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Child abuse and neglect in a pediatric emergency department: epidemiology and outcome

Short title: Child protection in the emergency department

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ABSTRACT

Introduction: Managing child abuse and neglect in pediatric emergency departments (PEDs) is difficult because of the complexity of screening and the prolonged care process. This study's main objective was to measure the child protection activity in a PED.

Methods: A retrospective, single-center study was conducted in the PED of the Lille University Hospital from 16 September2017 to 11 February 2019. All patients who required a social evaluation by the PED staff were included. Children admitted at first to the PED but for whom social management was exclusively performed by other units were not included. The whole population was analyzed first and then by type of abuse. The primary endpoint was the rate of patients who needed social management in the PED. The length of stay in the PED, the number of reports for investigation by child protective services, and reports to a judge were secondary assessment criteria.

Results: The study involved 245 patients (median age, 5 years; interquartile range [IQR], 2–13; boys, 49%), accounting for 0.6% of the PED visits. The main reasons for visiting the PED were somatic complaints (31%), sexual assault (23%), and behavioral disorders (20%). The median length of care in the PED was 5 h (IQR, 3–13). Thirty-three percent of the patients were monitored in the short-stay unit of the PED; 78% returned home. The main social measures taken were reports to child protective services (34%) and reports to a judge (24%); 51% of the patients required further actions by the PED physician after discharge.

Conclusion: Management of child abuse in the PED is important and time-consuming. A hospital team specialized in child protection is essential for the initial care and monitoring of child victims.

Keywords: Children, Child abuse, Child protection, Pediatric emergency medicine

Glossary:

Child protective services: services départementaux de protection de l'enfance

Interim placement order: ordonnance de placement provisoire

Report for simple follow-up by child protective services: note d'information au conseil départemental

Report for investigation by child protective services: information préoccupante

Report to a judge: signalement judiciaire

Social workers: assistant(e)s social(e)s

Social workers' network: association humanitaire, milieu associative à orientation sociale, assistant(e) social(e) d'écoles

Staff in charge of educational support: action educative en milieu ouvert (AEMO)

The social workers' network: réseau des travailleurs sociaux

1. INTRODUCTION

It is critical to improve the detection and management of child maltreatment. The World Health Organization (WHO) defines child maltreatment as abuse and neglect that occurs in children under 18 years of age [1]. Maltreatment includes all forms of physical and/or psychological abuse, sexual abuse, neglect or negligent treatment, commercial or other forms of exploitation, resulting in actual or potential damage to the child's health, survival, development, or dignity, and taking place within the context of a relationship of responsibility, trust, or power. WHO has made child detection and management of child maltreatment one of its priorities [2]. Previous studies have shown that child maltreatment has short- and medium-term consequences on children's health [2] and incurs high service costs [3]. Maltreated patients are twice as likely to visit emergency departments as the general population [4]. Hospitals, and particularly pediatric emergency departments (PEDs), are crucial sites for screening. A hospital child protection strategy requires multidisciplinary management of physical, social, and psychological care, educational and/or judicial family assessments, based on a trusted relationship. Previous studies have analyzed data on risk factors and long-term consequences of child maltreatment, but they rarely investigated the issues of the frequency, management, and follow-up of child abuse in PEDs.

According to French national data in 2017, 308,400 children under 18 years of age were followed by child protection services, probably an imprecise figure. It has consistently increased [5] despite significant underscreening [6,7]. Hospital departments, most particularly PEDs, were part of the detection network for children in need of protective measures. Two referents at the PED of the Lille University Hospital helped ensure that these children were properly detected and managed. The referents standardized their data collection on the child protection management in their unit. Assessing this activity and its resulting workload in a

PED may provide detailed epidemiological data and may plead in favor of the creation of a hospital team specialized in child protection in each PED.

The main objective of this study was to report and analyze the data of the child protection activity in the Lille University Hospital's PED. The secondary objective was to describe in detail the different categories of child abuse and neglect identified.

2. METHODS

2.1. Study design, inclusion criteria, and outcomes

A descriptive, retrospective, single-center study was carried out in the Lille University Hospital PED. Children admitted to the PED from 16 September 2017 to 11 February 2019 who required a medicosocial evaluation were included. The data collection was based on the file of the social pediatric referents. Children admitted to the PED whose medicosocial management was conducted exclusively in the hospitalization units were not included.

The primary endpoint was the rate of patients referred to the PED who required medicosocial management. The other evaluation criteria, overall and by category, were the length of stay in the PED (short-stay unit included), the number of reports for investigation by child protective services and reports to a judge, and the number of cases that required action by the PED practitioners after patient discharge.

2.2. Definitions

Medicosocial management was defined as the actions taken by the practitioners during or after the child's stay in the PED. It corresponded to reports for investigation by child protective services or reports to a judge, depending on the situations encountered. It also included reports for simple follow-up by child protective services, which includes the Mother-and-Child Protection Services and the Child Welfare Agency. Medicosocial management may also include reports to the judge in charge of juvenile affairs or reports to the staff in charge of

educational support, if measures were already in progress. The social worker's network comprised child protective services, childcare facilities, social emergency centers (phone number 115 for immediate emergency accommodation), and medical emergency assistance.

2.3. Data collection method and regulatory aspects

The children's data were collected and updated prospectively in a specific file by PED practitioners, referents in child protection. A standardized form was developed to retrospectively complete the data collected from this file. These new data were downloaded from the computerized patient record at the PED. All these data, secondarily anonymized, were entered in an Excel spreadsheet. This single-center collection of observational and retrospective data was the subject of a declaration to the National Data Protection Agency (CNIL) through the Lille University Hospital intranet site.

2.4. Statistical analyses

The whole population was first described. Then a description by category was made. The rate of visits, for which child abuse and neglect were identified as compared to the total number of visits, was calculated with its 95% confidence interval (CI). The dichotomous variables were presented as percentages with their 95% CIs. Continuous variables were presented as medians with their interquartile range (IQR). The statistical analyses were performed using LibreOffice V6.1.6.3 software.

3. RESULTS

Over the study period, 245 of the 42,014 patients admitted (median age, 5 years; IQR, 2–13; boys, 49%) were managed for child abuse and neglect at the PED of the Lille University Hospital, i.e., on average one every 2 days or 0.6% of the total number of consultations (95% CI, 0.5–0.7). In 143 cases (59%) the patient arrived during on-call periods and 168 situations (69%) required management during on-call periods. Patients were mainly referred to the PED

by the person(s) having parental authority (75%). The reasons for referral are detailed in Table 1. A total of 111 out of 208 children (53%; 37 missing data) were already registered by social services. Among the previous social measures found, 25 children (22%) were known by the social workers' network, 20 (18%) had been reported for investigation by protective services, and 66 (59%) had a judicial follow-up with 21 children (31%) in out-of-home care (foster family or institution).

The median length of stay in the PED was 5 h (IQR, 3–13; mean, 9 h). This duration was not influenced by the fact that some children were already known to social services (p=0.2). During this stay, a median of one additional examination per patient was ordered (IQR, 0–2): a urinary test in 76 cases (31%), blood analysis in 74 (30%), and imaging in 29 (12%). No further examination was requested for 121 children (49%). Further specialist medical advice was sought for 129 patients (53%) mainly from psychiatrists (41%) and social workers (32%). The details are shown in Table 1. A mean of two calls (± 2) per patient were made (median, 2; IQR, 1–3), with a maximum of 14 calls for one visit. The institutions contacted were child protective services for 138 (56%) children, judiciary institutions for 52 (21%), social workers for 34 (14%), and the National Education department for 27 (11%).

The diagnoses at the end of the evaluation, which justified the medicosocial management at the PED, are detailed in Table 2. Eighty-three situations (34%) required a report for children already known by the child protective services and the Juvenile Court Judge, 58 (24%) required a judicial report, and 30 (12%) required a report for investigation by child protective services. The referent from the social worker’s network was contacted to intervene in 29 (12%) cases, and a report to the Juvenile Court Judge or the staff in charge of educational support was made for 24 children (10%), when the child was already known by the judicial institutions without any degree of emergency.

Temporary hospitalization at the short-stay unit of the PED was required for 82 children (33%). Discharge from the PED was a return home for 189 patients (78%). Nineteen patients (8%) required conventional hospital admission. Actions were carried out after discharge from the PED for 124 patients (51%). The social procedures and the outcome of patients who required medicosocial management at the PED are described in Table 3, overall and per reason for visiting the PED.

4. DISCUSSION

This retrospective study over a 17-month period identified 245 children who required medicosocial management at the PED. The primary reason for visiting the PED was a somatic complaint (31%); an allegation of sexual assault was the second most common reason. The final main diagnosis was suspicion of sexual abuse in 24% of cases and suspicion of physical abuse in 20%. The time spent at the PED for the management of these patients was substantial, on average 9 h (± 11 h). This did not take into account the time spent afterwards to finalize the medicosocial management in more than half of the cases (*n*=124).

The volume of visits to the PED with the need for medicosocial management may be relatively small in comparison with the number of visits (0.6%). However, this is a situation that occurs every 2 days on average. This rate does not take into account patients who underwent primary resuscitation care and hospitalization and for whom social management was secondarily provided in the department where they were hospitalized (e.g., transfers to intensive care, neurosurgery, or conventional surgery for severe trauma, shaken babies, extensive burns, etc.). A literature review in 2008 estimated the prevalence of physical abuse at 1% of all visits by injured children to PEDs [8]. Retrospective studies found lower rates, with a possible underestimation: 0.07% of visits to emergency departments for suspicion of child abuse and neglect in a Spanish single-center study conducted between 2008 and 2017 [9]

and 0.1–0.3% in two American studies conducted in PEDs [10,11]. The Canadian sentinel network recorded approximately 0.15% of pediatric maltreatment over a 14-year period [12]. A prevalence of 0.88% was found in a Dutch single-center study using a screening tool for child abuse in the ED [13]. An Italian multicenter, 15-day randomized prospective study found a 2% prevalence of suspicion of maltreatment in PEDs [14]. However, comparisons between countries are difficult because this activity may vary according to the type of PED admissions, the screening methods used in- and outside PEDs, and available social networks.

This study showed relevant and very time-consuming social pediatric activity in the PED. This is to our knowledge the first analysis of the time spent managing suspicion of child abuse in a PED. A high average length of stay in the emergency room was shown. This reflects the need for an incompressible amount of time to build trust, for additional tests (median, 1; IQR, 0–2), several external calls per patient (median, 2; IQR, 1–3), and meetings with several stakeholders. Hospitalization in the short-stay unit of the PED was necessary for 33% vs. 20% for other patients, which may also explain these patients' length of stay in the PED. The time spent in the short-stay unit made it possible to evaluate the parent–child relationship, to build trust between the child and his parents, and to set up multidisciplinary actions and exchanges. Precarious children, rarely described, required prolonged medicosocial management. They accounted for 9% of the patients included, 55% were admitted to the short-stay unit, and 68% returned "home" (i.e., to the street) despite the social worker's intervention.

The main limitation of this study was its retrospective design, probably underestimating the amount of time spent by PED staff on this medicosocial pediatric activity. For example, the number of calls given did not account for the actual time spent for each child by the medical staff. The number of intermediate calls or failed calls before getting to the right person was not considered, only the final call. The time spent by the nursing staff with

unaccompanied, disturbed, or agitated children was not taken into account, because this time could not be estimated a posteriori. The study design may also have induced a classification bias. However, most of the data were entered prospectively by the pediatric referents in child protection in the PED, thus limiting this bias. As mentioned above, this data set was not exhaustive of all children seen in the PED for a medicosocial pediatric reason, leading to an assumed selection bias. The children needing immediate medical care with rapid subsequent hospitalization were deliberately not included because the social interventions were performed during their hospitalization by another referent physician in child protection. This study did not aim to be exhaustive on the number of social pediatric referrals to the PED, but instead to estimate the workload induced by situations of maltreatment on the activity of the PED. Some child abuse situations identified in the PED may not have been reported to the referring practitioners, despite the systematic monitoring system implemented, particularly for non-working hours. However, this seems unlikely. It is also possible that some child abuse situations may not have been identified in the PED [6].

Recognition of child abuse and neglect in the ED is difficult [10,15]. One-third of the children attending the PED during the study period came for a somatic complaint. These patients and those coming for a behavioral disorder had a wide range of diagnoses, sometimes hard to suspect at first glance: carelessness, sexual assault, physical abuse, and psychological abuse. In an Italian study, the main reasons for ED visits were fever, head injury, and inguinal pain [14]. The difficulty of diagnosis and management [6,16,17], the distress that these situations can create for the practitioner, the time required for appropriate management, the lack of knowledge, and the lack of a specialized team may explain the insufficient detection of these patients in the ED [18]. The introduction of detection tools in the ED [13,19,20] could strengthen the identification of abuse and neglect [21]. Despite recent studies [22,23], none of these detection tools has been validated to date [24,25]. In addition, the

implementation of a protocol adapted to the characteristics of the patients and the resources available to physicians could facilitate the management of patients according to the diagnosis. For example, patients suspected of having undergone sexual assault, a situation with a validated protocol, had a shorter length of stay compared to patients admitted for other situations of child maltreatment, although these situations remained relevant.

The clinician's apprehension is probably an underestimated variable [26]. It would be interesting to assess its importance and the factors causing this apprehension through a survey. Better detection of children needing protection is necessary. In Taiwan, a training program for nurses has improved their ability and reduced their apprehension to report child abuse [27]. Better detection from the ED of children at risk will increase this workload, which must be taken into account by the relevant decision-makers. The creation of a hospital team specialized in child protection in each PED could help determine additional training on childhood maltreatment for ED staffs and could improve screening in multi-stakeholder settings. In addition, better screening and management upstream of the EDs could limit the impact on the ED's workload [28].

5. Conclusion

Management of child abuse in the PED is important and time-consuming. The creation of specific units for children at risk is essential for the initial care and monitoring of victims. It could reduce the amount of time spent in the PED and decrease the workload of emergency physicians.

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Table 1. Anamnestic and social data according to the reason for consultation in the pediatric emergency department

Reasons for PED visit / Variables	Total (*n*=245)	Somatic complaint** (*n*=76)	Sexual abuse (*n*=58)	Behavioral disorder (*n*=48)	Physical abuse (*n*=41)	Precarious situation (*n*=22)
Mean age in months (SD)	85 (68)	58 (59)	101 (56)	125 (56)	78 (88)	66 (61)
Male gender, *n* (%)	121 (49)	45 (59)	16 (28)	25 (52)	21 (51)	14 (64)
Managed on-call, *n* (%)	168 (69)	47 (61)	38 (66)	36 (75)	35 (85)	12 (54)
Arrival modality						
With parents, *n* (%)	181 (74)	58 (77)	43 (74)	35 (73)	32 (78)	13 (59)
With emergency services, *n* (%)	25 (10)	4 (5)	10 (17)	2 (4)	5 (12)	4 (18)
Medical transfer, *n* (%)	16 (7)	9 (12)	4 (7)	1 (2)	0 (0)	2 (9)
Others*, *n* (%)	22 (9)	4 (5)	1 (2)	10 (21)	4 (10)	3 (14)
Known by social services, *n* (%)	112 (46)	25 (33)	22 (38)	31 (65)	21 (51)	13 (59)
Additional examinations						
Blood test, *n* (%)	74 (30)	25 (33)	23 (40)	11 (23)	8 (20)	7 (32)
Urinary analysis, *n* (%)	76 (31)	25 (32)	28 (48)	11 (23)	7 (17)	5 (23)
Imaging, *n* (%)	29 (12)	10 (13)	2 (3)	4 (8)	11 (27)	2 (9)
Specialized advice						
Forensic doctor, *n* (%)	38 (16)	1 (1)	29 (50)	2 (4)	5 (12)	1 (4)
Psychiatrist, *n* (%)	100 (41)	26 (34)	21 (36)	33 (69)	14 (34)	8 (36)
Social worker, *n* (%)	78 (32)	20 (26)	9 (16)	24 (50)	10 (24)	15 (68)
In-hospital social pediatrics, *n* (%)	22 (9)	3 (4)	8 (14)	1 (2)	9 (22)	1 (5)
Other specialist, *n* (%)	43 (18)	16 (21)	8 (13)	6 (13)	5 (12)	8 (36)

PED: pediatric emergency department

* Educator, social services, boarding school, friend

**Common medical complaint in 49% of cases (cough, fever, bronchiolitis, convulsion, chronic disease, pain), psychiatric disease (16%), trauma (14%), accidental drug ingestion (9%), burn (7%), other in 5% (cast repair, co-intoxication, caustic ingestion).

Table 2. Final suspected diagnoses retained according to reasons for admission to the pediatric emergency department (PED)

Reasons for PED visit / **Social diagnosis**	**Total (*n*=245)**	**Somatic complaint (*n*=76)**	**Sexual abuse (*n*=58)**	**Behavioral disorder (*n*=48)**	**Physical abuse (*n*=41)**	**Precarious situation (*n*=22)**
Social precariousness, *n* (%)	37 (15)	17 (22)	0 (0)	2 (4)	0 (0)	18 (82)
Lack of care, *n* (%)	38 (16)	28 (37)	2 (3)	6 (13)	0 (0)	2 (9)
Rape, *n* (%)	33 (13)	4 (5)	29 (50)	0 (0)	0 (0)	0 (0)
Sexual touching, *n* (%)	26 (11)	1 (1)	22 (38)	1 (2)	2 (5)	0 (0)
Physical abuse, *n* (%)	50 (20)	9 (11)	2 (4)	7 (15)	32 (79)	0 (0)
Psychological abuse, *n* (%)	20 (8)	5 (7)	1 (2)	12 (25)	1 (2)	1 (6)
Psychosocial, *n* (%)	26 (11)	6 (8)	0 (0)	18 (38)	2 (5)	0 (0)
Other medical concern, *n* (%)	15 (6)	6 (8)	2 (3)	2 (4)	4 (10)	1 (5)

Table 3. Management of patients who required a social evaluation in the pediatric emergency department during the study period.

Reasons for PED visit / Social management	Total (*n*=245)	Somatic complaint (*n*=76)	Sexual abuse (*n*=58)	Behavioral disorder (*n*=48)	Physical abuse (*n*=41)	Precarious situation (*n*=22)
Social measures						
Report for investigation by child protective services, *n* (%)	30 (12)	3 (4)	3 (5)	9 (19)	15 (37)	0 (0)
Report for simple follow-up by child protective services, *n* (%)*	83 (34)	39 (51)	21 (36)	13 (27)	6 (15)	4 (18)
Report to a judge, *n* (%)	58 (24)	9 (12)	23 (40)	8 (17)	11 (27)	7 (32)
Report to the staff in charge of educational support, *n* (%)	24 (10)	4 (5)	2 (3)	11 (23)	6 (15)	1 (5)
Social pediatric consultation, *n* (%)	10 (4)	1 (1)	8 (14)	0 (0)	1 (2)	0 (0)
Social worker management, *n* (%) [#]	29 (12)	15 (20)	1 (2)	5 (10)	0 (0)	8 (36)
Other[##], *n* (%)	11 (4)	5 (7)	0 (0)	2 (4)	2 (5)	2 (9)
Short-stay unit admission, *n* (%)	82 (33)	26 (34)	11 (19)	19 (40)	14 (34)	12 (55)
Outcome						
Return home, *n* (%)	192 (78)	64 (84)	48 (82)	35 (73)	29 (71)	15 (68)
Hospitalization, *n* (%)	19 (8)	8 (11)	4 (7)	2 (4)	2 (5)	3 (14)
Trusted third party, *n* (%)	9 (4)	1 (1)	0 (0)	3 (6)	5 (12)	0 (0)
Urgent social action[###], *n* (%)	23 (9)	3 (4)	5 (9)	6 (13)	5 (12)	4 (18)
Runaway, *n* (%)	2 (1)	0 (0)	1 (3)	1 (4)	0 (0)	0 (0)
Mean length of stay in PED, h (SD)	9 (11)	8 (8)	15 (20)	9 (10)	7 (7)	12 (13)
Action** after discharge from PED	124 (51)	39 (51)	32 (55)	21 (45)	26 (65)	6 (27)

SD: standard deviation; PED: pediatric emergency department; JCJ: Juvenile Court Judge; AEMO: Educational Assistance in an Open Environment;

[#] With social partners of the area's social structures, the childcare facilities, the social emergency centers (phone number: 115), and the medical emergency assistance

[##] Refer to private-practice psychiatrist, dermatological consultation, no action taken

[###] Corresponds to an interim placement order (by law)

*For children already known by the child protective services and the Juvenile Court Judge

** Need for action after patient discharge from the emergency department