A survey of the 16 Canadian child and youth protection programs: A threadbare patchwork quilt

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BACKGROUND: Child abuse and neglect (CAN) represents an international public health and societal problem, the extent and nature of which are inadequately understood. Child and youth protection programs (CYPPs), based in 16 Canadian paediatric academic health science centres, identify, manage, treat and prevent cases of CAN.
OBJECTIVES: To ascertain the structure, resources and functioning of Canadian CYPPs.
METHODS: Telephone interviews were conducted with the directors of the 16 CYPPs.
RESULTS: Full-time equivalent staffing ranged from 0.25 to 18.7 people. All programs were staffed with physicians. The majority of programs had social workers (14 of 16) and administrative staff (12 of 16), while fewer programs had a dedicated nurse (nine of 16) or psychologists (six of 16). All CYPPs provided medical examinations and psychosocial assessments, consultation and coordination of CAN cases within the hospital and with community professionals, expert medico-legal opinions and representation in court, and hospital in-service and community outreach education and advocacy. Nine centres participated in regular multi-agency reviews of cases. Fourteen centres had specialized teams for acute sexual assault. Academic activities include lectures to medical students (16 of 16), undergraduate clinical electives (11 of 16), mandatory clinical rotations for paediatric residents (10 of 16) and/or electives (15 of 16), a fellowship (one of 16) and research on CAN-related issues (11 of 16). CAN documentation was inconsistent and limited, underestimating the number of cases assessed within the CYPPs.
CONCLUSION: CYPPs appear to need further resources to care for maltreated children and their families. A national, standardized database to document CAN cases would aid in the allocation of resources to help develop policies and programs that effectively address the needs of CAN victims and their families, and to prevent CAN.

Key Words: *Abuse; Child; Documentation; Neglect; Programs*

Une enquête sur les 16 programmes canadiens de protection de l'enfance et de la jeunesse : Une courtepointe élimée

HISTORIQUE : La violence et la négligence envers les enfants (VNE) constituent un problème de santé publique et un problème de société sur la scène mondiale, dont on comprend mal l'étendue et la nature. Les programmes de protection de l'enfance et de la jeunesse (PPEJ), sis dans 16 centres universitaires de santé pédiatriques canadiens, visent à repérer, à prendre en charge, à traiter et à prévenir les cas de VNE.
OBJECTIFS : Déterminer la structure, les ressources et le fonctionnement des PPEJ canadiens.
MÉTHODOLOGIE : On a procédé à des entrevues téléphoniques avec les directeurs des 16 PPEJ.
RÉSULTATS : Le personnel équivalent temps plein oscillait entre 0,25 et 18,7 personnes. Des médecins participaient à tous les programmes. La majorité des programmes étaient dotés de travailleurs sociaux (14 sur 16) et de personnel administratif (12 sur 16), mais moins de programmes disposaient d'infirmières permanentes (neuf sur 16) ou de psychologues (six sur 16). Tous les PPEJ assuraient les examens médicaux et les évaluations psychosociales, les consultations et la coordination des cas de VNE au sein de l'hôpital et auprès de professionnels communautaires, les avis médicolégaux et les comparutions en cour, de même que les services en milieu hospitalier, les activités de formation communautaire et la défense d'intérêts. Neuf centres participaient à des analyses multi-agences régulières de cas. Quatorze centres étaient pourvus d'équipes spécialisées pour les agressions sexuelles aiguës. Parmi les activités universitaires, soulignons les cours à des étudiants en médecine (16 sur 16), les stages cliniques optionnels aux étudiants du premier cycle (11 sur 16), les rotations cliniques obligatoires (dix sur 16) ou facultatives (15 sur 16) pour les résidents en pédiatrie, la formation en surspécialisation (un sur 16) et la recherche sur les enjeux reliés à la VNE (11 sur 16). La documentation sur la VNE était contradictoire et limitée, sous-estimant le nombre de cas évalués au sein des PPEJ.
CONCLUSION : Les PPEJ semblent manquer de ressources pour soigner les enfants maltraités et leur famille. Une base de données nationale et normalisée pour documenter les cas de VNE faciliterait l'attribution des ressources visant à prévenir la VNE et à élaborer des politiques et des programmes qui répondront avec efficacité aux besoins des victimes de VNE et de leur famille.

A United Nations study (1) on violence against children has recently been carried out under the Secretary General's office to compile existing research on the forms, causes and impacts of violence that affect children and youth, and to make recommendations to improve worldwide efforts to eliminate violence against children. Canada's response to the United Nation's questionnaire on violence against children describes legislative, regulatory and administrative structures, but there are significant gaps in data regarding incidence, harms and outcomes of child abuse and neglect (CAN) (2).

There is no comprehensive source of information on CAN in Canada, and existing data probably underestimate the true extent of the issue. Institutional information on CAN injuries is sparse and incomplete.

The Canadian Incidence Study of Reported Child Abuse and Neglect in 2003 (3) estimated that outside of Quebec, 3.8% of Canadian children were the subjects of CAN investigations; maltreatment was substantiated in 47% of these cases. This is likely an underestimation of the actual incidence, because it represents only the cases that were reported to and

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investigated by child welfare authorities. It is of note that the determination of physical harm was made by child welfare workers rather than by health care workers, so some cases may well have been missed.

In contrast, physicians at 11 tertiary care paediatric hospitals in Canada confirmed physical harm in 364 infants in a review of shaken baby syndrome cases reported to child protection teams over a 10-year period between 1988 and 1998 (4). Again, this selected sample may not reflect the actual number of shaken children in the community, and is not comparable with the Canadian incidence study data due to differences in sampling and definition.

Data regarding childhood injuries are gathered in the emergency departments of 14 participating hospitals for the Canadian Hospitals Injury Reporting and Prevention Program (5). However, less than 2% of reported cases indicate suspected CAN, and it is acknowledged that the system does not adequately capture these injuries because the data collection forms have been primarily designed for 'accidental' or noninflicted injuries.

To inform research and to develop evidence-based policy and practice to reduce the incidence and impact of CAN, a clear idea of the nature and extent of CAN is needed. This has been addressed to some extent in the United States. The systems of care for maltreated children in 157 National Association of Children's Hospitals and Related Institutions (NACHRI) in the United States were assessed in 2001 (6). Seventy-two per cent of the responding institutions had a child protection team, and these teams were found to provide the most complete tracking, documentation and follow-up of children who were suspected of having been abused or neglected.

One underutilized window on CAN issues in Canada is the child and youth protection programs (CYPPs), based in 16 paediatric academic health science centres (PAHSCs). The CYPPs deal with the most serious, 'tip of the iceberg' cases of CAN, and are in a unique position to document the burden of health care for maltreated children. Thus, the present survey was undertaken to investigate the structure, resources and functioning of these 16 CYPPs, and to assess the number of referrals and quality of documentation of CAN cases seen within their programs.

METHODS

Between June and September 2004, the primary author (SB) conducted a 30 min to 45 min telephone survey with each of the CYPP heads at the 16 sites. The survey consisted of a combination of specific and open-ended questions regarding institutional demographics, child welfare involvement with cases and service functioning of their programs. Management and treatment of physical abuse, sexual abuse and mental health sequelae were discussed. Questions on the documentation of cases addressed use of special forms, photography, colposcopy, covert video surveillance and database existence and quality. Directors were asked about their programs' experience with CAN cases over the previous year. Information on academic activities, including training of medical students, paediatric residents and other trainees, as well as research in progress, was also elicited. A final question was asked regarding the adequacy of resources. Survey questions were modified from the survey conducted in the United States (6).

RESULTS

All 16 CYPP directors participated in the survey.

CYPP characteristics

The total full-time equivalent (FTE) dedicated staff varied widely among programs (0.25 to 18.7) (Table 1). All programs were staffed with physicians, and the majority also had social workers (14 of 16) and administrative staff (12 of 16), while fewer had a dedicated nurse (nine of 16) and psychologists (six of 16). A physician was most commonly the head of the program (15 of 16).

CYPP functioning

All programs identified, assessed and treated cases of CAN within the hospital, as well as provided expert consultation and assistance in child welfare investigations and the management of CAN. This entailed medical examinations and psychosocial assessments for hospital-based patients, as well as for children and youth referred by child welfare services.

A specialized on-call team for acute sexual assault cases was available at 14 centres. Nine of these consisted of sexual assault nurse examiner teams and five included on-call physicians. Nonacute sexual assault cases were seen in a specialist clinic at all centres.

Most programs provided mental health crisis intervention and brief supportive counselling, but only three programs had program staff dedicated to ongoing mental health treatment. Eleven programs referred all their CAN cases to community-based practitioners for mental health treatment, while three programs referred cases to their own hospital's mental health services.

All centres provided expert medico-legal opinions on CAN cases in written reports and during testimony in court.

All programs provide hospital in-service and community outreach education, and most participated on community committees to raise public awareness of CAN.

All centres were involved in academic activities (Table 2). Ten programs had a mandatory clinical rotation for paediatric residents, and 15 programs offered an elective. All programs provided lectures on CAN to medical students and 11 programs offered a clinical elective. Only one program provided a fellowship in CAN. Eleven centres were actively involved in research (the survey did not differentiate between published and unpublished research).

Institutional experience of CAN

Data were collected in a variety of ways, so program referral data were both difficult to obtain and were not comparable among institutions. Most program directors (11 of 16) did not know the number of CAN cases in their hospital because only the more difficult and complex cases were referred to them.

TABLE 1
Child and youth protection program staff

	FTE staff (number of individuals on staff)						
Paediatric centre (location)	**MD**	**SW**	**Admin**	**Nurses**	**Psy**	**Beh/CL**	**Total FTEs**
Janeway Children's Health and Rehabilitation Centre (St John's, Newfoundland)	1.0 (3)	2.5 (4)	0.0 (0)	0.2 (3)	0.5 (1)	0.0 (0)	4.20
IWK Health Centre (Halifax, Nova Scotia)	1.0 (2)	1.6 (2)	0.6 (1)	0.0 (0)	0.0 (0)	0.0 (0)	3.20
Centre Hospitalier Universitaire de Québec (Quebec City, Quebec)	1.6 (4)	0.2 (2)	0.2 (1)	0.1 (11)	0.0 (0)	0.0 (0)	2.10
Centre Hospitalier Universitaire de Sherbrooke (Sherbrooke, Quebec)	0.75 (3)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.75
Montreal Children's Hospital (Montreal, Quebec)	1.0 (5)	0.8 (4)	0.3 (1)	0.0 (0)	0.0 (0)	0.0 (0)	2.10
Centre Hospitalier Universitaire de Sainte-Justine (Montreal, Quebec)	3.8 (8)	2.6 (3)	3.2 (4)	8.5 (9)	0.6 (2)	0.0 (0)	18.70
Children's Hospital of Eastern Ontario (Ottawa, Ontario)	2.0 (3)	1.0 (1)	1.4 (2)	0.0 (0)	0.0 (0)	0.0 (0)	4.40
Kingston General Hospital (Kingston, Ontario)	0.2 (1)	0.2 (2)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.40
The Hospital for Sick Children (Toronto, Ontario)	1.6 (4)	2.6 (3)	1.0 (1)	1.0 (1)	1.0 (1)	0.0 (0)	6.60
McMaster Children's Hospital (Hamilton, Ontario)	1.1 (5)	1.0 (1)	1.6 (2)	0.5 (1)	0.0 (0)	1.0 (1)	5.20
Children's Hospital of Western Ontario (London, Ontario)	0.25 (1)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.25
Winnipeg Children's Hospital (Winnipeg, Manitoba)	1.8 (2)	3.5 (4)	3.0 (3)	1.2 (2)	1.0 (1)	0.9 (1)	11.40
Royal University Hospital (Saskatoon, Saskatchewan)	0.2 (1)	2.0 (2)	1.25 (3)	0.0 (0)	0.0 (0)	0.0 (0)	3.45
Alberta Children's Hospital (Calgary, Alberta)	0.4 (1)	6.2 (8)	3.2 (4)	2.6 (4)	4.0 (5)	0.0 (0)	16.40
Stollery Children's Hospital (Edmonton, Alberta)	1.0 (2)	1.5 (2)	0.9 (1)	1.5 (2)	0.0 (0)	0.0 (0)	4.90
Children's & Women's Health Centre of British Columbia (Vancouver, British Columbia)	1.3 (4)	2.9 (3)	2.0 (2)	1.0 (1)	0.3 (3)	0.0 (0)	7.50

Admin Administrative and support staff; Beh/CL Behavioural therapist or child life worker; FTEs Full-time equivalents; MD Medical doctor; Psy Psychologist; SW Social worker

TABLE 2
Academic activities

	Education						
	Medical students		Paediatric residents		Other specialities		
Paediatric centre (location)	**Lectures**	**Clinical elective**	**Mandatory**	**Elective**	**Elective**	**Fellowship**	**Research**
Janeway Children's Health and Rehabilitation Centre (St John's, Newfoundland)	+	–	–	+	–	–	+
IWK Health Centre (Halifax, Nova Scotia)	+	+	+	+	–	–	+
Centre Hospitalier Universitaire de Québec (Quebec City, Quebec)	+	–	+	+	–	–	+
Centre Hospitalier Universitaire de Sherbrooke (Sherbrooke, Quebec)	+	+	+	+	+	–	–
Montreal Children's Hospital (Montreal, Quebec)	+	+	+	+	–	–	+
Centre Hospitalier Universitaire de Sainte-Justine (Montreal, Quebec)	+	+	+	+	+	–	+
Children's Hospital of Eastern Ontario (Ottawa, Ontario)	+	+	+	+	+	–	+
Kingston General Hospital (Kingston, Ontario)	+	–	–	–	–	–	–
The Hospital for Sick Children (Toronto, Ontario)	+	+	+	+	+	+	+
McMaster Children's Hospital (Hamilton, Ontario)	+	+	+	+	+	–	+
Children's Hospital of Western Ontario (London, Ontario)	+	–	–	+	+	–	–
Winnipeg Children's Hospital (Winnipeg, Manitoba)	+	+	+	+	+	–	+
Royal University Hospital (Saskatoon, Saskatchewan)	+	–	–	+	–	–	–
Alberta Children's Hospital (Calgary, Alberta)	+	+	–	+	–	–	+
Stollery Children's Hospital (Edmonton, Alberta)	+	+	–	+	+	–	–
Children's & Women's Health Centre of British Columbia (Vancouver, British Columbia)	+	+	+	+	+	–	+

Some sites only recorded the number of case referrals, without differentiating between new or follow-up cases, or in- and outpatients. In one program, a family assessment was counted as one referral, while other programs tallied the number of all family members assessed. Some programs documented only those individuals who were physically examined or only those seen in the emergency department. Two programs had a database of only those cases discussed at meetings of their

multiagency child protection team. Most centres did not document the number of telephone consultations with parents or outside professionals.

Twelve of the programs maintained records of cases in electronic form, while two programs kept only a paper record. The final two kept neither a paper nor an electronic record of their CAN cases. Notably, the director of one such program recalled that his program had been involved with eight CAN-related deaths during the previous year. There was no standardization of data collection across sites.

Directors felt that their programs were under-resourced to fulfill their mandate to care for maltreated children in a PAHSC setting, and that documentation underestimated the quantity and quality of their workload. Lack of time, administrative personnel and database support were the main reasons cited for limited record keeping. Directors also identified deficits in mental health treatment, community education and advocacy, education of paediatric residents and medical students, ongoing training of program staff and administrative support for research.

DISCUSSION

Until recently, child abuse was a speciality not recognized by the medical establishment, and CAN programs at PAHSCs developed without an overarching system to guide their efforts. This is the first Canadian study to assess the system of care for maltreated children and youth in the hospital-based CYPPs within the 16 PAHSCs.

All of the 16 Canadian hospital-based CYPPs play similar and crucial roles in the care of maltreated children and youth. They provide expertise in the identification, intervention, treatment and prevention of CAN. However, the survey reveals a wide variation in program resources, ranging from one program staffed by a sole part-time physician (0.25 FTEs) to another program staffed by 26 multidisciplinary professionals (18.7 FTEs). This latter program (Sainte-Justine UHC) functioned under the division of social paediatrics such that only 14 professionals (8.0 FTEs) practiced within the hospital and the rest worked with a high-risk population in the community. This program has a long history of work in CAN and opened a clinic more than 30 years ago, even before the creation of the provincial child protection law. The director of the program with the largest in-hospital resources (Alberta Children's Hospital [Calgary, Alberta]) thought that their program was insufficiently resourced for their mandated scope of practice, which included not only acute care but also parental risk assessments, assessments of children in care and individual and family mental health treatment. Only one program director (Winnipeg Children's Hospital [Winnipeg, Manitoba]) thought that their program was adequately resourced, and interestingly this program was independently funded by the provincial Ministry of Family Services and Housing.

Program data collection varied widely and generally underestimated the number of children and youth assessed for maltreatment. Lack of resources was cited as the main reason for limited record keeping. CAN results in a significant economic burden on society, apart from the immeasurable pain and suffering of victims and their families. A report to the Law Commission of Canada estimated that the minimum total costs directly related to child abuse in Canada, for all victims of all ages, totalled at least $15.7 billion in 1998. The costs included six major areas – judicial, social services, education, health care, employment and personal costs. CAN-related health care costs were at least $222.5 million in 1998 (7). Similar costs are assumed annually by society. The true costs of CAN are certainly greater than these estimates, in part because CAN is under-reported.

Beyond financial costs, much is at stake for these children. Hospitalized children who are identified as having been abused or neglected have longer hospital stays, more severe injuries, worse medical outcomes and higher hospital charges, and such children are more likely to die during the related hospitalization than are other hospitalized children (8). Childhood maltreatment strongly predicts poor psychiatric and physical health in adulthood, and individuals with a history of childhood abuse are more likely than individuals with no such history to become high users of medical care and emergency services (9).

The correct diagnosis of CAN is crucial. A false-negative determination puts the child at risk of reinjury and possibly death, whereas a false-positive determination may lead to the inappropriate removal of a child from their home and subject a family to false accusations, with all the attendant social, emotional and legal implications. In a retrospective study (10) of abusive head trauma in children younger than three years of age, the diagnosis of CAN was missed by physicians in 31% of patients at the time of presentation. Of 364 cases of shaken baby syndrome seen in Canadian paediatric centres, 40% had no signs of external injury (5).

Physicians must maintain a high index of suspicion to make the correct diagnosis. A recent study (11) revealed that Canadian paediatric residents receive little exposure and limited training in CAN. Over 90% of residents thought that they needed further training in child protection, including 85% of graduating residents. There are no specific objectives from the Royal College of Physicians and Surgeons of Canada for training in child protection. In 2001, only three paediatric academic centres had mandatory clinical rotations in CAN. Our survey, conducted in 2004, revealed that paediatric residents in 10 of the 16 centres completed a mandatory clinical rotation in child protection. The American Board of Medical Specialities (ABMS) has recently approved child abuse paediatrics as a new subspeciality, and this reflects the growing body of knowledge and expertise in the field not routinely taught during medical school and residency.

Child maltreatment cases present challenges for all those directly providing services, taxing the skills and emotional resources of every professional involved. Cases are often complex and extremely time consuming. There are a number of risks and demands shouldered by professionals who choose to work in this field, including concerns for personal safety and litigation, the cumulative effects of vicarious exposure to trauma and the stress of testifying in court. Also, there is no

central coordination of CAN cases, which may result in frustration when dealing with child welfare, law enforcement and other agencies. Moreover, many of the services are not adequately reimbursed by traditional health care sources.

Excessive demands and stresses may translate into professionals' reluctance to become involved with CAN cases. A survey of current and former multidisciplinary members of the Canadian CYPPs revealed that more than one-third of current child and youth protection professionals are burnt out and that almost two-thirds have seriously contemplated alternative work situations. As well, 38% of former hospital-based professionals indicated that high levels of job stress and perceived burnout were important factors in their decision to leave the program (12). Both current and former members highlighted the need for increased staff to strengthen their programs and make workloads more manageable, thereby reducing stress.

The NACHRI has a recently published document titled "Defining the children's hospital role in child maltreatment" (13). This document provided a comprehensive set of guidelines, which have been endorsed by the American Academy of Pediatrics and the National Children's Alliance, for the development and sustainability of a child protection program within children's hospitals. The companion document "Children's hospitals child abuse services: 2005 survey findings" (14) detailed the staffing and financial resources currently dedicated to the prevention and treatment of child abuse at the NACHRI member hospitals. Both of these documents are important resources to assist hospitals and community partners in addressing CAN.

Reliance on self-report can be seen as a limitation of the present study, as we relied on the respondents' knowledge of the child protection program at their site. However, respondents were the directors of the programs, so we anticipated that their knowledge was accurate. Also, it was unlikely that the participants would feel a need to alter or censor their responses given the nature of the questions.

The present study reviewed CYPPs within academic tertiary care institutions. It is unknown whether these observations would also apply to community hospital-based child protection programs. In our opinion, it is likely that programs in the larger institutions fare relatively well, and that community-based hospitals have even fewer resources than those at larger institutions. Despite these limitations, the information from the current survey is valuable for increasing our understanding of CAN in Canada.

CONCLUSIONS

Our study shows that CYPP data collection varies widely, and generally underestimates the number of children and youth assessed for maltreatment at Canadian CYPPs. A national standardized data system is needed to document and track CAN cases. This database would enable the CYPPs to advocate for resources to sustain their programs, as well as to develop evidence-based programs and policies to effectively address the needs of child maltreatment victims and their families, and to work toward the prevention of child maltreatment.

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