MDTs). Though Oregon has statewide funding and legislative support to train medical professionals on CA/N through the RTCCs, the support does not reflect a statewide systematic effort as each RTCC may allocate more or less of their funding for training medical professionals.

In the Fall of 2009 the first board exam will be held for a subspecialty certificate in Child Abuse Pediatrics through the American Board of Pediatrics. Medical professionals who may have been uncomfortable in the area of CA/N may become more comfortable as child abuse in and of itself is now a more formally recognized medical field.

After speaking with local chapters of medical associations and other local sources it was found that medical professionals are generally trained in CA/N via the following methods:

- Conferences held a few times a year that may or may not offer training in CA/N.
- Organizations that medical professionals belong to do not actively promote training/continuing education in CA/N but are willing to post information/links about it on their websites.
- The RTCC in Portland (CARES NW) offers training to medical professionals in the area of CA/N and aims to tailor presentations to the audience requesting training.

Barriers to training and how to make it more effective:

- Training may be unwanted by medical professionals who see CA/N as a topic they do not want to have a specialty in/may be uncomfortable in interacting with children and families about the topic.
- Training may be more effective if presented in concert with, or solely by, a member of the community to whom the presentation is being made.

Markenson et. al (2007) surveyed emergency medical services personnel in the United States as to their knowledge and reporting of child abuse. Results showed that most respondents **receive less than or equal to one hour of continuing education in the area of CA/N. Seventy-eight percent of respondents asked for more educational opportunities in the area, and 3% stating that they required no additional training.**

Specific **areas of deficiency** in CA/N knowledge were reported by respondents to be: identification of child maltreatment, interviewing techniques, and appropriate education.

Lazenbatt and Freeman (2006) found that **77% of survey respondents stated that they required further training to increase their knowledge of mechanisms for reporting suspicion of child abuse.** Also, **99% of respondents stated that ongoing vocational training should include the identification and reporting of suspected child abuse cases.**

In a 2006 survey of licensed physicians in Kentucky it was found that **81% of physicians strongly agreed that they would welcome Child Abuse Recognition Education (CARE) trainings.**

Despite this documentation of a “want” for training in the area of CA/N there are still many barriers in training medical professionals and in getting them to report CA/N.

Local sources have suggested that medical professionals in Oregon typically fall into three categories when it comes to receiving continuing education about child abuse and neglect (CA/N). Those who have no interest in learning, those who may be required to take part in learning about CA/N, and those who are passionate about learning in the area of CA/N.

Potential issues:

- Those typically receiving training are in the third category of doctors and receive training because they seek it out and have a great interest in the area.
- Those who typically do not receive training (doctors in the first two categories) may have the most need.
- The barriers associated with providing training may be a systems issue: We may increase our training efforts to the medical community but still may not yield a more informed medical population in the area of CA/N as the trainings are not reaching the population of medical professionals with the most need.

Possible solutions:

- Target those medical professionals in the first two categories noted above.
- Find a way to interest all medical professionals in the topic (i.e., find a reputable medical professional in the area of the group receiving training to co-present the training).
- Relate training in CA/N with the ethics of being an informed medical professional.
- Provide rationale when training medical professionals to create greater meaning in the training for them.

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