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Child Abuse: Reporting and Classification in Health Care Settings



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Child Abuse: Reporting and Classification in Health Care Settings

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The views expressed in this report are those of the authors,
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Executive Summary

It has been almost three decades since the Canadian and U.S. governments began a sweeping program to combat child abuse, which included the introduction of mandatory reporting statutes. Efforts to respond to child abuse and neglect include professional training, public education, research, efficiency and capacity enhancement of the service delivery system, central child abuse registries and computer databases. In addition, all major professional groups with a role in protecting children have contributed their energy and talents to reduce the incidence and effects of child abuse. Health care professionals, particularly physicians, remain the primary target of child abuse reporting statutes, given the high likelihood of their encountering maltreated children in a medical setting, and the expectation that they are most qualified to diagnose and treat certain types of child abuse. Unfortunately, an increasing number of leaders of the hospital/medical community have stated that they do not feel that health care professionals are adequately trained to identify child abuse and neglect.

Given the problems that exist concerning the identification, classification and reporting of child abuse by physicians in health care settings, this report was initiated with the goal of providing an overview of the current knowledge and issues in these areas. The specific objectives of the report are as follows:

- to identify and discuss a range of issues related to the definition, scope and reporting of child abuse;
- to study Canadian legislation and case law regarding the duty to report child abuse; and
- to provide an overview of the identification, classification and reporting of child abuse in eight selected hospital sites.

In order to accomplish these objectives a three component study was conducted. The first component involved a review of the literature of issues related to child abuse in Canada and other countries. The second component involved a comprehensive review of the Canadian legislation and case law regarding the reporting of child abuse. The final component involved collecting information by telephone interviews with hospital personnel to develop “institutional profiles” of eight selected hospital-based programs that focus on the recognition, reporting and/or treatment of child abuse across Canada. The sites were pediatric hospitals in Vancouver, Calgary, Winnipeg, Toronto, Hamilton, Ottawa, Montreal and Halifax. Recommendations on the reporting and classification of child abuse by health care professionals derived from the report are outlined below.

Recommendations for Practice, Policy and Legislative Reform

The recommendations for the practice of health care professionals who deal with cases of child abuse or maltreatment fall into three areas: training, support in making clinical and diagnostic decisions, and the use of special programs. More specifically, they are listed as follows:

- Comprehensive training programs should be developed for the identification, classification, reporting and treatment of child maltreatment, and these programs should be part of the required curriculum of all Canadian medical schools.
- In-service training for physicians who treat children and/or families should also be developed and made available to all practising physicians.
- Protocols should be developed for the handling of all types of suspected child abuse in all settings (e.g., in a hospital, private community practice, etc.). These should also be made readily available to all practising physicians.
- Risk assessment tools to guide physicians in interviewing about psychosocial factors and other indicators of child abuse should be developed and made available.
- Consultation services regarding child abuse should be available to physicians either through direct contact (e.g., a specific member of a child abuse team) or, for physicians in more remote areas, through 1-800 numbers. Also, teams should be available to the community.
- Information packages about child abuse should be available to both physicians and their patients in all community clinics.

- Health care professionals who do report suspected child abuse to child protection services should receive feedback as to why these cases were substantiated or unsubstantiated.
- Provinces and territories should review child abuse reporting laws; review should involve consultation with medical professionals, especially about the adequacy of definitions. Issues to be addressed include limitation periods, the professionals who will be required under law to report, the clarity of definitions, and the possible inclusion of extra-familial abuse.
- Physicians should be appropriately compensated for the additional time needed to conduct an assessment for suspected child abuse.
- If the flow of cases and size of the community warrant, special hospital-based child protection programs should be developed. In addition to developing targeted services for abused children, these programs could facilitate many of the practice recommendations listed above.

Recommendations for Research

The following suggested topics for research originated from this report. They are relevant to child abuse identification and reporting, practical and feasible to carry out. Given the lack of Canadian research in the area of child abuse as revealed in this report, the need for monitoring and research cannot be overstated.

- A number of barriers to the reporting of child maltreatment have been identified in the literature; proposed strategies for removing them also exist. An important issue of policy significance is how best to apply these proposed solutions to increase reporting probabilities. Well-designed and coordinated demonstration projects with a strong evaluation component could generate valuable information. In this regard, a number of demonstration projects could be designed to assess the effectiveness of protocols, multidisciplinary teams, training programs, etc.
- In Canada, the impact of mandatory reporting laws on the child welfare system is unknown because of a total lack of research. A survey of mandated reporters' attitudes towards and experience with the child protection agencies should be conducted. A similar survey of child protection staff would be equally useful.
- Does the class or race of the child/parent affect the likelihood of abuse reporting?
- What are the substantiation rates? Do they vary by status of reporter (i.e., doctor versus public health nurse versus member of the public)?
- Data analysis strategies are crucial to the generation of new and practical knowledge. During this review project a number of useful analytic approaches became apparent:
 - A substantiated or unsubstantiated report represents the outcome of a decision. However, in reality there are many more case disposition categories than substantiated and unsubstantiated. To be useful, analysis should focus on the actual range of dispositions rather than on only one dichotomized outcome.
 - Reporting laws require mandated professionals to report suspicions of child maltreatment. Over the years, the number of reports has rapidly increased. One strange phenomenon has been detected in U.S. studies: mandated professionals and non-mandated reporters contribute approximately the same proportions of reports, and this roughly equal split has remained steady over the years. This is contrary to expectation, because some reporting laws designate only professionals as mandated reporters. Consequently, we would expect to see the proportions of reports from mandated professionals increase over time, and a corresponding decrease in the proportions of reports from non-mandated reporters. This consistent equal split does not support this expectation. In analysis of reporting behavior, mandated reporters should be compared with non-mandated reporters on all key variables.
 - Cases diagnosed as child maltreatment should be compared with those not so diagnosed in order to isolate decision factors. Such knowledge would be useful to the construction of diagnostic instruments. Follow-up research involving both groups of cases should also be conducted.
 - Cases substantiated and referred by the hospital to the child protection services should be monitored. Specifically, those ultimately rejected by the child protection services should be compared with those substantiated and accepted.

1.0 Introduction

1.1 Historical Context

Canadian and U.S. “child savers” of the late 1800s identified the plight of maltreated children. With the collapse of extended family networks due to massive rural-to-urban migration, child factory labour and the growth of urban poverty, child maltreatment and neglect became a social problem. Early members of the social work profession, with strong support from legislators, churches and philanthropists, undertook a number of efforts to protect destitute and maltreated children. Their efforts directly led to the founding of the Society for the Prevention of Cruelty to Children in 1874 in the United States, and the establishment in 1893 of the first Canadian child protection organization in Toronto, i.e., the present day Children’s Aid Society of Metropolitan Toronto. These early social work professionals were also the primary movers behind the introduction of child protection statutes in almost all Canadian provinces and U.S. states.

While social workers are credited for their pioneer work and ongoing contributions to child protection, the medical profession is recognized for its efforts in drawing worldwide attention to the problem of child abuse. In 1962, Dr. Henry Kempe and his associates coined the term “the battered child syndrome,” and published their findings in the prestigious *Journal of the American Medical Association*⁽¹⁾. This article shocked the world into action. In the United States, the whole nation was put on alert for child abuse, and political commitments to combat the problem followed. All 50 U.S. states and the District of Columbia passed mandatory reporting laws by 1967. This rapid development was unprecedented in the history of child welfare. The establishment by Congress of the National Center on Child Abuse and Neglect (NCCAN) in 1974 marked a further commitment to combat child abuse⁽²⁾. Many of these developments were a result of the persistent efforts of members of the medical profession.

Ontario was the first Canadian province to enact reporting legislation, in 1965. Shortly afterwards, similar reporting laws were enacted in most Canadian jurisdictions. In 1973, Ontario embarked on a major coordinated program to

combat child abuse. Given the central role of health care professionals in the identification, reporting and treatment of child abuse, they were important partners in all aspects of the Canadian efforts to combat abuse. In the area of child protection legislation, changes to require mandatory reporting continued into the 1980s in all provinces and territories. Currently, only the Yukon does not legislatively require reporting (see Appendix A for excerpts from Canadian reporting statutes).

1.2 A Current Problem

It has been almost three decades since the Canadian and U.S. governments began a sweeping program to combat child abuse, which has included the introduction of mandatory reporting statutes. Efforts to respond to child abuse and neglect include professional training, public education, research, efficiency and capacity enhancement of the service delivery system, central child abuse registries and computer databases. In addition, all major professional groups with a role in protecting children have contributed their energy and talents to reduce the incidence and effects of child abuse. Health care professionals, particularly physicians, remain the primary target of child abuse reporting statutes, given the high likelihood of their encountering maltreated children in a medical setting, and the expectation that they are most qualified to diagnose and treat certain types of child abuse.

Unfortunately, an increasing number of leaders of the hospital/medical community have stated that they do not feel that health care professionals are adequately trained to identify child abuse and neglect. For example, at a 1994 hearing called by the Temporary Commission of Investigation of the State of New York, charged with revamping the state’s child protection system, two pediatric consultants to multi-disciplinary child abuse teams said that physicians are “often ill-equipped to conduct the medical examinations necessary in sexual and physical abuse cases”⁽³⁾. They also told the Commission that “members of the medical profession are often reluctant to become involved in child sexual abuse cases . . . doctors

often do not know what to look for or what they are looking at when they examine a sexually abused child.” Dr. Jaeger said that “most doctors do not want to accept that some children are sexually abused, and therefore do not question their patients appropriately.” Dr. Cheryl Levitt, author of a recent report on child abuse for the College of Physicians and Surgeons of Canada, said that she “determined that doctors often fail to diagnose child abuse . . . due to poor training in the subject by medical schools.” She further said that “a lot of doctors feel they don’t know who to call and they are unsure of what impact their call will have”⁽⁴⁾.

1.3 Objectives of This Report

Given the evidence that there are problems in the identification, classification and reporting of child abuse by physicians in health care settings, this report was initiated with the goal of providing an overview of current knowledge and issues in these areas. The specific objectives of the report are as follows:

- to identify and discuss a range of issues related to the definition, scope and reporting of child abuse;
- to study Canadian legislation and case law regarding the duty to report child abuse; and
- to provide an overview of the identification, classification and reporting of child abuse in eight selected hospital sites.

In order to accomplish these objectives a three component study was conducted. The first component (Section 2.0) involved a review of the literature of issues related to child abuse in Canada and other countries. The second component (Section 3.0) involved a comprehensive review of the Canadian legislation and case law regarding the reporting of child abuse. The final component involved collecting information by telephone interview with hospital personnel to develop “institutional profiles” of eight selected hospital-based programs that focus

on the recognition, reporting, and/or treatment of child abuse across Canada.

The sites were pediatric hospitals in Vancouver, Calgary, Winnipeg, Toronto, Hamilton, Ottawa, Montreal and Halifax. These brief profiles are presented in Section 4.0 of this report. Section 5.0 sets out recommendations on the reporting and classification of child abuse by health care professionals.

1.4 Limitations

Because of the scope and time frame of this study as well as the state of research in the area of child abuse, this report has inherent limitations that are briefly outlined as follows.

1.4.1 Limited Canadian literature

A practical problem in conducting this project was that Canadian writings and useful research in the area of child abuse identification and reporting are extremely limited⁽⁵⁾. Over 90% of the books, articles and data related to child abuse are American, and most of the remaining ones relate to situations in the United Kingdom and Australia. This meant that it was necessary to rely heavily on U.S. literature, which may not always be directly applicable to Canada.

1.4.2 Medical setting profiles are not representative

A second major limitation is that the institutional profiles outlined in Section 4.0 of this report are not representative of hospital services in Canada. Hospitals in large metropolitan areas with well-developed child abuse programs were chosen intentionally. Since this is the first attempt to bring this type of information together in Canada, sites with the “most experience” were identified. It was anticipated that information from these sites would help define problems of identification, classification and reporting of child abuse, and the site descriptions may provide good models for future development in other locations.

2.0 The Definition, Scope and Reporting of Child Abuse: A Review of the Literature

2.1 Definitions

One thing that practitioners, researchers, legislators and policy analysts working in the field of child abuse agree on is the vagueness of the definitions of child abuse and neglect. The issue of definitions is exceedingly complex, and has so far defied a solution. This problem has been clearly and repeatedly documented in the literature.

2.2 Scope of Child Abuse and Types of Reports Submitted

National incidence statistics indicate that the number of reports of children suspected of or confirmed as having been abused is on a steep rise. For example, a major U.S. study estimated that in 1993 the number of children recognized by mandated reporters to have likely been abused or neglected in the United States was almost 42 per 1,000 children, an enormous increase over the 1986 figure of 22.6 per 1,000⁽⁶⁾. A recent incidence study of allegations of abuse and neglect reported to a sample of Ontario Children's Aid Societies (CASs) suggested that the provincial rate of reported child maltreatment was 21 per 1,000 children⁽⁷⁾.

In this section and the next, the nature of statistics on identification and reporting pertaining to the hospital/medical setting is examined. Specifically, current statistical information on reporting trends and types of cases reported is presented. Section 2.3 focuses on reporting probabilities and report substantiation rates. Some of the statistical information available is not reliable or is incomplete for a number of reasons, but it is nevertheless useful for understanding the general picture of the current status of child abuse identification and reporting in the hospital/medical setting.

2.2.1 Canadian data

National statistics on child maltreatment are not available in Canada. The most ambitious nationwide attempt to gather child abuse (sexual abuse) data was made by Robin Badgley in the early 1980s⁽⁸⁾. However, this report is remembered more for its impact on the legislation than for its data value. The report became an impetus behind the proclamation of Bill C-15 four years later, and amendments of both the *Criminal Code of Canada* and the *Canada Evidence Act*. The Canadian Centre for Justice Statistics also compiles national crime statistics on assaults against children reported to the police. At this moment, however, these potentially valuable statistics have limited usefulness because most of the data come from some urban police forces in Ontario and Quebec only⁽⁹⁾. The lack of national statistics on child maltreatment was identified as a major problem in a recent federal government report entitled *Child Welfare in Canada: The Role of Provincial and Territorial Authorities in Cases of Child Abuse*⁽¹⁰⁾. The report confirms that provinces and territories keep statistical data developed to meet the administrative and case management needs of each jurisdiction and as such they are not comparable. This problem has greatly hampered efforts to develop a national agenda to address the issue of child maltreatment in Canada.

Even at the local or regional level, Canadian child abuse statistics, especially those focusing on the hospital/medical profession, are rare. To date, the Ontario Incidence Study (OIS), carried out in 1993, is the most complete and reliable source of Canadian data on child abuse reporting, even though it focused only on Ontario⁽⁷⁾. The study data were supplied by intake and protection workers in 14 of the 15 CASs sampled from a total of 50 non-Native agencies (none of the three Native CASs was included). Detailed information was recorded by the workers on each of the 2,447 target cases.

The OIS is important not just because it was the first incidence study successfully undertaken in Canada¹, but also because of its definitional framework⁽⁷⁾. The definitions embodied elements from both the literature and the 1984 *Child and Family Services Act of Ontario*. In addition, the definitional framework adhered as closely as possible to the classification schemes under the “Harm Standard” and the “Endangerment Standard”² used in the National Incidence Study (NIS) of Child Abuse and Neglect conducted by Westat, Inc. for the US Government since 1979. There are at least four advantages of this combined definitional approach. First, it circumvents the ambiguities related to abuse identification at the child protection level without ignoring the legislative realities or requirements that guide child protection work. Second, because the definitional framework transcends idiosyncratic definitions used in agencies, it is totally portable, in both time and place. This has a

very significant research advantage because it facilitates comparisons of trends or changes over time, both between and within places. Third, the framework allows specific indices to be constructed for the measurement of the different types of maltreatment, e.g., physical abuse, emotional maltreatment, because the elements or indicators that make up each type are known. Fourth, by adhering to the classification convention used in the NIS, international comparisons are less difficult⁽¹³⁾.

The main OIS findings pertaining to the health care profession have been re-tabulated, and are presented together in Table 2.1.

A number of points are worth noting about the OIS findings:

- Health care professionals together reported a total of 15% of all cases in the study. Hospitals and mental health professionals were the largest contributors in the health

Table 2.1
Referrals from Health Care Professionals, 1993, by Maltreatment Type*
 (% of all study cases and substantiation rate for each professional group also presented): Ontario Incidence Study

	Physical Abuse	Sexual Abuse	Neglect	Other	Report Source %	% of Study Total	Substantiation Rate for Report Source
Hospital	852 (37%)	495 (26%)	607 (36%)	155 (29%)	2109 (33%)	5%	35%
Public Health Nurse	0 (0%)	48 (2%)	186 (11%)	0 (0%)	234 (4%)	1%	71%
Family Physician	614 (27%)	784 (42%)	213 (12%)	136 (25%)	1747 (27%)	4%	20%
Mental Health Professional	836 (36%)	554 (29%)	672 (40%)	245 (46%)	2307 (36%)	5%	23%
Total	2302 (100%)	1881 (100%)	1678 (100%)	536 (100%)	6397 (100%)	15%	Avg. = 28%
Maltreatment Type %	36%	29%	26%	8%	100%		
* All figures came from Table 7.1 of the OIS report ⁽⁷⁾ . Reprinted with permission of the authors.							

¹ Another successfully completed large-scale study of child abuse was the 1991 Ontario Health Supplement survey of Ontario residents aged 15 years and older. This Supplement survey, using a self-administered questionnaire, focused exclusively on the prevalence of childhood physical and sexual abuse. The survey found that 10.7% of male respondents and 9.2% of female respondents reported a history of severe physical abuse while growing up⁽¹¹⁾. Severe sexual abuse during childhood was more commonly reported by females (11.1%) than males (3.9%). However, the study data were not related to the hospital/medical setting.

² The Harm definitional standard was used in NIS-1, NIS-2, and NIS-3. The less stringent Endangerment standard was added in NIS-2 and NIS-3. The meanings of these two standards are rather complicated. In summary terms, the Harm Standard includes all children who experienced demonstrable harm as a result of maltreatment, and the Endangerment Standard includes both children who experienced demonstrable harm and those threatened with harm. Therefore, the Harm Standard involves a much stricter set of criteria for abuse identification than is the case for the Endangerment Standard⁽¹²⁾.

care group, with 5% of all cases each, followed closely by family physicians (4%). Public health nurses reported 1% of all the study cases.

- Physical abuse was the predominant form of maltreatment (36%) reported by the health care group. Sexual abuse (29%) and neglect (26%) were also reported in large numbers.
- Of all the physical abuse cases reported by the health care professionals, hospitals and mental health professionals topped the list with 37% and 36% respectively. Family physicians accounted for the remaining 27%. Public health nurses did not report any physical abuse cases.
- With regard to sexual abuse reporting, family physicians reported the most, i.e., 42% of all cases in the health care group. Reports from hospitals and mental health professionals accounted for 26% and 29% respectively.
- Hospitals and mental health professionals together filed three-quarters of all neglect reports in the health care group. Public health nurses, despite their small volume of reports overall, were responsible for 11% of all neglect reports. This was very close to the 12% for family physicians.
- The substantiation rate for reports filed by public health nurses was 71%, the highest in the entire study. Most of the cases reported by public health nurses concerned the usually difficult-to-validate neglect category (i.e., almost four-fifths of reports filed by public health nurses were due to suspicions of child neglect).
- Reports submitted by family physicians had a low substantiation rate (20%). Almost half of the referrals (45%) from physicians were made because of suspected sexual abuse⁽⁷⁾.
- The substantiation rate for hospital-based reports was 35%, and 23% for reports submitted by mental health professionals. The overall substantiation rate for all health care professionals was 28%, just about the same as the study average of 27%.

In summary, to date no reliable national studies have been conducted on the incidence of child abuse in Canada. It should be noted, however, that Health Canada recently launched the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS). The objectives of this study, which is being conducted by a team of researchers across Canada, led by Nico Trocmé at the University of Toronto, are as follows:

- to provide national estimates on the incidence of child abuse and neglect;
- to develop baseline information on and monitor trends in the reporting of abuse and neglect;
- to improve our understanding of the forms and severity of abuse;
- to assist in the targeting of resources for children at risk of abuse; and
- to collect information to help develop programs and policies for at-risk children and youth.

The study will focus on cases of child abuse and neglect that have been identified by or reported to child welfare agencies. Estimates of the number of cases of abuse and neglect gathered in this study will not include unreported cases. Results from the study will be available in 2000.

2.2.2 U.S. data

In the United States there are two major sources of national statistics: NCPA (National Committee for the Prevention of Child Abuse) and NCCAN (National Center on Child Abuse and Neglect). NCPA, a privately funded organization, conducts the annual 50-state statistical survey of Child Protection Services (CPS) caseloads, services and administrations^(14,15). NCCAN is responsible for the Congress-mandated series of National Incidence Studies^(6,12,16-19). A primary function of the NIS is to estimate reporting probabilities. This is the reason for having the “sentinel” data component, a very costly and difficult to administer data collection mechanism with over 5,600 mandated professionals or “sentinels” carefully selected to statistically represent all professional groups and all regions of the United States (in NIS-3⁽⁶⁾ there were 5,612 sentinels in 842 agencies serving 42 counties). During the study period, these sentinels report to NIS all suspected maltreated children seen by them, not just those they reported. The type of abuse, and type and seriousness of the harm or injury are captured using NIS-supplied data forms and definitions. Because NIS researchers can link identifying information on these sentinels in the sample to pending cases in the local CPS, they are able to determine who reported what, and how many were reported. Combining this information with the data on all cases seen by these sentinels, NIS researchers can estimate

how many cases met the study definitions but were not reported. Unfortunately, neither the NCPCA nor the OIS has this extra data component.

In terms of focus and methodology, the OIS is somewhat comparable to the NIS, with one important exception, i.e., the NIS has a sentinel data component whereas the OIS does not. Because of this, the NIS can estimate the reporting probability for each class of mandated reporters.

In addition to these two neutral sources, smaller scale population surveys, analyses of hospital records, and secondary analyses of NIS data also exist. The findings from these various sources are presented in this section.

The AAPC (U.S. Association for Protecting Children) and NCPCA data show a steady increase in the estimated number of children alleged to have been abused and reported to the CPS in the last 17 years, from 1.154 million in 1980 to 3.126 million in 1996. This represents an increase of 171% in 17 years. However, the NCPCA data also suggest that the 1996 increase of 0.48% over 1995 (3.111 million) was negligible, and that the number of reported cases appears to have levelled off since 1994^(14,15,18).

The NIS data indicate a strong upward trend as well, but the pattern is different. Using the Harm Standard data (as used in the OIS study), Table 2.2 shows an increase of 149% in the estimated number of reports of abused children between 1980 and 1993, and 67% between 1986 and 1993.

(However, the AAPC and NCPCA percentage increases are quite different for the same period; using the AAPC and NCPCA statistics found in the sources, our re-calculations yielded approximately 171% for 1980-1993 and 50% for 1986-1993.) Under the Endangerment Standard (which has less stringent abuse determination criteria), the estimated number of abused children nearly doubled (98%) from 1986 to 1993. This is a good example of how changing definitions can drastically alter our understanding and perception of the nature and scope of the problem of child abuse or maltreatment. In a macro-level analysis of the relation between the broadness of child abuse definitions used in a state's reporting law and the number of reports submitted, those states with broad definitions had much higher child abuse reporting rates than those with restrictive ones⁽²⁰⁾. This research helps to further explain why under the Endangerment Standard far more cases of suspected child abuse were identified and reported than was the case under the Harm Standard³.

The recently released NIS-3 reports indicate that professionals in hospitals and mental health agencies recognized abuse and neglect much more fully in 1993 (NIS-3) than was the case in 1986 (NIS-2). Since 1986, hospitals more than tripled the rate at which they identified maltreated children (under the Harm Standard), and mental health agencies nearly quadrupled their recognition rate. The authors of the reports attributed this increase to a much higher level of

Table 2.2
Total Number of Reports that Met the Harm Standard or the Endangerment Standard (NIS-1, NIS-2 and NIS-3)

	NIS-1 (1980)	NIS-2 (1986)	NIS-3 (1993)
Harm Standard	625,100	931,000 (49% over NIS-1)	1,553,800 (149% over NIS-1) (67% over NIS-2)
Endangerment Standard	Not applicable	1,424,400	2,815,600 (98% over NIS-2)

³ Other than child abuse definitions, certain definitions commonly used in the field also obfuscate because they can mean different things to different people. The NCPCA researchers identified three such problematic definitions: those related to a) a child abuse report (before or after intake screening), b) a case (child, family, incident, or other unit of analysis), and c) a reportable act (dependent on where the abuse took place and the relationship between the alleged perpetrator and the child)⁽¹⁴⁾. In addition, national statistics are greatly affected by the adequacy of local record systems, multiple counting of the same case, differential return rates, missing data and other system-induced problems. Interpretation and use of child abuse statistics, especially national statistical findings, are rarely straightforward and require a combination of highly developed technical skills, content knowledge and experience.

recognition efficiency now achieved by these professionals as a result of better training on and closer following of the NIS procedures and definitions. However, during the same period, the proportion of reports actually investigated by CPSs decreased significantly, from 44% to 28% for Harm Standard reports, and from 51% to 33% for Endangerment Standard reports. Because the actual number of cases investigated by the CPS remained stable while the number of reports increased, the authors reasoned that the decline in the investigation rate was an indicator of system saturation⁽⁶⁾. This means that the CPS might have reached its capacity to respond with its available resources, a crisis situation predicted in 1979 as inevitable by a former Executive Director of NCPA. He stated: “As the identification process becomes more efficient and more thorough, the system will overload and short. Treatment services which are already functioning to capacity will sink, slowly at first and then rapidly”⁽⁵⁾. A particularly noteworthy finding is that “the decline (in CPS investigation rates) was significant only among children recognized in law enforcement agencies and hospitals”⁽⁶⁾. Why the dip in CPS investigation rates applied in particular to hospital and law enforcement reports is puzzling.

2.2.3 Reports from hospital/health care professionals

The following research findings represent some of the current knowledge about child abuse reporting based on studies of hospitals and health care professionals in this area.

- One of the first and most often cited studies of reporting by hospital/medical professionals revealed that, in Virginia, child abuse reports from physicians constituted 8% of the total number received by the CPS between 1979 and 1983⁽²¹⁾. In a related study of physicians’ reporting behaviour, almost all the 252 physician respondents said they would be inclined to report all cases of physical abuse (91%) or sexual abuse (92%). However, their ratings became far less unanimous when they were asked to respond on reporting inclinations related to maltreatment types with less physical evidence. Only 58% indicated that they would report all physical neglect cases, 45% would feel inclined to report all emotional abuse cases, and 43% would report all suspicions of medical neglect⁽²²⁾.

- The 1991 NCPA survey of CPS caseloads reported that just over half (51.5%) of all child abuse allegations received by CPSs came from mandated professionals, i.e., those required under legislation to report. (This figure, of course, varies from place to place; for example, in the State of New York, mandated professionals in 1994 submitted 60.1% of all reports⁽³⁾.) The remaining 48.5% were submitted by non-mandated reporters. Medical professionals contributed 10.5% of all reports⁽¹⁸⁾. The 1993 OIS also reported that there was an almost equal split between mandated and non-mandated reporters, and that almost the same percentage (10%) of all reports originated from hospital/medical sources — 5% from hospitals, 4% from physicians and 1% from public health nurses (see Table 2.1).
- In a large-scale review of the medical records of 642 traumatized children treated in the emergency department or admitted to a Kansas hospital over a six-month period in 1992, only 23 cases (4%) were reported to child protection services at the time of examination. However, the researchers also reported that inadequate medical documentation did not allow them to differentiate accidental trauma from abuse in another 41 (6%) cases. Because of poor documentation, the reviewers could not estimate the true number of children suspected of having been abused who therefore should have been reported under the mandatory reporting law. Inadequate documentation aside, the attending physicians may have been reluctant to report for a variety of reasons⁽²³⁾.
- In what is now considered a classic study, Hampton and Newberger⁽²⁴⁾ suggested that hospital personnel identified, according to the Harm Standard, 11.9% (77,379 out of 625,000) of the estimated total number of maltreated children in the 1979-80 nationwide incidence study. The NIS-1 hospital data set used by the researchers involved 805 Harm Standard cases; of these, 66.6% were reported. The authors concluded that this reporting rate was too low. They also showed that reported cases, compared with non-reported cases, had a much higher proportion of the following types of maltreatment: physical abuse (75.6%), sexual abuse (80.8%), physical neglect (65.8%), and miscellaneous maltreatment (85.4%). On the other hand, non-reported cases had a much higher

proportion of the following types of maltreatment: emotional abuse (63.9%), educational neglect (94.5%), and emotional neglect (57.4%). In addition, the researchers undertook a discriminant function analysis, and came up with a number of significant findings. First, black children from poor families had the highest probability of being reported by the hospital to the CPS. Second, victims of emotional abuse from families of higher income were least likely reported. Third, severity of injury became a decision criterion only after the effect of income was held constant. These findings are widely cited as evidence of reporters' bias.

- A key finding of all three NIS has been that there are no overall race differences in the incidence of child maltreatment, a general finding with perhaps certain exceptions, as already described⁽²⁴⁾. A recent analysis demonstrated that the NIS sample design, which does not include non-mandated reporters, could cause problems in interpreting the NIS data. For example, using the black subsample in the NIS-1, the researchers found that, after adjusting for the NIS sample design bias, "medical agencies no longer significantly over-report Black victims to the CPS. In addition, Black victims living in lower-class families are no more likely to be reported"⁽²⁵⁾. This analysis is very significant for three reasons. First, it identifies a major potential weakness in the NIS methodology, one that would prevent direct interpretations of even basic data. Second, it questions a long-accepted finding⁽²⁴⁾ that being black and poor would result in a much higher probability of being reported by medical agencies to the CPS. Third, this research serves as an excellent example of the value of a secondary analysis of data.
- In another major secondary analysis of NIS data — this time, both NIS-1 and NIS-2 — researchers concluded that "in 1980, CPS was less likely to be aware of cases of emotional or physical *neglect* than cases of physical or emotional *abuse* known to hospital personnel. In 1986, CPS was more likely to be aware of hospital cases involving black children than white, controlling for type of abuse"⁽²⁶⁾. Although the general findings seem to be valid, a closer look at

their analysis identifies two problems. First, the 1980 probability of reporting by hospital personnel of physical/emotional abuse cases to the CPS was much higher than that of physical/emotional neglect cases; this became almost the opposite in 1986. The authors did not explain this reversal. The second problem is that the analysis results for "black versus non-black" are missing for 1986.

- Finally, a useful but not well-known study was carried out by Giovannoni in the mid-1980s in nine CPSs located in one urban and two rural U.S. counties⁽²⁷⁾. This research analyzed 1,140 reports completed by CPS workers on maltreatment allegations made by both mandated and non-mandated reporters over a 5-10 month period. Emphasis was placed on precision in terminology, consistency in data collection and use of appropriate statistical methods. The researcher found that "there were no significant differences among them (mandated reporters) or between them and non-mandated reporters in their reports of physical injury". Giovannoni also discovered that the largest category of maltreatment reported by medical sources (n = 93) was "failure to provide," which constituted 34% of all their complaints, followed by sexual abuse (22%), emotional abuse (20%), physical injury (18%) and physical abuse (16%). (Note: multiple maltreatment forms were recorded for some children.) These findings are somewhat different from those of other research, but serve to illustrate that child abuse research findings can vary with place, time and/or methodology. More important, this research demonstrates the desirability of looking at the total picture by including, in this case, both mandated and non-mandated reporters.

2.3 Reporting Probabilities and Report Substantiation Rates⁴

Knowing the number and types of cases reported to the CPS and by whom is useful because this information reveals which

⁴ For the purpose of this project and to be consistent with the language used in the child abuse reporting literature, the term reporting probability is synonymous with the term reporting rate, and is defined as the number of abused children recognized and reported divided by the total number recognized. The term under-reporting rate is synonymous with the term non-reporting rate, and is simply 1 - the reporting probability. However, the definition of substantiation is more controversial because it is most often left to the discretion of the investigating CPS worker. Generally, if it is the clinical opinion of the worker that there is sufficient evidence that abuse occurred, then the case is substantiated.

categories of professionals are most involved in child abuse reporting. However, it does not supply the proportion of abused children identified but not reported, or the proportion of abuse reports actually substantiated by the CPS.

2.3.1 Reporting probabilities

If the reporting probabilities of professionals are known, the extent of underreporting among them can be estimated. This is key information on the effectiveness of mandatory reporting laws. In addition, barriers to reporting can be identified and strategies to remove these barriers formulated. The reporting probability can be used as an overall proxy measure of how well the mandatory reporting system works and, to a lesser extent, how well children are protected.

Currently, the most widely used figure to represent overall reporting probability among mandated professionals is 56% (or an underreporting rate of 44%). The actual rates, of course, vary across professional groups, geographic regions and types of settings. Hence, it is very important to have separate reporting probabilities for these different categories. This figure of 56%, computed from the Harm Standard data, has its origin in NIS-2⁽²⁸⁾. It has since become a widely used figure and may have even been accepted as the standard. There are no new estimates from the latest NIS-3 data. Table 2.3 summarizes the various figures found in the literature⁵ regarding both reporting probabilities and report substantiation rates.

The overall reporting probability of 66% (or an under-reporting rate of 34%) for hospital personnel most frequently referred to in the literature was originally computed from the 1980 NIS-1 data by Hampton and Newberger and reported in their classic comparison between reported and unreported abuse cases known to the hospital⁽²⁴⁾. A few years later, a new rate for the same population, computed from the 1986

NIS-2 data⁽³⁰⁾, was almost identical to the original Hampton-Newberger rate. In addition, Ards and Harrell made reference in their article to a reporting probability of 56% for the hospital⁽²⁶⁾. They cited NIS-1 as the source, but did not explain how they estimated the rate. However, as far as it can be determined, the overall reporting probability of 66% for hospital personnel seems to have remained stable. Again, reporting probabilities for the hospital/medical profession vary with place, setting and time. Skillfully conducted secondary analysis of the NIS data indicate the extent of subgroup differences with respect to these rates. (Note: All the NIS data sets are available for secondary analysis from Westat^(17,34).)

2.3.2 Report substantiation rates⁶

The CPS does not substantiate or validate all the reports of child abuse they receive. A low substantiation rate could mean that, for a variety of reasons, the CPS is passing over a large number of complaints, and only a small portion of the total number of abuse reports is accepted for child protection service. This might be the result of mandated professionals filing a very large volume of reports that do not meet CPS intake criteria. A low substantiation rate could also be a result of CPS rejection of a large number of invalid reports submitted by the average citizen, who is not trained in child abuse detection and identification. Therefore, substantiation rates may be used as a proxy measure of the degree of fit between the two sides: the reporter and the CPS. They may even suggest something about the reporting behaviour of professionals, the appropriateness of the reporting guidelines or criteria, resource or operational problems within the CPS system, the problems of child abuse definitions, or all of these. However, the real value of substantiation rates is realized when they are tied to report

⁵ A 1987 nationwide U.S. study⁽²⁹⁾ to determine why mandated reporters (including members of the medical profession) were not reporting suspicions of child maltreatment to the CPS indicated that although 44% of the 1,196 respondents consistently reported suspected abuse 39% had at one time or another decided not to report (33% had reported later, and 6% had never reported).

⁶ The OIS substantiation rates will not be presented again in this section. It should be noted that a plausible reason why the OIS rates were considerably lower than U.S. rates is that the OIS included 'Suspected' as a third disposition category; the other two categories were 'Substantiated' and 'Unsubstantiated'. Because of this, many 'Suspected' cases would have been classified as 'Substantiated' had this third disposition category not been available to caseworkers, thereby raising the substantiation rate. In contrast, the U.S. disposition categories used in most studies consist of just two 'Substantiated' and 'Unsubstantiated' a practice that has been criticized as 'far too simplistic' ⁽³⁵⁾. In addition, probably for the same reason, the overall OIS rate of 27% in 1993 was much lower than Quebec's 44.7%⁽³⁶⁾. (Note: according to a different source, Quebec's substantiation rate for fiscal year 1991-92 was 49.53%⁽⁵⁾.)

Table 2.3
Reporting Probabilities and Substantiation Rates (Major Findings)

Source	Reporting Probability*	Type of Professional Studied			Scope	Substantiation Rate†
		Entire Sample	Hospital	Physician		
Giovanoni 1995 ⁽²⁷⁾			X	X	1985 3 counties CPS	42%=physical injury 52%=physical abuse 60%=sexual abuse 69%=emotional abuse 50%=lack of supervision 30%=failure to provide 46%=drug/alcohol abuse
Ards and Harrell 1993 (NIS-1) ⁽²⁶⁾	56% Harm Standard cases		X		1980 nationwide CPS and professionals	
Hampton and Newberger 1985 (NIS-1) ⁽²⁴⁾	66.6% Harm Standard cases		X		1980 nationwide CPS and professionals	
NCCAN 1988 (NIS-2) ⁽³⁰⁾	66% Harm Standard cases		X		1986 nationwide CPS and professionals	53% Harm Standard cases
Saulsbury and Hayden 1986 ⁽²¹⁾				X	1979-83 Virginia	53%
Finkelhor 1990 (NIS-1) ⁽³¹⁾		X			1980 nationwide CPS and professionals	43% Harm Standard cases
McCurdy and Daro 1994 (AAPC, '86) ⁽¹⁴⁾		X			1986 nationwide CPS	40-42%
Sedlak 1990 (NIS-2) ⁽²⁸⁾	56% Harm Standard cases	X			1986 nationwide CPS and professionals	
Besharov 1990 (APWA, '86-'88) ⁽³²⁾		X			1986-88 nationwide CPS	41%
NCCAN 1993 (NCPCA, '91) ⁽¹⁸⁾		X			1991 nationwide CPS	41%
McCurdy and Daro 1994 (NCPCA, '92) ⁽¹⁴⁾		X			1992 nationwide CPS	40%
US Department of Health and Human Services (1995) (NCPCA, '93) ⁽³³⁾		X			1993 nationwide CPS	38%
Wang and Daro 1996 (NCPCA, '95) ⁽¹⁵⁾		X			1995 nationwide CPS	32%
Wang and Daro 1996 (NCPCA, '96) ⁽¹⁵⁾		X			1996 nationwide CPS	31%

*Percentage of recognized abuse cases actually reported.

†Percentage of reports substantiated or validated by the CPS.

volumes. For example, if the substantiation rate drops as the report volume rises (as has been happening in the United States during the last 10 years), it could be argued that CPS workers have been rejecting more and more cases by applying highly restrictive intake criteria in order to cope with the influx of reports with fixed resources. As a result, there has been a steady decrease in the substantiation rate as the volume of abuse reports continues to increase. The 1993 NIS-3 data support this analysis, and have led the chief researchers to warn of a looming crisis in the child protection system. (Related issues and controversies, especially the relationship between substantiation rates and report volumes, have been discussed by others^(29,31,32,37-43).)

In Canada, a study of the incidence of child sexual abuse in Quebec suggests that the lower rates of estimated incidence in Quebec in comparison with Ontario and U.S. studies is probably related to the institutional response to the reports of child abuse, which results in a lower number of referrals to CPS and may not indicate actual lower incidence⁽⁴⁴⁾.

The main sources of substantiation rates quoted in the field have been the NCPA annual surveys of CPSs. Because substantiation rates are known to vary with "systems" conditions (i.e., report volume and CPS resources, see earlier discussion), different ones have been estimated and used over the years. To facilitate understanding of what the different rates are and how they have changed over the years, they are presented in Table 2.3.

Two trends are obvious. First, the overall substantiation rates have been decreasing over the years, from 43% in 1980 to 31% in 1996. The steepest decline took place between 1993 and 1995. As already described, the NIS-3 found that the number of abused children recognized by professionals in the 1993 study increased 149% over the 1980 figure. This significant jump in reports might have been the direct cause of the sudden dip in CPS's report substantiation rate at about the same time, unless there were other system-wide factors. Second, the substantiation rates of reports from medical sources were considerably higher than the overall rates. The substantiation rates for the different maltreatment types reported by Giovannoni⁽²⁷⁾ further supported this general finding. However, it should be mentioned that, in the Giovannoni study, the substantiation

rates for the medical profession were about the same as those for law enforcement, schools and social services.

The specific reasons for the general finding that reports from the medical profession result in a higher substantiation rate have not been empirically determined, but some plausible explanations have been offered. First, because of their special training physicians are better judges than non-medical professionals of the nature and causes of injuries. Second, physicians, compared with other mandated reporters, may have a more elevated threshold for suspecting abuse and therefore tend to report only those cases in which they are certain the injuries are non-accidental. Third, the high professional status accorded by society to the medical profession may mean that the opinions of physicians are more influential and their reports are more likely to be regarded as substantiated⁽²¹⁾. A fourth explanation may be that the biomedical orientation favoured by physicians helps them to focus on cases in which visible evidence of maltreatment is present, the types of reports that normally pass CPS's case validation. The last or fifth reason may be an "opportunity" factor. It is possible that the consequences of abuse brought to the attention of hospital staff are more likely to be severe, medically involved and life-threatening. As a result, hospital personnel report more of these cases than other professionals. This last explanation reaffirms the importance of the role of hospital personnel in child abuse identification and reporting.

Despite the potential usefulness of substantiation rates, understanding some of their limitations can help us to appreciate the difficulties of collecting data or doing research in child abuse. Three main limitations have been identified. They are mainly the result of ambiguous definitions of the terms used in computing substantiation rates and lack of data consistency.

First, the denominator in the calculation can be controversial. For example, Flango discovered that an important variable that can affect the result is the number of disposition categories permitted. He illustrated the problem this way: "If the only reporting options available are 'substantiated' or 'unsubstantiated,' a (child abuse) registry with 30 confirmed reports out of 100 would have a substantiation rate of 30%.

The same registry (with 'undetermined' also available as a third disposition category) would have a substantiation rate of 40%, if the 25% of the cases where workers were unable to make a determination (and had them originally classified as 'unsubstantiated') were removed from the denominator"⁽³⁷⁾.

Another cause of a problematic denominator is related to multiple counting of incidents of maltreatment on the same case. For example, as a result of greater awareness of child abuse, the CPS is now more likely to receive multiple calls on the same child from different mandated professionals. The problem arises when states do not control for duplicate counting of reports. "If the substantiation rate is simply the number of substantiated cases divided by the number of reports, as it is in many states, it might appear as though the substantiation rate were declining (if duplicate reporting is not controlled). It is very possible that this explains at least part of the decline in the substantiation rate in New York"⁽³¹⁾. Still another factor that directly affects the calculation is the category of reports used to form the denominator. Using the total number of unscreened reports received at intake as the denominator can result in a much lower rate than using only those reports brought forward for investigation.

The second limitation is related to the unit of analysis used in the calculation. Not all suppliers of substantiated cases define a case in the same way. Worse, many data systems cannot adjust for the different units of analysis or relate them to one another. For example, the NCPCA investigators discovered that, in gathering data for the estimation of substantiation rates, "some states could only provide the number of substantiated families whereas others provided the number of substantiated incidents"⁽¹⁴⁾. They had asked for the number of substantiated child-victims.

The third limitation is created by the way states define "substantiation," i.e, the numerator in the calculation. According to Finkelhor, "Alaska, for example, narrowly defines a case as substantiated only if court action is taken. Simple administrative determination is not enough"⁽³¹⁾. Even for those states that define a case as substantiated when it is accepted for child protection service upon completion of an investigation, "due process concerns have led to more conservative criteria for substantiating a case" in some states⁽³¹⁾. An example of a conservative practice is the

requirement that the family receive written notice or protocols that allow the perpetrator to review records. All these extra administrative practices affect substantiation rates.

Given these inherent limitations in calculating substantiation rates, it is clear that all substantiation rates computed from data supplied by sources that follow different sets of guidelines must be treated with great caution. It also suggests that, where possible, separate subpopulation rates (appropriately adjusted for their idiosyncratic characteristics) rather than the total unadjusted rate should be used. The calculation of substantiation rates serves as an excellent example of a statistic that looks very simple, but is actually very difficult to interpret.

Finally, the literature is almost totally silent on the issue of what an optimal substantiation rate is, other than one unclear suggestion of "50%, or perhaps between 33% and 67%"⁽³⁷⁾. However, it is useful to know that, compared with the substantiation rates in some European countries, U.S. and Canadian rates are very low. For example, Belgium, with a reporting system based on voluntary self-identification, has a substantiation rate of 90%, as might be expected⁽⁴⁵⁾. The 1993 rate reported by the Netherlands, with a similar reporting system, was 85%⁽⁴⁶⁾. One plausible explanation of the overall low substantiation rates found in the United States and Canada is that they are the result of "a contradiction between the least intrusive approach, which requires a high level of harm or risk for substantiation and case opening, and the trend toward mandatory reporting, which encourages public responsibility to prevent harm" to children⁽³⁶⁾.

Two influential U.S. scholars have offered an analysis on the issue of a desirable substantiation level. They said: "A certain proportion of unfounded (unsubstantiated) reports. . . is an inherent — and legitimate — aspect of reporting suspected child maltreatment and is necessary to ensure adequate child protection. Hundreds of thousands of strangers report their suspicions; they cannot all be right. But unfounded rates of the current magnitude go beyond anything reasonably needed. Worse, they endanger children who are really abused (because). . . forced to allocate a substantial portion of their limited resources to unfounded reports, child protective agencies are less able to

respond promptly and effectively when children are in serious danger"⁽³⁸⁾. Issues related to report substantiation are exceedingly complex and require far more careful analysis.

2.4 Issues Regarding the Identification and Reporting of Child Maltreatment by Health Care Professionals

With their special training, clinical experience with trauma and high probability of encountering child patients, hospital/medical professionals are often in an optimal position to identify child maltreatment. The expectation that they are best qualified to identify child abuse makes them the focus of child abuse reporting laws in many jurisdictions. In addition, the expertise and opinions of medical professionals are frequently sought and relied on by other professionals working in the field of child abuse who may not feel fully qualified to act on their own because of lack of clinical knowledge in child abuse identification, reporting, treatment and prevention. The contributions of health care professionals on multidisciplinary child abuse teams are valued. Among health care professionals, pediatricians in particular are considered as key experts in child abuse diagnosis, as they were among the first professionals to question the etiology of certain childhood injuries and to bring worldwide attention to child abuse issues.

Although U.S. studies indicate that medical professionals' reporting probability of 66% is 10 percentage points higher than the overall average for all professionals, the literature suggests that health care professionals should have reported far more than just the two-thirds of maltreated children they recognize. In addition, the number of abuse reports submitted by all health care professionals together accounts for just a relatively small proportion of the total, i.e., approximately 10% in both U.S. and Ontario studies. Consequently, their reporting behaviour has become the focus of a number of research projects. This section summarizes the understanding of two major groups of factors found to affect child abuse identification and reporting by health care professionals. It should again be emphasized that almost all the research in this section is from the United States, and

differences in social and legal structures may result in different attitudes and practices among health care professionals in Canada.

2.4.1 Problems with identification: knowledge gaps

Medical diagnosis entails the delineation of a disease, establishment of an etiology and suggestion of a course of treatment. In many medical diagnoses, determining the disease is relatively straightforward, although it is not always clear with respect to etiology or the treatment options. A good example is a neglect condition called "failure to thrive"⁽¹³⁾. This etiologic model generally works well in medicine, and actually played an important role in the "discovery" of child abuse by the pediatric radiologist Dr. J. Caffey in 1946. The way the "battered child" was portrayed by Dr. Kempe and associates in 1962 was done in adherence to this model; so was the intervention plan. The idea was that the physician would recognize the battered child syndrome, make a diagnosis of non-accidental injury, and report the incident to the CPS for intervention. In the 1960s and early 1970s, this etiologic orientation was central in child abuse training. The perpetrator was portrayed as someone who, with deep-seated psychopathological disorders, viciously and repeatedly attacked a helpless infant. In fact, child abuse was almost synonymous with physical abuse for almost a decade, under the influence of this perpetrator-victim etiologic model.

The attractiveness of this simple causal model began to fade with two developments that took place in the first half of the 1970s. First, research had determined that the problem of serious mental disorders in the general population was just as prevalent as it was in the population of abusive parents. Second, and more important, the list of mandated reporters greatly expanded, and at the same time the definition of child abuse was significantly broadened in the U.S. legislation to include child neglect, emotional abuse, medical neglect, and factors injurious to a child's moral development. These legislative developments in the United States influenced the definition in child protection legislation in most Canadian provinces. Another development was the "discovery" and subsequent explosion in reporting of sexual abuse near the end of the 1970s.

Broadening the definition of child maltreatment in the legislation meant that physicians must now diagnose and report a wide range of other conditions, not just non-accidental physical injuries or “failure to thrive.” “Infants born drug addicted, newborns with features of fetal alcohol syndrome, children who were unimmunized or with health needs that were being neglected, deprived youngsters who were being psychologically abused at home, and infants with non-organic failure to thrive were all within the newly defined realm of pediatric responsibility”⁽⁴⁷⁾.

2.4.1.1 Limitations of the biomedical model: dilemmas of the broader concept of abuse

This sudden development in the definition of child maltreatment has created three major dilemmas for physicians. First, many of these new reportable conditions do not fall into the traditional biomedical framework in medicine. An abused child is no longer only an infant with bruises or fractures caused non-accidentally or a child who fails to thrive — the two child maltreatment conditions that medical professionals can most reliably identify and capably treat under the biomedical model⁽¹³⁾. Now, child abuse is “no longer seen as a discrete event but rather as a symptom of family distress”⁽⁴⁷⁾. The “new” forms of child maltreatment are non-visible traumas. Physicians now are required to look for non-physical signs of probable harm⁷ to the child as well, an expectation that goes beyond the medical training of most physicians. As a result, “situations which fall within this (biomedical) perspective were ranked higher than situations which were not (i.e., psychological abuse and educational neglect)”⁽⁵⁰⁾. Among others, Morris and colleagues reported in their classic study that the types of child abuse cases most likely reported by physicians indeed involved visible physical harm⁽⁵¹⁾. This also means that physicians’ biomedical orientation causes them to frequently overlook non-physical warning signs of maltreatment, e.g., psychological

difficulties in a child caused by prolonged denial of parental affection or proper nurturing, a reportable condition in the legislation of most North American jurisdictions.

Second, a related dilemma is the expectation that physicians must become social diagnosticians as well, given the varied types of maltreatment closely linked to parental or family dysfunction that physicians now have to be concerned with. This expectation has proven to be a difficult one. For example, even if mild abnormal expressions of emotion are detected in a child, making a proper diagnosis of child maltreatment requires additional information of a psychosocial nature, including family functioning, child rearing practices of the parents and mother-child interactions. Such information cannot be easily obtained in the examination room. Even if the information is available, connecting it to the observed behaviour in a child for the purpose of identifying possible child maltreatment is not what physicians are normally trained for, given their biomedical orientation and lack of training in social diagnosis⁸.

Third, despite the recognized need for physicians to be competent in psychosocial diagnosis, the availability of appropriate education or training has been slow in coming. The slow evolution of education appears to be related to a low status accorded to the psychosocial area of practice in traditional medical training programs⁽⁴⁷⁾, as well as lack of clear physical markers for making a diagnosis of psychosocial problems. Lack of training in psychosocial practice has been identified as a most frustrating barrier to successful identification of child maltreatment in an era of “new morbidity,” and physicians have come forward to openly voice this concern⁽³⁾.

2.4.1.2 Emerging forms of child abuse

Parental substance abuse as a psychosocial problem affecting children has been on a steep

⁷ These problems particularly affect physicians in private practice or working in community clinics because cases encountered in the hospital usually involve severe harm. Identification of sexual abuse can also be very difficult if the incident is not reported until a few days or weeks afterwards⁽⁴⁸⁾. Another difficult form of maltreatment to detect is Shaken Baby Syndrome, for reasons of lack of obvious external signs⁽⁴⁹⁾.

⁸ Primarily as a response to the difficult situation faced by physicians, a number of child abuse prediction instruments were developed between 1975 and 1985. These instruments had one common purpose, i.e., to identify abusive parents using a wide range of indicators found to correlate with abusive acts. Such predictive instruments would certainly help all professionals, particularly physicians, in child abuse identification, and allow them to focus their resources on treatment. Unfortunately, none of these efforts materialized for reasons of lack of an acceptable level of reliability and validity^(13,52).

rise in the last few years in the United States. The lead NIS researchers speculated that the sudden jump in the estimated number of maltreated children in the general population — in the “serious injury or impairment” category (defined as “long-term impairment of physical, mental, or emotional capacities, or required professional treatment aimed at preventing such long-term impairment”) — from 143,000 in 1986 to 568,000 in 1993 was likely due to a crack epidemic in the United States^(16,53). At the same time, NCPA researchers estimated that in 1995 substance abuse by parents was identified as a problem in 40% of all substantiated CPS cases (data from 50 states), but that in 1996 the figure went up to 76% (data from 28 states)⁽¹⁵⁾.

In addition, the proportion of CPS reports involving non-visible harm is quite high. The 1993 OIS determined that 40% of all cases investigated by Ontario’s CASs belonged to this category (30% neglect and 10% emotional maltreatment)⁽⁷⁾. The NIS-3 reported that Harm Standard neglect cases had increased by 85% between 1986 and 1993, and Harm Standard abuse cases by only 46%⁽⁶⁾. A particular concern is the finding that Harm Standard emotional neglect reports had increased by 333%, from 49,200 in 1986 to 212,800 in 1993, the largest increase among all maltreatment types. The second largest increase involved Harm Standard physical neglect cases: a 102% increase, from 167,800 in 1986 to 338,900 in 1993. Compared with physical abuse (42% increase) and sexual abuse (83% increase), this sharp increase in reported maltreatment cases with primarily non-visible injury in merely eight years is significant. The NCPA data tell a similar story. The proportion of substantiated neglect cases in 1990 was 45%, whereas the 1996 figure went up to 60%⁽¹⁵⁾.

These statistics together provide an understanding of the types of cases coming to the attention of professionals these days: a high proportion of them involve non-accidental trauma or neglect. These are exactly the types of maltreatment cases that physicians have been saying they do not know how to identify because they lack psychosocial training. At this time, however, it is not clear whether these increases in reporting reflect an actual increase in incidence or are a result of increase in knowledge and awareness among those who report.

2.4.2 Reasons for non-reporting: personal perceptions, beliefs, and values

The primary purpose of a medical diagnosis of child abuse is to determine the likelihood that the child has been maltreated or has been exposed to situations in which harm would be a probable outcome without appropriate and timely intervention. If the diagnosis is suspicion of maltreatment, under the mandatory reporting laws the case must be reported to the CPS. Although the majority of medical professionals report their suspicions without hesitation, some medical diagnosticians believe that, given their experiences with previous reports or the particular situation involved, a more socially or morally responsible course of action is to find better options, in the best interests of the child.

In addition to overt reasoning, the values and attitudes specific to the diagnostician can also influence the decision in a subtle way. If, everything considered, the decision is not to report, especially when the harm or injury does not appear to be severe or visible, the physician will not classify the condition as a reportable one. The influence of the diagnostician’s personal values, beliefs and perceptions on reporting decisions helps to account for the fact that not all suspicions of maltreatment are reported. In addition, propensity to report varies among physicians, because the mix of personal variables is not the same, nor is the availability of and accessibility to alternative options. A prominent scholar in child abuse sums up this problem when she says: “On the one hand, physicians act as medical diagnosticians; on the other, the treatment to be invoked by their diagnoses is not solely a medical but also a social and legal one. The social and legal consequences may, and in fact do, deter some clinicians from making a diagnosis that would invoke them”⁽¹³⁾. Therefore, in order to promote full reporting of child maltreatment, it is important to understand the specific factors that deter certain medical professionals from meeting their professional and legal obligations to report.

Unfortunately, non-reporting contributes to the perpetration of the socio-political climate that under-resources the child protection system. By underreporting the breadth of the problem, professionals contribute to the very situation they profess to want to change.

2.4.2.1 Views on physical punishment

Physical abuse sometimes occurs as a result of a parent's attempt to control or modify a child's behaviour by corporal punishment. The *Criminal Code of Canada* allows the use of force by a parent or guardian against a child as long as it is "reasonable" and for the "purpose of correction." The relationship between physical punishment and child abuse is important, especially in a multi-ethnic, multicultural society such as Canada, where the degree of acceptance of physical punishment varies greatly between cultures. Physicians' views on physical discipline vary, and the extent to which a physician accepts physical punishment may influence his/her decision to report suspicions of child maltreatment.

U.S. research by Morris and associates⁽⁵¹⁾ discovered that the more a physician accepted the use of physical discipline, the less likely was his/her inclination to report physical abuse cases. However, disapproval of the use of certain physical disciplinary methods did not automatically lead the physician to consider the act abusive and therefore to decide to report the situation to the CPS. For example, while 86% of physicians considered "open-hand face slapping leaving a red mark" an inappropriate discipline, only 11% would use it as a condition for filing a report. Another example is that although almost all (98%) considered "spank with belt, leaving bruises" inappropriate, only half (48%) said they might report the incident as abuse⁽⁵¹⁾. However, all physicians considered "hit and fracture ribs" an inappropriate discipline, and all would report on the basis of this condition.

Taken together, these findings are further evidence that the relative severity of injury influences a physician's reporting decision. However, certain types of visible injuries, if presented as the outcomes of parental discipline, may or may not result in reporting to the CPS, depending on the diagnostician's acceptance of these discipline approaches. The overall threshold of discipline severity seemed high among the physicians in the study, but the data also suggested that younger physicians tended to have

a lower threshold, an indication of the usefulness of incorporating child abuse materials into medical schools. Finally, the study findings also bring into sharp focus the difficulties in interpreting the meaning of "reasonable cause" to believe that a child has suffered abuse or neglect, a term widely used in U.S. child abuse reporting legislation^(54,55).

2.4.2.2 Ethnic background and social class

In their analysis of the NIS-1 hospital subset, Hampton and Newberger⁽²⁴⁾ discovered that poor black children had the highest probability of being reported by the hospital to the CPS (for details, see Section 2.2.3 on types of reports from health care professionals). It appears that this finding has since been widely accepted, although there has been little research to support it⁹. Partly in response to this finding, NIS researchers have repeatedly asserted that in the United States there are no race differences in the overall incidence of maltreatment or maltreatment-related injuries, and that this key finding has been very consistent from study to study⁽⁶⁾. Ards and Harrell in 1993⁽²⁶⁾ and most recently Ards, Chung, and Myers⁽²⁸⁾ in 1998 presented data to question the original Hampton and Newberger finding (see Section 2.2.3). However, given the assumption in the literature that race and social class can bias reporting on the one hand, and lack of empirical evidence to either confirm or refute this assumption on the other, the exact impact of these two variables on reporting behaviour remains unclear.

2.4.2.3 Effectiveness of the CPS

U.S. researchers have determined that how professionals view the effectiveness of the CPS greatly affects reporting probabilities. This is one of the strongest and most consistent research findings in child abuse reporting. For example, Morris and associates reported evidence that "lack of confidence in the legal or social agencies" could cause physicians not to report; 14% of their respondents gave this reason for non-reporting⁽⁵¹⁾. An earlier study reported that 8% of physician-respondents cited "past dissatisfaction with social services' handling of

⁹ One of the few attempts to replicate this finding was made by O Toole and associates⁽⁵⁶⁾. Responses of physicians to vignettes suggested that black children or children from lower social class with severe injury were more likely to be diagnosed as abused. Another attempt came from Benson and associates in Northern Ireland⁽⁵⁷⁾. Again using vignettes to solicit responses from physicians, they found some weak evidence that there was a tendency for Northern Ireland medical practitioners to diagnose child abuse and to report it to social control agencies more often when the parent was identified as lower SES. Both studies were relatively weak in methodology.

cases” as the reason for being reluctant to report⁽²²⁾.

The current high level of health care officers’ dissatisfaction with the CPS can best be understood in the context of the historic development of the CPS system. Briefly, as a result of drastic and sweeping legislative reforms that took place between 1963 and 1974, particularly the manner in which mandatory reporting was implemented, CPSs were overwhelmed by the substantial increase in maltreatment reports. Unfortunately, increases in reports have never been matched by proportional increases in funding. Caught in this difficult situation, CPSs have been implementing “innovative” operational measures. Among other things, they began applying criteria to constrict the volume of reports and the investigative response to them. (The declining report substantiation rates are a possible indicator of this phenomenon and the impact of this system-wide practice, see Section 2.3.2 on substantiation rates.) The practice of selective intake alone has had a direct negative impact on professionals’ perceptions of the usefulness of reporting suspicions of maltreatment to the CPS.

U.S. research indicates that one of the most common complaints by mandated professionals against the CPS is that their reports of suspected abuse are often ignored,^(29,38) and this makes them reluctant to report in the absence of clear evidence of substantial abuse. Because mandatory reporting laws require suspicion or reasonable belief and not certainty of harm as the basis of reporting, many of these reports are rejected by CPS personnel who are required to apply restrictive intake criteria; consequently, cases with tangible evidence of harm are more likely to be accepted for service. “The mandated reporting laws structure the nature of the interaction between child protection and other professionals. ...What may seem to be clinically relevant signs of distress, perhaps reflective of maltreatment, will not be sufficient for the child protection worker who judges the situation against a legal standard of evidence”^(13,54). This issue has become increasingly central as the substantiation rates keep declining. As a result, two things have happened. First, professionals are reluctant to refer marginal child maltreatment cases. Second, mandated reporters feel intensely frustrated at the CPS’s perceived lack of sensitivity to serious or potentially serious abuse,

and are angry that their professional judgement is ignored⁽²⁹⁾. The outcome of this conflict is under-reporting.

In addition to this problem, professional reporters also express a number of other CPS-related reservations about the usefulness of reporting. First, they complain that the CPS seldom informs them of the progress of cases they have referred^(29,58). Second, they are concerned about the diminished capacity of the CPS to protect abused children, particularly in light of insufficient funding, and say that they sometimes have a sense that reporting does more harm than good. Some also believe that they could help the child and family better than could the CPS^(22,29,41,47,59-61). Third, “many indicated that they had decided not to report because previous similar cases had been mishandled or ignored by CPS”^(22,29). Fourth, with regard to filing reports concerning educational abuse, Besharov indicated that “an even larger number (of meeting participants) would have Child Protective Service Agencies play no role in such cases, leaving intervention entirely to the school authorities unless other forms of abuse and neglect are present”⁽⁶²⁾. Finally, physicians are unsure about the usefulness of reporting child maltreatment to the police, believing that “police personnel do not have the appropriate professional skills and are not efficient in handling situations of child maltreatment”⁽⁵⁰⁾. These secondary concerns and beliefs also contribute to under-reporting.

2.4.2.4 Awareness of reporting laws

It is significant that research suggests that almost all practising health care professionals have at least some knowledge of mandatory reporting laws, and that being unaware of the existence of mandatory reporting law has rarely been a significant reason for not wanting to report, even in earlier times. One of the first studies in child abuse identification and reporting, conducted in 1983, found that only 6 (2%) of the 252 physician-respondents expressing reluctance to report certain types of child maltreatment selected “unaware of the law requiring such reports” as the reason⁽²²⁾. A recent survey of psychologists in British Columbia indicated that the respondents possessed a high level of knowledge of the reporting law, but this did not by itself increase their propensity to report⁽⁶³⁾. Better legal

knowledge related to specific obligations, liability, reporting procedures, and other details is always needed, as was determined in a large-scale survey of professionals who had attended a two-hour course on child abuse identification and reporting between late 1990 and the end of 1991. The research also discovered that, in terms of pre-course knowledge of mandatory reporting requirements and indicators of child maltreatment in the health care group, psychiatrists, physicians, nurses and psychologists scored higher than optometrists, podiatrists and chiropractors, even though their overall knowledge level was judged to be quite low⁽⁶⁴⁾.

2.4.2.5 Confidentiality of the doctor-patient relationship

The mandatory reporting laws generally override statutory rules about privileged or confidential information. However, concerns about a perceived breach of confidentiality cause anxiety among professionals about reporting suspected child abuse. Medical “consultation is thus sought with the understanding that ‘it will go no further,’ and physicians have long respected this”⁽⁴⁷⁾.

While physicians seldom object to the principle of reporting, some of them worry about the negative impact reporting could have on the clinical relationship with the patient and on the patient’s family. For example, in a nationwide U.S. survey of 907 licensed psychologists, “twenty-seven percent of the therapists indicated that their clients withdrew from treatment immediately or shortly after the report, and attributed this to their having filed the report”⁽⁶⁰⁾. In addition, given the traditional way the CPS operates, it is quite possible that a report, accepted at intake and brought forward to investigation, will end up being rejected upon conclusion of an investigation. Professionals are particularly concerned about the situation in which the investigation, depending on how it is carried out, could actually end up damaging the child and the family instead of protecting the child. In this situation, it is difficult for the professional to revive his/her clinical relationship with the “damaged” patient/client^(5,29,54,58,65).

Many professionals, while realizing their legal duties to report suspicions of child maltreatment, are unsure how best to inform their patients/clients that there is a limit to confidentiality under the mandatory reporting law⁽⁶⁰⁾. Other related concerns identified are as

follows: mandatory reporting statutes “are irreconcilable with patients’ legitimate interest in privacy, they are irreducibly opposed to the principle of patient care, and they frustrate the exercise of the therapist’s independence and professional judgement”⁽⁶⁵⁾. Partly because of these worries about confidentiality and related matters, 30% of physicians in one study cited “feel that you can work with the family to solve the problem without outside intervention” as the reason for being reluctant to report⁽²²⁾.

2.4.2.6 The economics of reporting

A number of overt economics-related factors have also been identified in the U.S. literature as possible inhibitors of reporting by some health care professionals in that system^(22,29,47,51). The three more commonly cited ones are as follows:

- **Time demand:** It takes time to collect information and document the case, and to prepare and file a child maltreatment report. Subsequent activities, like interviews by the CPS or police, court appearances, preparing special reports, etc., consume even more non-billable time.
- **Liability:** Despite the legislated assurance of immunity for good faith reporting, the issue of liability remains a rather central concern for professionals, especially in the United States, where civil suits are quite common. The economic and emotional impact of a parental claim that a physician has made a wrongful accusation can be enormous.
- **Lost income:** Reporting can lead to lost income or can damage a medical practice as a likely result of not only losing the subject-family but also driving away existing or prospective patients, a particular concern for physicians in private practice located in rural communities or small towns.

The reasons for under-identification and under-reporting are numerous. The major ones presented above undoubtedly interact in a complex way with each other and with various other situation-specific and patient/client-specific variables in each diagnosis of child maltreatment. The influences of these variables are not mechanistic; they are expected to vary with time, context and societal values.

It is useful to reiterate that there is a lack of Canadian research in the area of child abuse and maltreatment, and the material reviewed is mostly U.S. research. The lack of Canadian literature or comparable data does not, however,

suggest that issues confronted by medical professionals in the United States are not also experienced by their Canadian counterparts. However, it seems reasonable to suggest that the barriers to child abuse identification and reporting uniquely caused by the U.S. society or service delivery system are less directly applicable than those tied to one's personal attributes or values, or professional training. For example, distrust of the CPS, which was found to be a major reason for under-reporting of child maltreatment in the United States, might not be an important reason in Canada. On the other hand, U.S. research findings concerning the receptiveness of corporal punishment as a child rearing practice, another factor found to affect reporting decisions, might be equally valid in Canada. Similarly, lack of confidence in psychosocial diagnosis, a serious concern voiced by members of the U.S. medical profession, might be an issue that requires immediate attention in Canada as well. However, because of a serious lack of Canadian research in this area, our present knowledge of the extent of under-reporting in Canada and the attendant reasons is at best limited. U.S. research findings will, out of necessity, continue to serve as the principal knowledge base for Canadian researchers and policy analysts in this area.

It is also important to point out that while the research literature focuses on the problems in child abuse identification and reporting, discussions of a medical practitioner's ethical, professional and legal obligations to report child maltreatment are also abundant, prominent and candid, especially in the non-research literature. The fact that a significant body of literature has been devoted to the subject of duties to report strongly reflects the societal value placed on the protection of children. Medical professionals are constantly reminded that the principle of acting in the best interests of the child is compatible with their professional training, and should be more important than personal beliefs and discomforts or the doctor-patient relationships. In addition, there is a strong belief in the field that medical practitioners, especially pediatricians, must not only report suspicions of child maltreatment, but should also advocate for the abused child and the family after a report is filed. "By staying involved, supporting the family, and helping to monitor the situation, the physician can play a valuable role after the report is made. This is a time when the pediatrician can strongly advocate on behalf of

the child and family to help ensure that appropriate supportive services be implemented"⁽⁴⁷⁾. A clear central message in the literature is that protecting the health and welfare of children is always a key responsibility of medical professionals, given their specialized training and personal commitments to the profession. In the case of child maltreatment, reporting the incident must be seen as the natural first step towards fulfilling this professional responsibility, independent of reporting laws and penalties for failure to report.

2.5 Striving Towards a Better System of Child Abuse Identification and Reporting

This literature review has uncovered a high level of anxiety and dissatisfaction among health care professionals with respect to child maltreatment identification and reporting. The main problems can be summarized as follows:

- Health care professionals are unsure of their knowledge base. In particular, they lack confidence in diagnosing sexual abuse, psychological abuse or neglect, or those maltreatment types related to the "new morbidity," for which psychosocial diagnostic knowledge and skills are needed. They are also frustrated at how little can be done to improve the lives of children and families, especially where poverty, unemployment, inadequate housing, intergenerational abuse, breakdown of the neighbourhood, drug epidemics, and inadequate community resources are present. The problematic relation between physical punishment and child abuse causes diagnostic confusion. Lack of diagnostic tools aggravates this situation.
- Although physicians accept their legal duty to report suspicions of child maltreatment, they worry about the negative impact the reporting might have for the doctor-patient relationship, one that is built on trust and confidentiality. They are particularly concerned with situations in which their reports may end up being rejected by the CPS as unsubstantiated. Not knowing how best to inform patients about the limits of confidentiality is also a concern.
- A large percentage of U.S. medical personnel question the usefulness of submitting child maltreatment reports to CPSs, which are considered to be

functioning far beyond capacity and whose real effectiveness in child protection has not been proven. These professionals may feel insulted and accuse the CPS of being insensitive to serious or potentially serious abuse when their reports are viewed as unsubstantiated. System-wide dissatisfaction with the CPS in the United States is a very significant problem. In Canada, we do not know how our health care professionals view the CPS because of an absence of research.

- Lack of time, lost income and liability are additional worries.

In recent years, the overall level of anxiety of health care professionals about reporting has increased as the numbers of child maltreatment cases have risen and substantiation rates have dropped. Evidence of under-reporting is strong, but we do not know if the rate has actually increased. In addition, the increase in substantiated reports involving substance abuse in the U.S. family is frightening, although we do not know if a similar trend also exists in Canada. As physicians encounter more and more cases with non-visible harm or cases of the “new morbidity” types, the need for psychosocial diagnostic expertise becomes even more urgent, but such training is still not generally emphasized in medical schools or residency programs.

The net result of all this causes under-reporting in the medical community, and this in turn suggests that many maltreated children are not getting help. In response to these system-wide problems, a number of strategies have been identified for hospital/medical personnel, and they are briefly described below.

2.5.1 Protocols

Protocols have been identified as important tools in child abuse work in all jurisdictions. The Badgley Report of 1984 was an important catalyst in the development of protocols in Canada. (In 1994 Newfoundland was the only province that did not have official protocols⁽¹⁰⁾.) There are now many different types of protocols in different jurisdictions in Canada. They are the products of professional groups either working on their own (protocols for the needs of their own organizations or settings) or collaborating with each other (protocols for community-based child maltreatment management).

All protocols have a common purpose: to provide a consistent, timely and appropriate

response to child maltreatment management. Hospital protocols typically begin with a description of legal obligations and consequences of non-reporting, clarification of terminology, and explanation of the role of the hospital in child maltreatment management vis-a-vis other agencies and professionals in the community. Protocols focus on the roles and responsibilities of hospital personnel, and on standards with respect to diagnosis, documentation, seeking consultation, handling of confidential information, working with the family and the child, reporting of maltreatment, sharing information with external authorities like the CPS and law enforcement, and preparing for courts. They also include a section on the handling of exceptional circumstances, like fatalities. Details vary between hospital protocols, but the issues are similar (for an example of a comprehensive protocol see the House Staff Manual of the Department of Pediatrics, University of Texas⁽⁶⁶⁾). A central message conveyed in most protocols is that staff have the support and assurances of the organization, even if errors have been made in following organizational procedures. Protocols are seen as an important part of the effort to address the issues of diagnostic uncertainties, ambiguous legal terminology, liability, concerns, and doctor-patient relationship^(3,38,54,61,67-69).

2.5.2 Screening/risk assessment tools

Screening/risk assessment tools are not the same as the child abuse prediction instruments popular in the 1970s and early 1980s constructed on the basis of mother-child interaction. The variables used in screening/risk assessment tools are mostly “objective evidence of possible abuse or neglect . . . firsthand accounts or observations of seriously harmful parental behavior . . . or concrete facts, such as the child’s physical condition, suggesting that the child has been abused or neglected”⁽³²⁾.

Child protection services in a number of Canadian provinces use risk assessment tools⁽¹⁰⁾. The Ontario Coroner’s inquest in the Kasonde case recommended that “the use of the risk assessment tool to all potential sources of risk to a child involving both custodial and non-custodial parents” be mandated⁽⁷⁰⁾. In the United States, reliance on risk assessment tools to identify severe or at-risk child maltreatment cases has become a common practice in CPS. In

addition to their value as case screening devices, risk assessment tools are also seen as partial but practical answers to the vague terminology found in child protection laws^(32,38). Back in 1979, Giovannoni and Becerra implied that tools using explicit criteria might be a logical answer to ambiguous child abuse definitions in statutes: “Vague statutory definitions would not pose such a problem if there were clear-cut criteria and standards for interpreting them available to those who must make judgements about specific cases”⁽⁷¹⁾. Screening tools fill the definitional gaps and have been well received by CPS.

The effectiveness of screening tools was demonstrated by Flango⁽³⁷⁾ in a macro analysis of the relation between use of screening tools and substantiation rates. Table 2.4 is a modified version of his original contingency table.

Flango found that 79% of those U.S. states that used risk assessment tools had a substantiation rate in the upper 50th percentile. On the other hand, 59% of states that did not use a risk assessment model belonged to the lower 50th percentile. This relation was statistically significant ($p < 0.025$ [2-tail]). Flango reported that, at the time of analysis (1991), 18 states were using some sort of assessment tool and another 11 were in the process of developing one. This research has potentially significant policy implications. Although the analysis concerned substantiation of reports made to states’ child abuse registers, use of decision-support devices

should apply to any situation in which assessment or diagnosis of child abuse is involved, including cases involving hospitals, CPSs, public health departments, etc.¹⁰ Risk assessment tools also have excellent potential to harmonize databases and facilitate data analysis and program monitoring.

2.5.3 Documentation

Keeping good records is good clinical practice and is particularly important in child maltreatment work, in which cases may result in court proceedings. Unfortunately, many U.S. hospitals do not have clear or complete documentation. For example, in a large-scale review of 642 hospital clinical records involving cases of child abuse at a Kansas hospital, the investigators discovered that 4% (28 cases) included no history of how the injury occurred, and only 209 cases (33% of the total) had a complete documentation of the examination⁽²³⁾.

The problem of poor documentation in hospitals can be readily addressed by means of a standardized record form, as demonstrated by a large-scale two-year study reported by the U.S. Academy of Pediatrics. The study concluded that the use of a standardized structured child abuse reporting form accounted for significant improvement in both the quality and the quantity of information collected and documented. “The structured forms increased identification of the abuser from 56 percent to

Table 2.4
Relationship Between Use of Assessment Tools and Child Abuse Substantiation Rates (n = 43 states)

Substantiation Rate	Assessment Tools Used	
	Yes	No
In upper 50%	11 (79%)	12 (41%)
In lower 50%	3 (21%)	17 (59%)
Total	14* (100%)	29 (100%)
*18 states had assessment tools, but only 14 had data on substantiation rates.		

¹⁰ Warner and Hansen⁽⁷²⁾ reviewed the literature on diagnostic tools and techniques found useful for child abuse identification. The following are the ones they located:

- Drawings, photographs and X-rays of abused children with pathognomonic injuries^(73,74).
- List of uncommon injuries, including fatal pepper aspiration and microwave oven burns⁽⁷⁵⁾.
- Munchausen syndrome by proxy, i.e. caregiver makes up symptoms, induces illness in the child, or orders unnecessary surgery for the child^(76,77).
- Injuries that are pathognomonic to physical abuse, including shaken baby syndrome and loop-mark bruises on the skin^(49,78).

95 percent, documentation of requests for photographs from 18 percent to 98 percent, and drawings of physical findings from 17 percent to 87 percent⁽⁷⁹⁾.

As well as being good clinical practice, clear and complete documentation is one of the best safeguards against liability. Good medical records, with interview transcripts and notes included, also serve as legal documents and are a valuable source of information for the CPS, law enforcement, and the judicial system^(23,48,79-82). It seems that for liability protection it is important for medical examiners to document all diagnoses of child abuse, including situations in which maltreatment is not the finding. The recommendation was that “if . . . you conclude that no child abuse has occurred and a report is unnecessary, document the factual circumstances upon which the alleged child abuse was brought to your attention, the details of the investigation . . . and the reason that you believe that the child at issue is not an abused or neglected child”⁽⁸³⁾.

2.5.4 Multidisciplinary child abuse teams

Like protocols, multidisciplinary child abuse teams have proliferated throughout North America, for many good reasons. They are seen as the answer to some system-wide barriers in child maltreatment service delivery^(3,47,84). There are several benefits of a multidisciplinary child abuse team. It may be seen as a far more elaborate and formal body than a multidisciplinary consultation committee. The operation of the team is guided by protocols officially endorsed by the respective member-agencies of the team, whereas the committee is conducted on a more *ad hoc* and casual basis. Some, but not all, of the benefits identified in this section can also be achieved through the less formal consultation committee format. In the hospital setting, multidisciplinary consultation committees are probably more prevalent than multidisciplinary child abuse teams, which are predominantly community-based and multi-agency in nature.

First, multidisciplinary teams help to improve communication between professionals and promote understanding of the policies and procedures of the various organizations involved as well as the types of constraints they must operate under as a result of legislation-imposed

criteria. (The investigators of a nationwide survey of mandated professionals reported that the “best CPS situation we encountered benefited from regular consultative interaction with the local professional community”⁽²⁹⁾.) Second, teams help to facilitate sharing of case information among the professionals involved, streamline data collection, and reduce operational redundancy, thereby saving everybody’s time. (Certain regulations may need to be amended to permit freer exchange of information among members of child abuse teams^(3,85).) Third, the multidisciplinary team is a good environment for sharing expertise and knowledge (medical, legal, psychosocial, nursing, child development, etc.), and fostering mutual respect and cooperation. Fourth, with better coordination and case planning, teams may help achieve better results, including reducing traumatic experience for the child-victim (especially in sexual abuse) and the family when multiple professionals or investigators are involved⁽³⁾. Fifth, as a result of improved communication and information gathering, a much higher conviction rate for child sexual abuse prosecutions is achievable⁽³⁾.

It should be noted that a key success factor of multidisciplinary child abuse teams is a detailed, realistic protocol, approved by the chief executive officers of the organizations involved¹¹. Top-level agency commitments of staff resources are critical. Further, it is useful to note that the Temporary Commission of Investigation of the State of New York considered the establishment of multidisciplinary child abuse teams and the use of inter-agency protocols as an important first step in revamping the state’s child protection system. The Commission made this key recommendation after extensive research and consultation with U.S. and United Kingdom experts in child abuse management.

2.5.5 Training

It is clear that with regard to psychosocial issues medical practitioners need training in identification and treatment to improve their handling of child abuse cases^(3,13,47,50,59,61). It is important that hospitals take immediate steps to ensure that psychosocial training is

¹¹ Special protocols are needed to coordinate simultaneous criminal and civil proceedings, a likely scenario for certain child sexual abuse cases in Canada⁽⁸⁶⁾.

provided to all medical staff with responsibilities in child abuse identification. In addition, special training in diagnosis and gathering of information on child sexual abuse has been identified as a pressing need^(3,48,69).

It is not easy for a health care professional to explain the limits on confidentiality under the mandatory reporting law without eroding a

patient's trust. Further, it can be difficult to maintain a viable clinical relationship with the patient after the reporting of child maltreatment. Doing it right requires a high degree of sensitivity, excellent judgement, and a high level of clinical skills^(54,58,60).

Appropriate training is needed on explaining reporting obligations to parents after a report is made of suspected child abuse.

3.0 Reporting Child Abuse: Canadian Legislation and Case Law

3.1 Introduction

There is now a widespread recognition that children are vulnerable to various forms of abuse and neglect — often perpetrated by parents, caregivers or other trusted adults — and that the protection of children requires a legal regime that supports the reporting to child welfare authorities of situations in which children are at risk of abuse or neglect, so that there may be an investigation and appropriate intervention.

The legal regime that governs the reporting of child abuse and neglect has been enacted in a society that also has very substantial respect for individual privacy and personal autonomy. For example, in general there is no obligation on Canadian individuals to report suspected crimes perpetrated by fellow citizens, let alone family members, to the police. Legislation and codes of ethics restrict the disclosure of information by professionals about their patients and clients. Although Canadian law generally gives priority to the protection of children over the privacy interests of adults, there are significant tensions between these competing concerns and substantial variations in how different Canadian governments and judges have balanced these competing interests.

Concerns about under-reporting of physical abuse resulted in the enactment of Canada's first child abuse reporting laws in the mid-1960s. The growing awareness of the inadequacy of the social and legal responses to child abuse and neglect led to further changes in the civil and criminal law in the late 1980s and early 1990s to make the legal system more responsive to the needs of children.

Reporting laws are only a small part of the legal regime that responds to the problem of child abuse and neglect. They play a critical role, however, in encouraging the reporting to child protection authorities of all cases in which there are reasonable grounds to believe that a child may be at risk of abuse or neglect, and then allow investigation and response as appropriate.

Although there are significant variations in the laws in different Canadian provinces and territories, in general these laws are intended to promote reporting by sanctioning those who fail to report. The laws also encourage reporting by providing legal protection to those who in good faith report cases that turn out to be unfounded.

A primary purpose in enacting reporting statutes is educational, to provide a focus for informing the public and professionals of their obligations to children. Prosecutions for failure to report are relatively rare, and almost all the reported Canadian cases involve professionals, generally health care professionals. The existence of legal sanctions also encourages those responsible for professional education to include child abuse and the relevant legal obligations in their programs and courses.

The existence of a legal duty to report child abuse and neglect is also important for professionals in their relationship with parents. If parents learn that a person has reported them to the child welfare authorities, this will usually place a great strain on their relationship with the reporter. In most provinces there are legal provisions or policies that attempt to shield the identity of the reporter, but if the reporter is a professional, the parents are likely to know his or her identity. It can be important for a professional, who may have to or want to maintain a relationship with the parents, to be able to emphasize that reporting suspicions of abuse is not a matter of choice but of legal duty⁽⁸⁷⁾.

An emerging legal issue has been the imposition of civil liability on those who fail to report when such failure results in a child's suffering further abuse. The prospect of civil liability both encourages reporting and provides compensation for victims of abuse who suffer further injury because of a person's failure to report.

3.2 The Duty to Report Child Abuse and Neglect

3.2.1 The offence provisions

In every Canadian jurisdiction except the Yukon¹² there is legislation that creates a duty to report cases of suspected abuse or neglect of children (excerpts from Canadian reporting statutes are contained in Appendix A). The reporter does not need to know that abuse or neglect has occurred; it is sufficient for there to be “reasonable and probable grounds to believe”⁽⁸⁸⁾ that it has occurred, or “reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse”⁽⁸⁹⁾.

In every jurisdiction the obligation arises with regard to physical and sexual abuse. There is, however, some variation in the types of situations that must be reported. In most provinces the obligation extends to all situations in which a child is believed to be “in need of protection,” which can be quite a broad concept. This may include, as in Manitoba⁽⁹⁰⁾, situations in which a child is “beyond the control” of a parent or, as in Newfoundland, the child is exposed to severe spousal abuse even if he or she is not a direct victim of abuse.

In some provinces, for example New Brunswick, a legal sanction is imposed only for a failure to report a narrower range of situations of abuse of the child, for instance when a person has reason to “suspect that a child has been abandoned, deserted or emotionally neglected, physically or sexually ill-treated or otherwise abused”⁽⁹¹⁾. Those situations in which a child may be in need of protection but abuse is not involved are not included in the mandatory obligation to report.

Although there is a range of situations that jurisdictions treat differently for reporting purposes, for a common core of situations involving abuse and neglect there is an obligation to report. The reported Canadian cases in which individuals have been prosecuted or faced civil

liability for failure to report have usually involved cases of physical or sexual abuse with clear evidence of abuse.

3.2.2 The standard of care: professionals and others

In a number of Canadian jurisdictions, health care providers, teachers and other professionals who perform duties with respect to a child are held to a higher standard of reporting abuse and neglect than others.

In Ontario and New Brunswick, those who are not professionals are statutorily required to report, and are granted civil immunity for reporting in good faith cases that turn out to be unfounded. However, in those two jurisdictions it is considered unfair or inappropriate to impose a penalty for non-reporting on ordinary citizens, and only professionals who fail to report are subject to prosecution¹³. One concern is that it might be inappropriate, for example, to prosecute a spouse or grandparent who fails to report that a parent may have abused a child. There is also a recognition that those who are not professionals lack the training to identify evidence of abuse, or may be ignorant of abuse reporting laws, so it might be unfair to prosecute them.

In other jurisdictions, the balancing of these concerns with the desire to protect children results in different statutory provisions. In Nova Scotia, professionals who provide services with respect to a child face a maximum penalty, upon conviction for failing to report, of \$5,000 or one year’s imprisonment, or both, whereas non-professionals face only a maximum penalty of \$2,000 or six months’ imprisonment, or both⁽⁹²⁾.

The Quebec statute recognizes that all adults who come into contact with children should take steps to assist in their protection from the most obvious forms of abuse, while requiring professionals to report in a broader range of situations. Under the *Youth Protection Act*⁽⁹³⁾,

¹² As discussed later, in the Yukon it is not an offence to fail to report, but those who report in good faith are entitled to civil immunity.

¹³ It is interesting to note that in Ontario the offence provision refers only to professionals providing services with respect to a child, whereas, for example, the New Brunswick statute simply refers to a professional person who acquires information in the discharge of the professional person’s responsibilities. This suggests that in Ontario a professional who, in the course of treating an adult believes that the person may have abused a child, does not commit an offence for failing to report. The argument suggests that a psychiatrist treating a pedophile might not be convicted for failing to report reasonable suspicions of child abuse. However, even in Ontario, a professional in this situation might have civil liability to the child if the failure to report results in further injury.

professionals commit an offence if they fail to report when they believe on “reasonable grounds” that a child’s security or development is in danger. This is defined in a broad range of circumstances, including failure of parents to take appropriate measures when a child has “serious behavioural disturbances” as well as situations of serious emotional rejection. Those who are not professionals providing care or assistance to children commit an offence only by failing to report a child believed on reasonable grounds to be “the victim of sexual abuse or . . . subject to physical ill-treatment through violence or neglect” — a narrower range of situations than applies to professionals.

With regard to situations in which suspicions of abuse or neglect could reasonably be expected to be reported, individuals in all jurisdictions are held only to the standard of care of a “reasonable person” with their training and position. This point was made in a 1984 Ontario decision, *R. v. Strachula*, in which a family doctor was charged with failing to report child abuse⁽⁹⁴⁾. The Crown introduced testimony from a pediatrician with expertise in child abuse that the accused family doctor should have suspected child abuse. In acquitting the accused, Judge Main stated:

The words [of the reporting statute] “every person who . . . in the course of the person’s professional or official duties” carry with them the implication that there is a distinction which must be made between the various classes of such professionals and that there is no universal standard of care applicable to all such persons, but rather a standard of care particular to the class in question . . . The standard of care applicable to paediatricians skilled in child abuse should not be the standard of care applicable to family practitioners or to others such as public health nurses, school teachers, family service workers or child care workers to name a few. The relevant standard must vary in accordance with the professional capacity of the person . . . involved.

This reasoning also suggests that a family doctor might be reasonably expected to identify and report abuse where a teacher might not. In those jurisdictions where non-professionals may be prosecuted, they would be expected to identify

and report only in the most apparent situations of abuse. In fact, the only reported cases in Canada of prosecutions for non-reporting of abuse or neglect have involved professionals, almost all of them health care professionals, who have the most training in identification of child abuse and the most education about their legal obligation to report.

In one Ontario case⁽⁹⁵⁾ two doctors were charged with non-reporting: an 18-month-old boy was seen in the office of one of the doctors and at the hospital emergency room on several occasions by the other doctor. The child had bruising around his penis, scrotum, stomach and legs, a tear in the penis and suspected internal injuries. The parents said the injuries occurred as a result of the child falling off a riding toy. Several experienced nurses urged each doctor to report suspicions of abuse to the child protection authorities, but the doctors declined to do so.

It was later learned that the boy had been abused by a mentally retarded uncle, and the doctors were charged with failing to report. The doctors both denied suspecting abuse, but the court convicted them, finding that there were reasonable grounds for a doctor in this position to suspect abuse, especially in light of the concerns expressed by the nurses and the hospital reporting policy. The doctors were fined \$400 each, and in later professional disciplinary proceedings suspended from practice for one month⁽⁹⁶⁾. The Ontario College of Physicians and Surgeons felt that the doctors “turned a blind eye” and should have suspected abuse (Discipline Committee, October 1990).

It should be noted that everyone who has reasonable grounds to suspect abuse has a duty to report, and that in theory the nurses in this case also could have been charged. A person may, however, satisfy the duty directly, or by ensuring that a colleague or other person makes the report to the child welfare authorities.

3.2.3 Reporting of extra-familial abuse

In several Canadian jurisdictions, the obligation to report is defined as arising when a child is abused or neglected by a parent/guardian or other person having “charge of a child.” This definition excludes from the reporting requirement abuse perpetrated by a stranger, or some other extra-familial person “not having charge of the child.” The rationale for this

restriction is that the obligation of a child welfare agency to investigate and respond to abuse arises only when the parents or guardians are unwilling or unable to protect the child, and in extra-familial situations it is the parents or guardians who should protect the child and determine what type of treatment or response is appropriate.

There have been a number of reported decisions from Ontario in which professionals have been charged with failing to report abuse and have argued that they should be acquitted since the alleged perpetrator did not have “charge of a child.” In one 1984 decision⁽⁹⁷⁾, Judge Main of the Ontario Family Court acquitted a doctor charged with failing to report that a 14-year-old girl, impregnated by her 16-year-old brother, was a victim of abuse, as the Crown did not prove that she was “in his charge.” In a 1995 decision Judge Abbey acquitted another doctor who failed to report that a young child had been sexually abused by her uncle⁽⁹⁸⁾. Although the child may have been alone with the uncle when the abuse occurred, there was no evidence that, in law, he had “charge of the child”; on the contrary, the mother had charge of the child, and there was no evidence that she had “failed to protect the child.”

In a 1987 Ontario decision⁽⁹⁹⁾, Judge Gotlib overturned a lower court acquittal and convicted a day care operator for failure to report to child welfare authorities that one of the staff had been excessive in disciplining a child. The appeal court ruled that the *Ontario Child and Family Services Act* was not intended solely to protect children from abuse by parents, and that the words “having charge of a child” were broad enough to include a staff person at a day care centre who was, at the relevant times, working without the direct supervision of the day care operator. However, the judge acknowledged that it is “singularly difficult for a lay person to interpret the legislation about which lawyers quarrel,” and taking account of the uncertainty of the statutory provision and the fact that the child suffered no injury, imposed an absolute discharge of the sentence for failure to report.

In Nova Scotia and Manitoba the reporting legislation makes clear that there is an obligation to report any suspected abuse of a child by any person. This broader reporting provision is related to the existence of a “screening register” in both

these provinces. As discussed more fully later, in Nova Scotia and Manitoba child protection agencies are responsible for the investigation of extra-familial abuse (generally in conjunction with the police) so that the names of abusers can be placed on a register and those persons can be screened from assuming volunteer or paid positions of responsibility over children.

3.2.4 Penalties for non-reporting

As indicated in Table 3.1, there is substantial variation in the maximum penalty for failing to report child abuse or neglect. The maximum fine ranges from \$500 in Manitoba and the Northwest Territories to \$10,000 in Newfoundland and British Columbia. Only Quebec has a minimum fine — \$200. Nova Scotia professionals who fail to report abuse face a higher maximum sentence (\$5,000 and one year’s imprisonment) than ordinary citizens (\$2,000 and six months’ imprisonment). This reflects the view that professionals are generally better informed about their obligation to report and have special responsibilities to children.

Although most jurisdictions allow for a jail sentence for non-reporting, the reported cases suggest that a fine is the usual penalty, reflecting the “educational” intent of these provisions. It is apparent that, for most individuals, the threat of prosecution is not a major factor in their decision to report. Rather, it is a feeling of moral obligation to children and society and, in the case of professionals, the threat of professional discipline and civil liability that motivates reporting.

3.2.5 Limitation periods and past abuse

In every jurisdiction where the failure to report abuse or neglect is an offence, the offence is “summary.” This means that the prosecution is conducted in a provincial or territorial Court, by a judge sitting without a jury.

The ordinary limitation period for commencing summary prosecution is six months after the date of the alleged offence. In some cases of non-reporting, the failure to report may not come to the attention of the authorities for months or even years after the offence occurred. In most jurisdictions, such cases are barred by statute from prosecution, though in some provinces the reporting legislation creates a

**Table 3.1
Provincial Legislation* Regarding Reporting of Child Abuse and Neglect**

	Offence Not to Report	Offence Only for Professionals	Maximum Penalty	Special Limitation Period	Good Faith Civil Immunity	Confidentiality Assured	Offence to Harass Reporter	Specific Duty to Report	Statutory Duty of Child Welfare To Notify	Solicitor Client Privilege Maintained	Report to Child Protection or Police	Statutory Child Abuse Register	Offence to Knowingly Make False Report
NFLD	YES		\$10,000 and 6 mo. jail	3 yrs.	YES		YES				CP/police		
PEI	YES		\$1,000		YES	YES				YES	CP/police		
NS	YES	Higher maximum penalty	\$2,000 and 6 mo.; for professionals \$5,000 and 1 yr.	2 yrs.	YES			YES		YES	CP	YES	
NB	YES	YES	\$1,000 and 6 mo. jail		YES	YES, unless court	YES		YES	YES	CP		
QUE	YES		\$2,500		YES	YES				YES	CP		
ONT	YES	YES	\$1,000		YES					YES	CP	YES	
MAN	YES		\$500 and 3 mo. jail		YES	YES, unless court	YES	YES	YES	YES	CP	YES	
SASK	YES		\$5,000 and 6 mo. jail		YES					YES	CP/police		
ALTA	YES		\$2,000, 6 mo. if default		YES	YES, unless Minister consents				YES	CP		
BC	YES		\$10,000 and 6 mo. jail	Unlimited	YES	YES, unless Superintendent consents				YES	CP		YES
YK	NO				YES						CP/police		YES
NWTT	YES		\$500 and 6 mo. jail		YES					YES	CP		

*See Appendix A for relevant reporting statutes.

special limitation period; in Newfoundland it is three years, in Nova Scotia two years and in British Columbia there is no limitation period.

In most jurisdictions, the offence legislation is written in the present tense, i.e., it requires reporting by a person who believes that a child “is” or “may be” in need of protection, or it at least has a sense of focusing on the present by requiring reporting of a child who “has been” abused rather than a child who “was abused.”

In Ontario, the reporting legislation was also originally drafted in the present tense. In *R. v. Cook* a family doctor was charged under the original legislation with failing to report the sexual abuse of a 15-year-old girl by her stepfather. The girl had disclosed to the mother that her stepfather had been fondling her breasts and legs on several occasions in the previous two years. The day after the disclosure the mother reported this to their family doctor — the accused — who told the mother to confront the husband, and that the mother, stepfather, and the daughter could return for counselling. About a week later the mother returned to the doctor and said her husband admitted the abuse and that she would no longer leave him and her daughter home alone; the mother also said that her husband would come to the doctor for counselling. The doctor did not report the abuse, but a few months later it was reported directly to the police, and the stepfather was charged. The doctor was then charged with non-reporting, but was acquitted by the trial judge, a decision affirmed by the Ontario Court of Appeal⁽¹⁰⁰⁾. The basis for the acquittal was that the Crown failed to prove that the doctor “reasonably” believed that a child “is suffering” from abuse, since she believed that the mother had taken adequate steps to protect the child. After the *Cook* decision the Ontario legislation was amended and now provides that the obligation to report arises if a professional has reasonable grounds to believe that a child “is or may be suffering or may have suffered abuse”⁽⁸⁹⁾.

Given the very narrow interpretation of the reporting legislation taken in *R. v. Cook*, it may be that cases will arise in other jurisdictions where those who are charged with failing to report may raise the same defence: that when they learned of the alleged abuse they were satisfied that the risk of abuse had passed and therefore there was no longer a duty to report.

It could, however, be agreed that *Cook* was wrongly decided and should not be followed in other jurisdictions.

3.2.6 Reporting to whom

The intent of reporting legislation is to ensure that appropriate steps can be taken by child protection authorities to investigate and protect children; it is not to ensure the reporting of crimes and the prosecution of abusers. Historically in Canada, child welfare agencies often would not report abuse to the police, except in the most serious cases, and prosecutions for child abuse and neglect were rare. Now, protocols between child welfare and police agencies require communication and cooperation. Child protection workers regularly report abuse and neglect situations to the police for possible prosecution, and joint investigations are common.

In most Canadian jurisdictions, reporting legislation requires a report of suspected abuse or neglect to the child protection authorities. In Newfoundland, Prince Edward Island, Saskatchewan and the Northwest Territories a person may satisfy the reporting obligation by reporting to child protection authorities or the police, with the police being obligated to report to the child protection authorities; the purpose of allowing reporting to the police in these jurisdictions is apparently a concern that individuals may have easier access to the police, especially in remote locales.

3.2.7 Privilege and confidentiality

In every jurisdiction with a reporting statute, the legislation specifies that individuals are obliged to report notwithstanding that the information otherwise be privileged or confidential. Thus, the reporting statute overrides statutory rules about confidentiality, for example, those relating to health care professionals. The reporting laws also override common law privilege, which might in some cases permit a priest to refuse to testify about a parishioner’s confession⁽¹⁰¹⁾. The Supreme Court of Canada does not recognize a complete privilege (right not to testify) for priests and other religious figures about conversations with parishioners, but it may be recognized, depending on the circumstances of a case.

Even in the Yukon, the only jurisdiction where failing to report child abuse is not an offence, the legislation makes clear that a professional who chooses to report that a child may be in need of protection is immune from professional disciplinary proceedings unless the report is made “maliciously and falsely”⁽¹⁰²⁾.

In general, the courts have placed the reporting obligation ahead of concerns about confidentiality. In *C.A.S. of Hamilton Wentworth v. M. (T.)*⁽¹⁰³⁾, Steinberg J. held that the duty of the police to report abuse takes precedence over obligations of confidentiality about police investigations in the Ontario provincial *Freedom of Information and Protection of Privacy Act*. Police and coroners therefore have a legal duty to report information about a deceased child who died in circumstances raising concerns about abuse and whose surviving siblings might be at risk; the child protection agency is entitled to information in police investigation records about the deceased child.

Similarly, a police officer who, in the course of his or her duties, learned that a priest may have sexually abused children in the past is obligated to report to the child protection authorities if there are concerns about the safety of other children⁽¹⁰⁴⁾. This obligation arises even if the officer is not the investigating officer, his superior tells him not to report, and the original complainant (victim) is no longer interested in pursuing the matter. The protection of children is a paramount consideration, and other children might still be at risk of abuse by the priest.

There is, however, one exception to the duty to report: lawyers. In all Canadian jurisdictions except the Yukon and Newfoundland, the

reporting legislation specifies that it does not abrogate the solicitor-client privilege, and therefore lawyers in these jurisdictions who learn information from their clients that leads them to suspect child abuse are not obliged to report to child welfare authorities. It is clear that in most jurisdictions in Canada a lawyer is not obliged to report abuse disclosed by a client because of solicitor-client privilege. An interesting question arises as to whether a lawyer may, in some circumstances, choose to report to child welfare authorities concerns about the possibility of future abuse. It is clear that a lawyer cannot directly disclose anything a client has revealed about the past. However, ethical codes like the Canadian Bar Association *Code of Professional Conduct* (1987) recognize (Rule 4, Comment 11) that “disclosure of information necessary to prevent a crime will be justified if the lawyer has reasonable grounds for believing that a [future] crime is likely to be committed and will be mandatory when the anticipated crime is one involving violence¹⁴. (See also *Child Abuse Reporting: A Challenge to Attorney-Client Confidentiality*, by Nancy Stuart⁽¹⁰⁶⁾.)

The exception to the duty to report extends to lawyers who represent children⁽¹⁰⁷⁾¹⁵. It is clear however, that in situations in which solicitor-client privilege does not apply, lawyers have an obligation to report. This might, for example, occur if in the course of a custody dispute the lawyer for one parent hears testimony in court from the other parent admitting abusive conduct.

In Newfoundland, the *Child Welfare Act*⁽¹⁰⁹⁾ s.38(5)(d) creates the obligation on professionals performing “duties with respect to a child” to

¹⁴ In writing about the issue of confidentiality for lawyers, Gavin MacKenzie comments as follows⁽¹⁰⁵⁾: “That an approach that weighs the competing interests in individual cases is preferable to an approach that invariably prefers the value of confidentiality may be demonstrated by considering . . . hypothetical clients . . . The . . . client is a father who has repeatedly abused his young children in the past, and who is still living with his children. A lawyer is representing him in a matter unrelated to child abuse, but nevertheless learns of the abuse in her professional capacity. The children are virtually certain to be abused repeatedly in the future unless authorities intervene. The abuse is likely to have severe hidden consequences for the children, who are likely to have a distorted notion of society and who may well become abusive parents themselves some day if no one acts to put an end to the abuse and provide counselling. Advising the client to discontinue his criminal acts is ineffective. Here the likely damage to innocent and helpless third parties should weigh heavily. The case for requiring disclosure of the client’s continuing crimes is strong, despite the chilling effect of such disclosure on solicitor-client communication in the future.”

¹⁵ The Law Society of Upper Canada comments⁽¹⁰⁸⁾: “The Sub-Committee . . . rejects the suggestion that there is a duty on the solicitor to make any disclosure to the court, or to anyone with respect to information in his possession acquired in the course of the solicitor and client relationship, even when, in the opinion of the solicitor, it is in the best interests of the child to act contrary to the child’s instructions. The solicitor is not the judge of the best interests of the child, and is not, under any circumstances, to be excused for a breach of the solicitor and client relationship. If the solicitor does not believe he can accept the instructions of the child, then he should withdraw from the matter. He should, in all events, conduct himself as if he was acting for an adult.”

report suspected abuse, and specifically includes solicitors. Section 38(6) provides that the reporting requirement applies notwithstanding that the information is privileged. This is the only province that does not explicitly maintain the solicitor-client privilege for child abuse reporting, indicating that it may not apply, at least for lawyers providing services “with respect to a child.”

3.2.8 Researchers privilege

In general, a person in Canada who is doing research and in the course of interviewing parents, children or others learns of a situation in which he or she should reasonably suspect child abuse, the researcher is legally obliged to report the abuse. Even if the promise has been made that any information or answers will be confidential, or that the identity of respondents will not be revealed, an obligation to report may arise.

The obligation of researchers to report child abuse is very different from other situations in which a social science researcher promises confidentiality and asks questions about a range of issues, including possible criminal activity or drug issues. When there is no child abuse, a researcher who reported a suspected crime to police would be acting unethically, and might incur civil liability; there might also be a question of whether a statement or “confession” made to a researcher after a promise of confidentiality would be admissible in a criminal trial.

If a researcher should learn information about possible child abuse, however, child abuse reporting laws (in every Canadian jurisdiction except the Yukon) override any promise of confidentiality, and the information about suspected abuse must be reported. This raises an ethical problem for those researchers who ask parents questions that might reveal information about child abuse. Should these researchers advise respondents that they would have to report information about abuse?

There is one possible exception to the law that researchers must report abuse. The federal *Statistics Act*⁽¹¹⁰⁾ s.17 provides that researchers who have been sworn to secrecy under that Act and are carrying out studies for Statistics Canada cannot disclose any identifying information learned in the course of their research. There is no reported Canadian case law on how the federal legislation relates to provincial and territorial

child abuse reporting laws. However, the ordinary approach of Canadian law is that specific federal statutes are “paramount to” general provincial statutes that conflict. Thus, if Statistics Canada conducts a survey related to children or child abuse, and the interviewers are sworn to secrecy, the interviewers are prohibited from reporting suspected child abuse. This precludes reporting of child abuse by any interviewers in the National Longitudinal Survey of Children and Youth that is being conducted by Statistics Canada as part of its Household Survey.

3.3 Protecting the Confidentiality of Those Who Report

Reporting a situation of suspected abuse to child protection authorities can require courage. A family member may suffer guilt for exposing the caregiver, and other family members may be very hostile as a result of the report, even if it is justified. Likewise, a neighbour who expresses concern about a child can face open hostility or even threats of violence from an angry parent or caregiver. Even professionals who report abuse, like teachers or doctors, may be reluctant to have their identities disclosed.

In Prince Edward Island and Quebec, the legislation specifies that the name of a person who makes a report of suspected abuse to a child protection authority will be kept confidential. In New Brunswick and Manitoba, the name of a reporter may be revealed if that person consents in writing or if there are judicial proceedings. In Alberta, the identity of a reporter is only to be revealed with the consent of the Minister of Family and Social Services. In British Columbia, legislation ensures the confidentiality of the identity of the reporter, unless the Superintendent considers this necessary to ensure “the safety or well being of a child” or disclosure is required in court proceedings. In other jurisdictions, it is typically the policy of child protection authorities not to reveal the names of reporters to persons being investigated for suspected abuse, although the legislation does not specifically prohibit revealing the identity of a reporter of child abuse, and some agencies will reveal the name of a reporting person to the parent.

A 1977 English decision by the House of Lords⁽¹¹¹⁾ ruled that the child protection authorities cannot be required to reveal the identity of a person who reports child abuse. The case involved a report of abuse that proved unfounded after investigation. The parent was very upset and wanted to sue the person who reported the abuse for defamation. The House of Lords held that, even in the absence of explicit legislation, it would be contrary to the “public interest” to disclose the person’s identity. This type of common law reasoning should apply in Canada as well, at least to the extent that it is not modified by legislation. Canadian judges have refused to allow litigants to obtain the name of an informant from child welfare agency records in cases in which the agency has sought to protect the identity of the informant^(112,113).

Statutory provisions and policies may afford some protection to confidentiality for those who report, in particular for individuals such as neighbours, but in many cases the parent is likely to be able to ascertain the identity of the reporter from the circumstances of the case. In particular, if the child is older and has disclosed the abuse to a person like a doctor, the identity of the reporter may be revealed to the parents by the child.

In Newfoundland, New Brunswick and Manitoba it is an offence under the reporting statute for a person, such as a parent, to “interfere with or harass” an informant.

3.4 Good Faith Reporting and Immunity

One of the important features of Canadian child abuse reporting legislation in every jurisdiction is the granting of immunity from civil action for those who report child abuse. In most jurisdictions this protection is given as long as the report is not made “maliciously or without reasonable cause.” The intent of these provisions is to encourage

reporting of reasonable suspicions of child abuse, and leave to child protection authorities the responsibility of determining their validity.

The legislation in most jurisdictions grants immunity from an “action” for unfounded reporting. This clearly includes a civil action by a parent wrongly accused of child abuse, for example, for such torts as defamation (libel for a printed false statement and slander for an oral false statement) and infliction of mental suffering. It has been held that the term “action” includes a disciplinary proceeding⁽¹⁰⁴⁾, for example, for a police officer or other professional who reports abuse¹⁶.

There have been no reported Canadian cases in which a parent has been able to pursue an action against a professional or other person for making an unfounded allegation of abuse or neglect to a child protection agency.

In the United States, where civil suits are more common than in Canada, a significant number of suits have been launched by parents against individuals who made reports of suspected abuse that ultimately proved unfounded. The U.S. courts have usually dismissed them by invoking “good faith immunity” provisions of child abuse reporting legislation. In order to encourage reporting, the U.S. courts have taken a broad interpretation of “reasonable grounds” for reporting. Professionals or para-professionals who are not acting maliciously will be liable in a civil suit only if they were “grossly negligent” or making “unnecessarily irresponsible” remarks. A person reporting in good faith on the basis of a child’s disclosure of abuse will usually be within the protection of these legislative provisions, even if the complaint should later prove unfounded¹⁷.

Reporting legislation grants immunity only for good faith reports of suspected abuse or neglect made to child protection authorities (and in some jurisdictions to police). Communications

¹⁶ In Quebec, the *Youth Protection Act*⁽⁹³⁾ s.43, in its English version, provides that no person may be “prosecuted” for reporting in good faith, an English term that seems limited to immunity from prosecution under provincial law. However, from the context and the French version (“poursuivre en justice”) it would seem that the term includes immunity from civil suit.

¹⁷ The following cases took a “broad and liberal” interpretation of the immunity provisions to restrict the scope for potential liability: *Sullivan v. Eastchester Union Free School District*⁽¹¹⁴⁾, *Voepel v. Cardinal Glennon Hospital*⁽¹¹⁵⁾, *Gross v. Myers*⁽¹¹⁶⁾, *Satler v. Larsen*⁽¹¹⁷⁾ and *F.A. v. W.J.F.*⁽¹¹⁸⁾.

In *Austin v. French*, unreported *Vir.* 1980, referred to in *D. Besharov*⁽¹¹⁹⁾, the court held that a case could proceed to trial by jury when parents were suing a doctor for malicious or negligent reporting. The court appeared to be of the view that liability could only be imposed if the doctor was grossly negligent or had made unnecessarily irresponsible and defamatory remarks.

about suspected abuse that are outside the legislation are not granted statutory protection. Thus, for example, if a doctor is considering whether to report, and discusses a case with a colleague before reporting to the child protection agency, the discussion is not technically covered by reporting legislation. However, the courts have developed the doctrine of “qualified privilege” which protects the sharing of information in appropriate communications by those who have an honest belief in the validity of an allegation of abuse, or a legitimate interest in discussing suspicions of abuse.

In one British Columbia case⁽¹²⁰⁾, two adult sisters disclosed to a therapist that they believed they had been sexually abused by their father, and later disclosed their allegations to their mother. The father began a defamation action against his daughters, based on his claim that the allegations were false. Justice Dorgan, of the British Columbia Supreme Court, ruled that unless the father could prove actual “malice” on the part of the daughters in making their allegations, he could not succeed in his defamation suit even if the allegations were untrue. The judge invoked the doctrine of “qualified privilege” and dismissed the action without a trial. The judge commented:

If the law did not recognize communications of this nature as being privileged, little protection would be afforded those members of a family who stand in most need of it. In my view it was entirely appropriate for the defendants, each of whom believed their father had abused them as young children, to turn to their mother, confide in her, and to seek her guidance and support. It was also appropriate that they sought professional help.

The judge went on to reject any possible claims of malice.

While the plaintiff [father] may truly believe that his daughters’ allegations spring from some sort of malicious motive on their part to harm him, and that therapy which tends to revive childhood memories is highly suspect, this belief does not constitute evidence in support of an argument of express malice unless there exists other evidence.

The conduct of these defendants [sisters] is wholly consistent with behaviour of

individuals who truly and honestly believe they were abused as children. Their communications, subject to qualified privilege, are consistent with those made by persons wishing to seek psychological help and therapy in order to resolve the emotional consequences of what they believe to have happened. I cannot conceive of the defendants’ providing evidence . . . which would satisfy the burden on the plaintiff to prove malice.

This British Columbia case can be contrasted with the Saskatchewan decision in *R.G. v. Christison*⁽¹²¹⁾, in which the parents were involved in an acrimonious custody dispute. The mother made repeated allegations of sexual abuse against the father and his new partner (both of whom were physicians). The mother’s allegations were investigated by child protection authorities and the police and were found to be baseless. However, the mother’s counsellor continued to support her in the claims of abuse, while other experts and assessors rejected them. Even after the child welfare authorities, police and courts rejected the allegations, the mother told various professionals, including teachers of the children, about her allegations and distributed a supporting report from her counsellor without telling the individuals who received the report that the claims had been investigated and rejected.

The father and his new wife sued the mother and her counsellor for defamation and infliction of mental suffering. The court ruled that the distribution of the report to members of the community was not protected by the statute. The judge accepted that a parent has a “qualified privilege” that allows the sharing of “good faith” but inaccurate information about possible abuse with professionals who work with the children. But here the court found that the mother was motivated by “malice” since when she distributed the reports she knew that they had been investigated and found baseless. The court had some sympathy for the position of the mother, and did not want to bankrupt her since she had joint legal custody and liberal access to the children; the mother was held solely liable for only \$1,000 in aggravated damages.

However, there was no such sympathy for the counsellor, who was found negligent by the

in the way that she assessed the case, wrote her report and identified with just one parent, and she had sole liability for \$15,000 in aggravated damages; the mother and counsellor were held jointly liable for \$27,000 for loss of reputation and various expenses suffered by the plaintiffs.

In the Yukon and British Columbia, individuals who make unfounded reports of abuse knowingly or without acting in good faith may be prosecuted under provincial child abuse reporting laws, which make it an offence to maliciously or knowingly make a false report. In any jurisdiction, the making of a knowingly false report with the intent to harass another person might also give rise to a charge of mischief under the *Criminal Code*.

3.5 Civil Liability for Failure to Report

In addition to the possibility of being prosecuted under provincial reporting laws for a failure to report abuse, individuals who fail to report reasonably suspected abuse may be sued by the child (or the child's representative) for monetary damages. While in theory any person who negligently fails to fulfil the statutory obligation to report abuse or neglect might be sued, in practice it has been professionals, and in particular health care professionals, who are sued. This is because these professionals are often in the best position to identify and report abuse, and their failure to do so can have grave consequences. These professionals (or their insurers) are also more likely to be able to satisfy any judgement than uninsured individuals.

For the past two decades the U.S. courts have accepted that a professional who fails to report suspicions of abuse that should reasonably have been identified and reported (by a professional with the qualifications of that person) may be liable to the child¹⁸. The failure to report exposes the child to further injuries, and if further injury occurs the person who failed to report may be liable for that injury, even though the injury is committed by another person. The abuser may also be liable, but generally these individuals are

insolvent and the person who failed to report (or the insurer) may have to bear the full financial liability.

This principle was first applied in Canada in a 1997 Alberta decision that held a radiologist liable for damages for brain injuries inflicted on a three-month old baby by her father⁽¹²⁵⁾. The baby was taken to the hospital by her parents, suffering from lethargy, crying and listlessness. Radiography of her skull was carried out, which revealed a bilateral subdural hematoma indicative of shaken baby syndrome. The radiologist did not report these x-ray findings to the treating physician; the baby's condition improved and she was released a few days later. Four days after her release, the baby returned to the hospital suffering from very severe brain damage that caused her to be severely disabled and dramatically reduced her life expectancy. The child protection authorities and police were notified at that time. Although the court in this civil suit found that the father caused the injuries by shaking the child he was never charged by the police.

After hearing extensive expert evidence, the court concluded that the radiologist was negligent for not reporting at the time of the first radiographic examination that the child *may* have been a victim of "shaken baby syndrome." The judge recognized that even if the doctor reported to the child protection authorities at that time, the child *might* have eventually been returned to the care of the parents and suffered the same injuries. Accordingly, although total damages were assessed at over \$300,000, the radiologist was found only 50% liable, with the reduction in liability reflecting the uncertainty over whether the failure to report was causally linked to the injuries.

3.6 Professional Discipline for Non-reporting

In addition to the possibility of prosecution or civil liability for failing to report abuse or neglect, there is the possibility of professional disciplinary sanction for non-reporting. In

¹⁸ See *Landeross v. Flood*⁽¹²²⁾, in which the principle of liability of the doctor was accepted for failing to report abuse; *O Keefe v. Osorio*⁽¹²³⁾, in which the jury awarded \$186,851 against a doctor who negligently failed to report physical abuse of a one-year-old child because the doctor believed the parent was receiving adequate psychiatric care; and *Brown & Truitt* ⁽¹²⁴⁾ and *Bailey*⁽⁸⁷⁾.

theory, such professionals as teachers, police officers and psychologists can be disciplined for non-reporting, but in practice it is health care professionals, and in particular doctors, who seem most likely to be sanctioned by their professional disciplinary bodies.

In Manitoba and New Brunswick child abuse reporting laws explicitly discuss notification by child protection authorities to professional bodies when a professional has failed to report. There is discretion about whether to report the professional, but if a report is made the professional disciplinary body is obliged to conduct an investigation.

Even if child abuse reporting laws do not specifically mention that a professional may be disciplined for non-reporting, there may be disciplinary action. In one Ontario case, two physicians failed to report a case of suspected child sexual abuse to the child welfare authorities, despite the recommendation of nurses that they do so⁽⁹⁵⁾. They were convicted under the provincial child protection laws of non-reporting of abuse, and fined \$400 each. Subsequently, each was charged with “professional misconduct” by the College of Physicians and Surgeons of Ontario⁽¹²⁶⁾, and after being found guilty by the Discipline Committee, each was subject to a one-month suspension, a sanction with much greater financial and professional consequences than the fine. In imposing its sanction, the Committee commented:

It is hoped that this case involving two otherwise conscientious, competent and caring physicians will remind all other members of the profession to remain vigilant and to act on reasonable ground of suspicion of child abuse. Furthermore, it is incumbent on all physicians to remain current with the law and with the expectations of society.

3.7 Child Abuse Registers

A number of Canadian provinces have statutory child abuse registers. In these jurisdictions, child protection agencies are required to report cases of

abuse to the centralized register, whose purpose is to help track and identify child abuse cases, and to provide information for research purposes. Proponents also argue that placing an abuser’s name on a register may act as a deterrent to further abuse, which may be especially important if no criminal prosecution is commenced.

Ontario’s controversial register is currently under review⁽¹²⁷⁾. At present, an individual on the register may be identified as an abuser if there is “credible evidence” that the acts occurred⁽¹²⁸⁾. In practical terms, this means a child protection worker’s strong belief that abuse occurred is sufficient evidence to justify placing a name on the register, even without legal proof of the abuse. However, alleged abusers do have a right to a hearing before a tribunal, at which the agency must establish “credible evidence” of the abuse. Further, access to the register in Ontario is limited, and in most cases it is used only by child protection staff and researchers. The Ontario register cannot be used for screening purposes.

In contrast, legislation in Nova Scotia and Manitoba provides that placing a name on the abuse register requires proof on the ordinary civil standard, the balance of probabilities. This legislation allows a review process for named individuals, including an appeal to the courts. However, access to the register in Manitoba and Nova Scotia is significantly wider than in Ontario and permits screening of individuals seeking employment or volunteer work in positions of responsibility with children.

Other Canadian jurisdictions do not have statutorily required child abuse registers. Some, like Alberta, do have a centralized province-wide computerized database of all child protection cases. This can be used for tracking children whose parents may move around the province. Quebec’s *Youth Protection Act* s.27 also allows for such a province-wide confidential record to be established.

4.0 Reporting and Classification of Child Abuse in Selected Hospital Sites

4.1 Introduction

Given the problems associated with the identification and reporting of suspected cases of child abuse discussed in Section 2.0 of this report, and the mandatory legal requirement to report all suspected cases in Canadian jurisdictions (with the exception of the Yukon) a survey was designed to collect preliminary information from a number of child abuse programs in hospitals across Canada. The survey instrument was based on the research that deals with strategies for increasing accurate reporting and appropriate responses to child abuse previously discussed in this report. It was anticipated that information collected directly from those who are experienced in dealing with the reporting of child abuse would be useful to verify and classify issues, and to identify recommendations for further action. Thus, eight sites across Canada were approached, and key informants were interviewed either by telephone or face-to-face, using an interview protocol (see Appendix B).

This section of the report presents a summary overview of the information on each program obtained by the interviewer. Issues identified by the respondents are summarized in the final part of the section.

The element common to all the sites is the existence of dedicated resources for dealing with the identification, reporting and/or treatment of child abuse. The sites selected represent a full range of models, from interagency, multi-disciplinary teams to hospital-based units or combinations of both. Although the multi-disciplinary child abuse team has been identified as having certain benefits (discussed in Section 2.5), to date no one model has been documented as being more effective than others. Thus, the specific purpose of this section of the report is to document how child abuse is identified, classified and reported in these selected sites.

4.2 British Columbia Children's Hospital Child Protection Service Unit (Vancouver)

Staff of the British Columbia Children's Hospital Child Protection Service Unit see approximately 700 patients per year, mainly from Vancouver and the Lower Mainland. These cases are complex (either because of the nature of the abuse or the number of agencies involved) and require tertiary medical assessment. The majority of maltreatment cases referred from outside sources have already been reported and investigated by either the Ministry for Children and Families or the police.

The program has 14 staff, including 8 full-time equivalents, and is funded by the hospital global budget with some additional funding from the Ministry for Children and Families and the University of British Columbia (for physicians' salaries).

The unit's mandate is to assess and provide consultation for all types of child abuse and neglect. The assessment process has a significant medical orientation — pediatrics and psychiatry have formal positions within the unit. The physicians working in the unit respond to in-hospital cases as part of an on-call system and also participate in the out-patient clinics that are run four days per week. The assessment process has a psychosocial component provided by personnel trained in social work and psychology. Further, consultation is offered to community physicians regarding identification of "grey zone" maltreatment cases (e.g., emotional neglect and reporting requirements). The unit strongly supports the involvement of both child protection workers and physicians in the community before it is brought in. The unit does not view the identification and reporting of child maltreatment cases as its primary role.

The provision of treatment by the unit is usually restricted to very difficult cases or short-term crisis intervention cases. The unit tends to see younger children — approximately 80-90% of physical and sexual assault cases are children under 10 years of age. The unit liaises with and also supports regional child protection

teams, province-wide, by reviewing complex cases and establishing protocols to manage these cases. The unit has developed specific protocols for physical and sexual abuse (see Appendix C). The protocols help increase knowledge and consistency of practice, especially in dealing with cases of physical and sexual abuse. Protocols to help physicians with identification of less clear-cut cases were also identified as a priority. It was felt that protocols for primary medical care settings needed to be simple and concise (e.g., protocol to assess suspicious bruising or broken bones).

The majority of cases seen in the unit in 1997 involved allegations of sexual abuse (52%) and physical abuse (35%). The staff reported that a growing number of complex cases (e.g., families with multiple victims and emotional abuse/neglect cases) are being referred. The majority of new cases were referred from sources outside hospitals. Physicians in the community (64%) and child protection workers (31%) were the two most frequent outside referral sources.

Training is provided to a wide variety of individuals in the hospital, including nurses, medical students and residents, through lectures and direct experience in the unit. Training of community physicians has been established as a priority in order to improve the identification and reporting of child maltreatment. Currently, training consists of lectures held through continuing medical education programs that are not mandatory.

The legislation in place in British Columbia was felt by members of the unit to be adequate and the recent more specific definitions of conditions such as medical neglect were seen as being very beneficial.

4.3 Alberta Children's Hospital Child Abuse Program (Calgary)

The Child Abuse Program of Alberta Children's Hospital provided service to approximately 650 cases during 1997, mostly from the Calgary region. The program has 12 full-time equivalent non-physician staff. The program is funded through the Calgary Regional Health Authority and the hospital budget, and is supported by a contract for services from the Calgary Rockyview Child and Family Services Board along with funds donated from the private sector. The majority of

cases seen are referred by sources outside the hospital (85%), and a significant number of these referrals (40% of total) are from parents or guardians. The program has a strong commitment to provide consultation to the community: approximately 46% of cases are dealt with by telephone consultation or inter-professional consultation. Many of the telephone consultations are provided to physicians in the community concerning issues related to abuse identification, reporting and referral criteria.

The program is not directly involved with the provision of medical assessments for child maltreatment. However, physicians from the emergency room, community pediatrics, psychiatry, and gynecology are regularly consulted and work with program staff as members of individual case management teams. Also, the program staff coordinate specialist medical appointments. The nursing staff and some of the social work staff from the program devote a considerable amount of time to consultation/liason activities and program intake. The crisis response to child maltreatment cases is an initial investigation through the emergency or in-patient ward, followed by consultation with one of the on-call program staff (nursing, psychology, or social work).

The Child Abuse Program manager chairs an inter-agency liaison committee that focuses on "systems" issues between the hospital, social services, police, emergency rooms, and intensive care. This committee does not currently function like a child protection team.

The Alberta Children's Hospital Child Abuse Program has assisted in the development of protocols that are used in all hospitals in the region (see Appendix C). A strength of this protocol is the synthesis of relevant information regarding identification, which includes operational definitions of the various types of abuse and reporting guidelines.

In the most recent year, the majority of cases seen by the program were of sexual abuse (47%) and physical abuse (38%).

Training of other professionals is an important component of this program. Approximately 250 staff hours per year are devoted to teaching and training activities. The importance of physician training in the recognition of abuse/neglect was

recognized. The program receives many calls concerning this issue from community physicians.

The mandatory reporting of child abuse was recognized as having a positive influence on the tendency of physicians to report. A staff member who frequently takes calls from doctors indicated that reminding physicians to tell the child and parents that reporting is a legal requirement often reduces the guilt and anxiety that many may experience. Research has been an ongoing part of the program over the last 10 years and has resulted in the establishment of a database to track the epidemiology of child maltreatment and treatment effectiveness.

4.4 Winnipeg Children's Hospital The Child Protection Centre

The Child Protection Centre provides medical assessments and follow-up to approximately 750 patients and during 1998 recorded 1,500 contacts with the psychology, social work and child life resources of the centre. The catchment area is the province of Manitoba, as well as portions of the Northwest Territories and northwest Ontario.

The centre has been funded by the provincial government since 1982 and has 14 full-time equivalent positions including physicians.

The centre has the following non-legal mandate:

- assessment of physically abused, sexually abused and neglected children;
- early intervention with abusive families;
- consultation with professionals and other members of the general public;
- interdisciplinary and public education; and
- research (medical and non-medical).

Medical assessments by centre staff take place in the emergency room, in-patient units, and two out-patient clinic settings — the Child Protection Clinic (where more clearly defined cases of child abuse are seen) and the Child Development Clinic (where developmental and behavioural problems suggestive of abuse are seen). There are well-defined links to a psychosocial assessment process, which results in a short-term treatment plan. The centre does not provide treatment services. Physicians and other centre professional staff are part of five regional hospital/community committees that meet on a weekly basis to

coordinate medical, legal and social assessment and treatment for the victim and the family.

The regional committees also ensure follow-through on reporting and other accountability procedures. It is estimated that through this joint process the centre is involved in up to 95% of cases of child abuse reported in the hospital catchment area. The Child Protection Centre staff will make follow-up phone calls to ensure that reporting has occurred by a community physician. Protocols are used for identification and classification of abuse. However, the broad mandate of the centre allows the staff to rely on case management and follow-up provided by the hospital/community physical and sexual abuse committees.

The medical staff in the centre have worked to develop more precise definitions of abuse that are based on the medical, legal, and forensic research literature. For example, better knowledge and standardization of physical injury patterns has allowed other physicians to better identify and report cases of maltreatment (e.g., injury patterns seen in shaken baby syndrome). As a consequence, the centre is seeing more cases in the grey zone of abuse and neglect (e.g., Munchausen's by proxy syndrome and medical neglect), because community physicians are becoming more comfortable and competent in dealing with routine cases.

A priority identified in the centre's annual reports is the need for better knowledge and understanding by physicians of the psychosocial characteristics and dynamics of families that may indicate child maltreatment. The psychosocial assessment services of the Child Protection Centre are under considerable stress. A 1996 survey of need also identified as a priority the need to educate rural physicians in the areas of identification and reporting of child abuse.

The Child Protection Centre sees the full spectrum of child maltreatment cases and, as in other centres, the most frequent categories seen are sexual abuse cases (45%) and physical abuse cases (55%). The majority of cases are referred through a child protection service; however, 10% of cases are self-referred.

Training and education are also a major focus of the centre. These activities are seen as crucial for improving identification, reporting and

follow-up of child abuse in the community. Out-patient clinics are regularly attended by medical students and law students. Educational initiatives for training professional and community groups are extensive, on average involving 500-700 staff hours annually. The need for more formalized training programs for physicians was identified as a priority, especially for the identification of types of maltreatment such as medical neglect. The centre emphasizes the utility of having a “hand over” mechanism in place for physicians who report suspected cases of abuse. To encourage both identification and reporting, they feel there needs to be a clear plan outlined to the physician regarding what will happen next, including time line, other requests for information, need for accurate documentation at the time of reporting, and feedback once the initial investigation is complete.

4.5 The Hospital for Sick Children Suspected Child Abuse and Neglect (SCAN) Program (Toronto)

The SCAN Program receives approximately 700 referrals per year from across Metropolitan Toronto and province-wide tertiary level maltreatment cases. The program is staffed by three full-time social workers, two full-time secretaries, and three part-time physicians.

The program’s mandate is to provide multidisciplinary consultation, assessment and treatment support and services to hospital programs and community programs for all types of child maltreatment. The mandate and entry process is deliberately broad to encourage identification and reporting. As in other programs, the SCAN staff offer extensive consultation services to physicians, including coverage of identification and reporting issues. They also accept self-referrals from parents. In addition to providing in-patient and community consultation services, three out-patient clinics operate on a weekly basis.

The SCAN program uses investigative protocols that have been developed by the Toronto Child Abuse Centre ((416) 515-1100) and are implemented city-wide. As well, the program has its own internal protocols. Approximately two-thirds of cases seen are of sexual abuse, the

remaining third being either physical abuse or neglect cases.

The SCAN program trains residents and medical students to deal with child abuse cases and also organizes 10 or more continuing medical education programs per year for community physicians.

Lack of knowledge on the part of practising physicians, both in the community and in the hospital, was identified as an ongoing issue that needs to be addressed through development of more formal training programs. Further, as well as training in how to identify and report, physicians need training in how to follow up with the victim and family. Follow-up was seen as an important part of the feedback that could help to improve physicians’ awareness of the psychosocial aspects of child maltreatment and in the long term contribute to early and accurate identification of cases.

4.6 Hamilton Health Sciences Corporation Child Advocacy and Assessment Program (CAAP)

The Child Advocacy and Assessment Program assesses or provides consultation for approximately 200 cases of child maltreatment per year. In addition, about 100 adolescents are seen annually by an affiliated adolescent program in which issues of child abuse are a primary concern. The catchment area is the central west region of Ontario.

There are six funded, non-medical positions (five part-time and one full-time) in the areas of nursing, social work, child life, and program support. In addition, there are six physicians (two psychiatrists and four pediatricians) who work part-time within the program. Psychological services are available on a consultation basis along with other consultation resources such as dermatology. The program was initially funded through telethon dollars, but is now funded out of a global medical budget of the hospital.

The mandate of the program is to provide tertiary level consultation, assessment and short-term management for all types of child maltreatment. The program supports the philosophy that child maltreatment is a

community responsibility, and thus it has a limited involvement in the first-line identification and reporting process, except for in-hospital cases seen primarily by program physicians. Although there is no formal child abuse team in place, there is extensive consultation and liaison with police, child welfare and child protection on a case-by-case basis.

About 60% of referrals to the program come from the Children's Aid Society, with most of the remainder coming from community practitioners. The program specializes in complex cases (e.g., multiple victims within families) that are time-consuming and require multidisciplinary assessment prior to disposition.

Protocols to assist with the response to all types of child maltreatment in the emergency room setting are under development. Physicians working within the program receive many inquiries related to reporting and identification of sexual abuse and fewer for physical abuse cases.

The program is highly involved in conducting research, especially regarding the epidemiology of child maltreatment. Approximately one-third of cases reviewed by the Child Advocacy and Protection Program are sexual abuse cases, one-third physical abuse, and one-third neglect.

Training of physicians was a priority identified by the program. A critical part of reporting, in the view of the program, is the need to improve knowledge of physicians about psychosocial issues more specifically related to abuse. Suggestions for improvement include having a mandatory rotation in child maltreatment built into all residency training programs, especially those that have high contact with children and families, e.g., pediatrics, family practice, emergency room medicine, radiology, surgery, neurosurgery and orthopedic surgery. Training of residents is a priority in this program. For example, pediatric residents spend at least two months working within the program, and residents seeking a career in child psychiatry often spend six months working within the program.

The lack of resources for children who have suffered maltreatment and the lack of post-reporting feedback were also seen as contributors to physician under-reporting behaviour. Together with physicians' lack of knowledge they were identified as the most important barrier to accurate identification and reporting of abuse by physicians.

4.7 Children's Hospital of Eastern Ontario Child Protection Service (Ottawa)

The Child Protection Service provides assistance to referrals from eastern Ontario, west Quebec and the Northwest Territories Baffin region, where tertiary consultation or assessment is required. Approximately 500 of this larger number of referrals are subsequently investigated by child welfare authorities and the hospital's Child Protection Team.

The Child Protection Service has six elements:

- policies and procedures related to identification and management of abuse cases;
- a structure, including (a) the Child Protection Executive Committee, which addresses policy and procedure and which reports to the Medical Advisory Committee and (b) a Child Protection Team, which reviews all cases of children assessed for suspected abuse;
- specialist medical and allied health staff;
- education of hospital staff and community with regard to child abuse;
- encouragement of research on child abuse;
- advocacy for development of abuse prevention programs and treatment services.

The service has 5.4 full-time equivalent positions: 3 social workers, 1 pediatrician and 1.4 administrative support staff. It is funded out of the hospital budget and the University of Ottawa budget (for physician salaries). In addition, there are strong links to other services and departments within the hospital that can be called upon on a case-by-case basis (e.g., psychiatry or child life).

The service uses a child protection team model. The Child Protection Team reviews the case after the investigation stage, which may jointly involve Children's Aid Society and police, as well as hospital personnel involved in medical and psychosocial assessment. The purpose of this Team is to provide expert opinions and assist with case coordination. For children "at ongoing risk" it has an "alert" system. A written conclusion and disposition is prepared on all cases reviewed by the Child Protection Team.

The service has well developed protocols for dealing with all aspects of identification of the child at risk, definitions of abuse, and guidelines for child welfare and police involvement. These protocols are readily available and are included in the hospital orientation program for new staff (except physicians). The service is extensively involved in providing training to students who will encounter child maltreatment in their profession. The service also consults with other programs concerning its well-defined alert system and protocols.

The majority of cases seen by the team present to the emergency room, but may also be seen in out-patient clinics (which include a Historical Sexual Abuse Clinic) and wards. Approximately 30% of cases are of sexual abuse, 17% physical abuse, 43% at risk for abuse, 5% neglect and the remainder unclassified fetal or emotional abuse. Physical abuse numbers have increased since 1989.

The service has been involved in research projects and has taken leadership in recognition of shaken baby syndrome.

A number of priorities were identified by the service, including the following:

1. Changes in provincial legislation and child protection systems to
 - better define abuse, neglect and the child at risk — indicators need to be specific (e.g., description of emotionally harmful behaviour such as rejection or cruelty);
 - more effectively share risk-related information between child welfare and professionals;
 - permit feedback of suspected abuse regarding the outcome of the report to professionals and lay reporters; and
 - provide adequate resources for the protection of children.
2. Improved professional training.
3. Increased availability of treatment for abuse.

4.8 Montreal Children s Hospital Child Abuse Services

The Montreal Children's Hospital provides two different services, one that deals with physical abuse and neglect of children, and one that deals with sexual abuse of children. The services are linked through collaboration between physicians

and social services without a formal administrative link. The sexual abuse service has an acute sexual abuse response team that responds to emergency cases. Medical personnel on the team also have out-patient clinics at which they assess and consult on non-emergency cases involving sexual abuse. Protocols are used in the emergency room for handling these sexual abuse cases.

The hospital does not have a designated unit with dedicated resources for physical abuse and neglect; however, it does provide comprehensive assessment and consultation services for physical abuse and neglect using a child protection team model. There are no in-hospital treatment resources, but social workers who work on the team do provide crisis counselling.

The members of the child protection team include one pediatric physician, who is the director of the physical abuse/neglect service (also an emergency room physician), a general pediatrician, who may provide out-patient follow-up, a child psychiatrist, a nursing representative, the director of social work, a hospital social worker who liaises regularly with the pastoral services representative, and a representative from the department of youth protection (child protection agency). The team audits all cases of physical abuse/neglect seen at the hospital and also makes disposition recommendations on individual cases.

Guidelines have been established to deal with reporting issues regarding physical abuse and neglect, but there are no formal protocols. There are strong links between personnel in the emergency room, where the majority of cases present, and crisis social workers, who can provide information and assistance to physicians in the emergency room regarding identification and reporting. Medical consultation is also available by the director of the service.

The Child Abuse Services just recently began to track information on cases of physical abuse and neglect and hence was unable to provide statistics or breakdown according to the type of abuse. The service does have a method of flagging cases considered at risk for abuse. The service is involved in training activities for medical students as well as for pediatric and emergency room residents. Improved training for community physicians, including increasing awareness of mandatory reporting, were

identified as priorities. The need for the programs across Canada to have a formal mechanism to exchange information was also seen as important for the development of protocols and sharing of common barriers to identification/reporting in the medical community.

4.9 Izaak Walton Killam Hospital for Children Child Protection Team (Halifax)

The Child Protection Team at the Izaak Walton Killam Hospital for Children operates as a hospital-based child-focused team providing rapid assessment, management and treatment to approximately 460 (461 in 1997) children from the Maritimes referred because of allegations or concerns about physical, sexual or emotional abuse and neglect. The program has four full-time staff, including one full-time physician, and is funded by hospital and university sources.

In 1997, the program received its referrals from the Halifax/Dartmouth area (39%), the rest of the province of Nova Scotia (33%), the emergency room (18%), hospital programs (7%), and other Maritime provinces (3%). The team sees children up to 16 years of age.

The mandate of the Child Protection Team is broad. Its role is to provide comprehensive care for alleged victims of child abuse and neglect and their families through direct service, consultation, advocacy, education and collaborative research. A large part of the consultation mandate is to provide immediate assistance regarding any aspect of care, including reporting requirements in cases of suspected child abuse and neglect. Team members also provide medical-legal examinations and assessment of cases if there has been difficulty in validating abuse or there are concerns about credibility. Both short-term and long-term treatment is provided according to client need. Finally, the Child Protection Team provides case consultation and coordinates all aspects of child maltreatment cases with community members, including police, child welfare, law and community physicians.

Hospital protocols aid in the identification of children in need of protection, and there are guidelines for investigation and gathering evidence in cases of physical and sexual abuse. The community is encouraged to call the team early on when abuse is suspected so that

assistance can be given regarding documentation and reporting. In many cases, once the team is involved it will assume responsibility for reporting and follow-up of the abuse. Many community physicians find this preferable and less damaging to their relationship with the family.

The majority of referrals are related to sexual (55%) or physical abuse (30%). Emotional abuse reflecting neglect and failure to provide conditions represent 15% of referrals.

The program provides training to medical students and residents who are to work as part of the team, as well as to nurses and social workers. Team members lecture regularly to the medical students and give continuing medical education talks.

The key issues identified by this program included (1) under-reporting because of a lack of training related to abuse in rural communities; and (2) lack of knowledge of psychosocial factors that would negatively affect a child and the psychosocial/behavioural indicators of child maltreatment.

4.10 Common Issues

Most programs are servicing between 500 and 700 cases per year. The majority of cases are of sexual abuse, followed by physical abuse and neglect. Consistent with the trends identified in Section 2.0 of this report, all programs reported experiencing an increase in referrals in the maltreatment grey zone, such as emotional neglect, in which diagnostic criteria are poorly defined and thus often require extensive assessment before determination of risk or a clear disposition.

The respondents focused on certain issues relating to identification, reporting and defining of child abuse.

4.10.1 Identification issues

- Physicians are still perceived to be reluctant to identify abuse. All the factors mentioned in the literature review in Section 2.0 (e.g., attitudes towards child discipline, “appropriate” parenting and relationship with the family) seem to have important influences on identification thresholds.
- Physicians lack training in questioning patients (children and parents) about

psychosocial factors (especially indicators related to abuse) and hence may fail to identify child maltreatment.

- Physicians lack knowledge of and training in forms of abuse that do not have clearly identifiable physical indicators, i.e., grey zone cases.
- Primary care physicians may not have a mechanism in the fee schedule to be paid for the time it takes to conduct an appropriate interview for abuse identification and reporting.

4.10.2 Definition issues

- Definitions of child abuse for reporting purposes are often too legal or psychosocial for the medical practitioner to easily understand.
- Definitions, especially for neglect, are vague; the lack of specific indicators in definitions allows for individual interpretation and possibly lack of reporting.

- Definitions of reportable situations may not be readily available in medical practitioners' offices, requiring a call to child welfare or a hospital program in order to obtain the definitions before further steps are taken.

4.10.3 Reporting issues

- Physicians may not be aware of mandatory reporting requirements, especially in remote areas (which often have the highest incidence of abuse).
- Physicians may not understand their obligation to report cases in which there is a suspicion but no overt evidence of abuse/neglect.
- Physicians may not understand the reporting system — whom to call, protection of anonymity, etc.
- Lack of feedback after reporting was also identified as a major problem and potential barrier to physician reporting.

5.0 Recommendations Regarding the Reporting and Classification of Child Abuse by Health Care Professionals

The findings of this report suggest a number of areas for proposed action. Recommendations based on these findings are summarized below under two broad categories: Practice, Policy and Legislative Reform; and Research.

5.1 Recommendations for Practice, Policy and Legislative Reform

The recommendations for the practice of health care professionals who deal with cases of child abuse or maltreatment fall into three areas: training, support in making clinical and diagnostic decisions, and the use of special programs. More specifically, they are listed as follows:

- Comprehensive training programs should be developed for the identification, classification, reporting and treatment of child maltreatment, and these programs should be part of the required curriculum of all Canadian medical schools.
- In-service training for physicians who treat children and/or families should also be developed and made available to all practising physicians.
- Protocols should be developed for the handling of all types of suspected child abuse in all settings (e.g., in a hospital, a private community practice, etc.). These should also be made readily available to all practising physicians. (See example protocols in Appendix C.)
- Risk assessment tools to guide physicians in interviewing about psychosocial factors and other indicators of child abuse should be developed and made available.
- Consultation services regarding child abuse should be available to physicians either through direct contact (e.g., a specific member of a child abuse team) or, for physicians in more remote areas, through 1-800 numbers. Also, teams should be available to the community.
- Information packages on child abuse should be available to both physicians and their patients in all community clinics.

- Health care professionals who do report suspected child abuse to child protection services should receive feedback on why these cases were substantiated or unsubstantiated.
- Provinces and territories should review child abuse reporting laws; review should involve consultation with medical professionals, especially about the adequacy of definitions. Issues to be addressed include limitation periods, the professionals who will be required under law to report, the clarity of definitions, and the possible inclusion of extra-familial abuse.
- Physicians should be appropriately compensated for the additional time needed to conduct an assessment for suspected child abuse.
- If the flow of cases and size of the community warrant, special hospital-based child protection programs should be developed. In addition to developing targeted services for abused children, these programs could facilitate many of the practice recommendations listed above.

5.2 Recommendations for Research

The following suggested topics for research originated from this report. They are relevant to child abuse identification and reporting, practical and feasible to carry out. Given the lack of Canadian research in the area of child abuse as revealed in this report, the need for monitoring and research cannot be overstated.

- A number of barriers to the reporting of child maltreatment have been identified in the literature; proposed strategies for removing them also exist. An important issue of policy significance is how best to apply these proposed solutions to increase reporting probabilities. Well-designed and coordinated demonstration projects with a strong evaluation component could generate valuable information. In this regard, a number of demonstration projects could be designed to assess the effectiveness

of protocols, multidisciplinary teams, training programs, etc.

- In Canada, the impact of mandatory reporting laws on the child welfare system is unknown because of lack of research. A survey of mandated reporters' attitudes towards and experience with the child protection agencies should be conducted. A similar survey of child protection staff would be equally useful.
- Does the class or race of child/parent affect the likelihood of abuse reporting?
- What are the substantiation rates? Do they vary by status of reporter (i.e., doctor versus public health nurse versus member of the public)?
- Data analysis strategies are crucial to the generation of new and practical knowledge. This review project alerted us to a number of useful analytic approaches:
 - A substantiated or unsubstantiated report represents the outcome of a decision. However, in reality, there are many more case disposition categories than substantiated and unsubstantiated. To be useful, analysis should focus on the actual range of dispositions rather than on only one dichotomized outcome.
 - Reporting laws require mandated professionals to report suspicions of child maltreatment. Over the years, the number of reports has rapidly increased. One

strange phenomenon has been detected in U.S. studies: mandated professionals and non-mandated reporters contribute approximately the same proportions of reports, and this roughly equal split has remained steady over the years. This is contrary to expectation, because some reporting laws designate only professionals as mandated reporters. Consequently, we would expect to see the proportions of reports from mandated professionals increase over time, with a corresponding decrease in the proportions of reports from non-mandated reporters. This consistent equal split does not support such an expectation. In analysis of reporting behaviour, mandated reporters should be compared with non-mandated reporters on all key variables.

- Cases diagnosed as child maltreatment should be compared with those not so considered, in order to isolate decision factors. Such knowledge would be useful to the construction of diagnostic instruments. Follow-up research involving both groups should also be conducted.
- Cases substantiated and referred by the hospital to the child protection services should be monitored. Specifically, those ultimately rejected by the child protection services should be compared with those substantiated and accepted.

Appendix A

Excerpts from Canadian Reporting Statutes

ALBERTA - CHILD WELFARE ACT⁽⁸⁸⁾

Sec. 3. Reporting child in need.

- (1) Any person who has reasonable and probable grounds to believe and believes that a child is in need of protective services shall forthwith report the matter to a director.
- (2) [*Confidential information*]. – Subsection (1) applies notwithstanding that the information on which the belief is founded is confidential and its disclosure is prohibited under any other Act.
- (3) [*Solicitor-client relationship*]. – This section does not apply to information that is privileged as a result of a solicitor-client relationship.
- (4) [*Limitation of liability*]. – No action lies against a person reporting pursuant to this section unless the reporting is done maliciously or without reasonable and probable grounds for the belief.
- (5) [*Duty of director*]. – Notwithstanding and in addition to any other penalty provided by this Act, if a director has reasonable and probable grounds to believe that a person has not complied with subsection (1) and that person is registered under an Act regulating a profession or occupation prescribed in the regulations, the director shall advise the appropriate governing body of that profession or occupation of the failure to comply.
- (6) [*Offence*]. – Any person who fails to comply with subsection (1) is guilty of an offence and liable to a fine of not more than \$2000 and in default of payment to imprisonment for a term of not more than 6 months.
s.91(4)Notwithstanding subsection (2), the name of a person who reports to a director pursuant to section 3 or 4 shall not be disclosed or communicated to any person without the consent in writing of the Minister. (1996, c. C-7.3, s. 23(14)(b).)

BRITISH COLUMBIA - CHILD, FAMILY AND COMMUNITY SERVICE ACT⁽¹²⁹⁾

Sec. 14. Duty to report need for protection.

- (1) A person who has reason to believe that a child
 - (a) has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or other person, or
 - (b) needs protection under section 13(1)(e) to (k)must promptly report the matter to a director or a person designated by a director.
- (2) Subsection (1) applies even if the information on which the belief is based
 - (a) is privileged, except as a result of a solicitor-client relationship, or
 - (b) is confidential and its disclosure is prohibited under another Act.
- (3) A person who contravenes subsection (1) commits an offence.
- (4) A person who knowingly reports to a director, or a person designated by a director, false information that a child needs protection commits an offence.
- (5) No action for damages may be brought against a person for reporting information under this section unless the person knowingly reported false information.
- (6) A person who commits an offence under this section is liable to a fine of up to \$10 000 or to imprisonment for up to 6 months, or to both.
- (7) The limitation period governing the commencement of a proceeding under the *Offence Act* does not apply to a proceeding relating to an offence under this section.

Sec. 18. Reporting a child in need of protection.

- (1) Subject to subsection (1.1), where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the person shall forthwith report the information to an agency or to a parent or guardian of the child. (1989, c. 3, s. 4.)
 - (1.1) *Reporting to agency only.* – Where a person under subsection (1)
 - (a) does not know the identity of the parent or guardian of the child;
 - (b) has information that leads the person reasonably to believe that the parent or guardian
 - (i) is responsible for causing the child to be in need of protection, or
 - (ii) is unable or unwilling to provide adequate protection to the child in the circumstances; or
 - (c) has information that leads the person reasonably to believe that the child is or might be suffering abuse by a parent or guardian of the child or by a person having care, custody, control or charge of the child;subsection (1) does not apply and the person shall forthwith report the information to an agency. (1989, c.3, s. 4; 1996, c. 4, s. 3.)
- (2) *Duty to report.* – Notwithstanding the provisions of any other Act, subsection (1) applies even where the person has acquired the information through the discharge of professional duties or within a confidential relationship, but nothing in this subsection abrogates any privilege that may exist because of the relationship between a solicitor and the solicitor's client. (1989, c. 3, s. 4; 1996, c. 4, s. 3.)

Sec. 18.1. Protection of informant.

- (1) No action lies against a person for providing information in good faith and in compliance with section 18.
- (2) *Identity of informant.* – No person shall, except as required in the course of a judicial proceeding, disclose to the family of a child reported in need of protection the identity of the informant, under section 18 without the written consent of the informant.
- (3) *No interference or harassment.* – No person shall interfere with or harass an informant under section 18. (1989, c. 3, s. 5.)

Sec. 18.2. Director reports to professional organizations.

- (1) Where the director has reasonable grounds to believe that a person has caused a child to be in need of protection as provided in section 17, or has failed to report information in accordance with section 18, the director may report the person to the professional society or association or regulatory organization of which the person is a member or that governs the professional status of the person.
- (2) *Professional organizations to investigate.* – Where a professional society or association or regulatory organization receives a report on a person under subsection (1), the professional society or association or regulatory organization shall investigate the matter for the purpose of determining whether the professional status of the person ought to be reviewed or disciplinary proceedings commenced against the person. (1989, c. 3, s. 5.)

Sec. 18.3. Summary conviction offences.

Where a person,

- (a) through an act or omission of the person, causes a child to be a child in need of protection as provided in section 17;
- (b) fails to report information as required under section 18;
- (c) discloses the identity of an informant in contravention of subsection 18.1(2); or
- (d) interferes with or harasses an informant in contravention of subsection 18.1(3); the person commits an offence punishable on summary conviction. (1989, c. 3, s. 5.)

Sec. 30.

- (1) Any person who has information causing him to suspect that a child has been abandoned, deserted, physically or emotionally neglected, physically or sexually ill-treated or otherwise abused shall inform the Minister of the situation without delay. (1997, c. 2, s. 4(a).)
- (2) This section applies notwithstanding that the person has acquired the information through the discharge of his duties or within a confidential relationship, but nothing in this subsection abrogates any privilege that may exist because of the relationship between a solicitor and the solicitor's client. (1994, c. 7, s. 1.)
- (3) A professional person who acquires information in the discharge of the professional person's responsibilities that reasonably ought to cause the professional person to suspect that a child has been abandoned, deserted, physically or emotionally neglected, physically or sexually ill-treated or otherwise abused but who does not inform the Minister of the situation without delay commits an offence. (1994, c. 7, s. 1.)
- (4) Where the Minister has reasonable grounds to suspect that a professional person has committed an offence under subsection (3), the Minister may, regardless of any action the Minister may take with respect to prosecution, require any professional society, association or other organization authorized under the laws of the Province to regulate the professional activities of the person to cause an investigation to be made into the matter. (1994, c. 7, s. 1.)
- (5) No action lies, in relation to the giving of information under this section, against a person who in good faith complies therewith. (1994, c. 7, s. 1.)
- (5.1) A person who wilfully gives false information under this section commits an offence. (1995, c. 43, s. 1.)
- (6) Except in the course of judicial proceedings, no person shall reveal the identity of a person who has given information under this section without that person's written consent. (1994, c. 7, s. 1.)
- (7) Any person who violates subsection (6) commits an offence.
- (8) Upon completion of any investigation undertaken by the Minister as a result of any information provided by any person, the Minister may so advise the person who provided the information, and shall inform
 - (a) the parent;
 - (b) any person identified during the investigation as a person neglecting or ill-treating the child; and
 - (c) the child, if in the opinion of the Minister he is capable of understanding, as to the findings and conclusions drawn by the Minister.
- (8.1) Notwithstanding subsection (8), the Minister shall not inform any person referred to in paragraphs 8(a) to (c) of the findings and conclusion drawn by the Minister if
 - (a) in the opinion of the Minister, the giving of the information would have the effect of putting the child's well-being at risk,
 - (b) in the opinion of the Minister, the giving of the information may impede any criminal investigation related to the neglect or ill-treatment of the child, or
 - (c) in the case of a person identified during an investigation as neglecting or ill-treating the child, the person has not been contacted as part of the Minister's investigation. (1997, c. 2, s. 4(b).)
- (9) Notwithstanding the *Evidence Act*, a spouse may be compelled to testify as a witness in the course of judicial proceedings brought against his spouse under this Act with respect to abuse or neglect of a child or an adult.
- (10) For the purposes of this section "professional person" means a physician, nurse, dentist or other health or mental health professional, an administrator of a hospital, a school principal, school teacher or other teaching professional, a social work administrator, social worker or other social service professional, a child care worker in any day care centre or child caring institution, a police or law enforcement officer, a psychologist, a guidance counsellor, or a recreational services

administrator or worker, and includes any other person who by virtue of his employment or occupation has a responsibility to discharge a duty of care towards a child.
(1992, c. 51, s. 11; 1994, c. 7, s. 1.)

(1992, c. 52, s. 11; 1994, c. 7, s.1; 1995, c. 43, s. 1; 1997, c. 2, s.4.)

NEWFOUNDLAND - CHILD WELFARE ACT⁽¹⁰⁹⁾

Sec. 38. Report of ill-treatment.

- (1) Where a person has information that a child has been, is or may be in danger of abandonment, desertion, neglect, physical, sexual or emotional ill-treatment, has been, is or may be otherwise in need of protection, the person shall immediately report the matter to the director, a social worker or a peace officer.
- (2) [*Report all information*]. – Where a person makes a report under subsection (1), the person shall report all the information in his or her possession. (1992, c. 48, s. 5.)
- (3) [*Director or social worker notified*]. – Where a report is made to a peace officer under subsection (1), the peace officer shall, as soon as possible after receiving the report, inform the director or a social worker.
- (4) [*Application*]. – This section applies, notwithstanding the provisions of another Act, to a person referred to in subsection (5) who, in the course of his or her professional duties has reasonable grounds to suspect that a child has been, is or may be in danger of abandonment, desertion, neglect, physical, sexual or emotional ill-treatment, or has been, is or may be otherwise in need of protection.
- (5) [*Idem*]. – Subsection (4) applies to every person who performs professional or official duties with respect to a child, including,
 - (a) a health care professional;
 - (b) a teacher, school principal, social worker, family counsellor, member of the clergy, rabbi, operator or employee of a day care centre and a youth and recreation worker;
 - (c) a peace officer; and
 - (d) a solicitor.
- (6) [*Action against informant*]. – This section applies notwithstanding that the information is confidential or privileged, and an action does not lie against the informant unless the making of the report is done maliciously or without reasonable cause.
- (7) [*Non-interference with informant*]. – A person shall not interfere with or harass a person who gives information under this section.
- (8) [*Offence to contravene this section*]. – A person who contravenes this section is guilty of an offence and is liable on summary conviction, to a fine not exceeding \$10,000 or to imprisonment for a term not exceeding 6 months or to both a fine and imprisonment.
- (9) [*Information or complaint may be laid*]. – Notwithstanding section 8 of the *Summary Proceedings Act*, an information or complaint under this section may be laid or made within 3 years from the day when the contravention occurred. (1992, c. 48, s. 5; 1992, c. 57, s. 1.)

NOVA SCOTIA - CHILDREN AND FAMILY SERVICES ACT⁽⁹²⁾

Sec. 23. [Reporting need for protective services].

- (1) Every person who has information, whether or not it is confidential or privileged, indicating that a child is in need of protective services shall forthwith report that information to an agency.
- (2) [*No action against reporting abuse*]. – No action lies against a person by reason of that person reporting information pursuant to subsection (1), unless the reporting of that information is done falsely and maliciously.

- (3) [*Contravention of subsection (1) is an offence*]. – Every person who contravenes subsection (1) is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.
- (4) [*Statute of limitations*]. – No proceedings shall be instituted pursuant to subsection (3) more than two years after the contravention occurred. (1996, c. 10, s. 2.)
- (5) [*False and malicious reporting*]. – Every person who falsely and maliciously reports information to an agency indicating that a child is in need of protective services is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both. (1996, c. 10, s. 2.)

Sec. 24. [Abuse by a parent or guardian].

- (1) In this Section, “suffer abuse”, when used in reference to a child, means be in need of protective services within the meaning of clause (a), (c), (e), (f), (h), (i) or (j) of subsection (2) of Section 22.
- (2) [*Professional reporting*]. – Notwithstanding any other Act, every person who performs professional or official duties with respect to a child including
 - (a) a health care professional, including a physician, nurse, dentist, pharmacist or psychologist;
 - (b) a teacher, school principal, social worker, family counsellor, member of the clergy, operator or employee of a day-care facility;
 - (c) a peace officer or a medical examiner;
 - (d) an operator or employee of a child-caring facility of child-care service;
 - (e) a youth or recreation worker,
 who, in the course of that person’s professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information upon which it is based to an agency.
- (3) [*No confidentiality rules apply*]. – This Section applies whether or not the information reported is confidential or privileged.
- (4) [*Obligation to report pursuant to section 23*]. – Nothing in this Section affects the obligation of a person referred to in subsection (2) to report information pursuant to Section 23.
- (5) [*No action against reporting of abuse*]. – No action lies against a person by reason of that person reporting information pursuant to subsection (2), unless the reporting is done falsely and maliciously.
- (6) [*Contravention of subsection (2) is an offence*]. – Every person who contravenes subsection (2) is guilty of an offence and upon summary conviction is liable to a fine of not more than five thousand dollars or to imprisonment for a period not exceeding one year or to both.
- (7) [*Limitation period*]. – No proceedings shall be instituted pursuant to subsection (6) more than two years after the contravention occurred. (1996, c. 10, s. 3.)
- (8) [*False and malicious reporting*]. – Every person who falsely and maliciously reports information to an agency indicating that a child is or may be suffering or may have suffered abuse is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both. (1996, c. 10 s. 3.)

Sec. 25. [Abuse by a person other than a parent or guardian].

- (1) In this Section “abuse by a person other than a parent or guardian” means that a child
 - (a) has suffered physical harm, inflicted by a person other than a parent or guardian of the child or caused by the failure of a person other than a parent or guardian of the child to supervise and protect the child adequately;
 - (b) has been sexually abused by a person other than a parent or guardian or by another person where the person, not being a parent or guardian, with the care of the child knows or should know of the possibility of sexual abuse and fails to protect the child;
 - (c) has suffered serious emotional harm, demonstrated by severe anxiety, depression, withdrawal, or self-destructive or aggressive behaviour, caused by the intentional conduct of a person other than a parent or guardian.

- (2) [*Reporting*]. – Every person who has information, whether or not it is confidential or privileged, indicating that a child is or may be suffering or may have suffered abuse by a person other than a parent or guardian shall forthwith report the information to an agency.
- (3) [*Contravention of subsection (2) is an offence*]. – Every person who contravenes subsection (2) is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.
- (4) [*Limitation period*]. – No proceedings shall be instituted pursuant to subsection (3) more than two years after the contravention occurred. (1996, c. 10, s. 4.)
- (5) [*No action against truthful reporting*]. – No action lies against a person by reason of the person reporting information pursuant to subsection (2) unless the reporting of that information is done falsely and maliciously.
- (6) [*False and malicious reporting*]. – Every person who falsely and maliciously reports information to an agency indicating that a child is or may be suffering or may have suffered abuse by a person other than a parent or guardian is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both. (1996, c. 10, s. 4.)

ONTARIO - CHILD AND FAMILY SERVICES ACT⁽⁸⁹⁾

Sec. 72. Definition.

- (1) In this section and in sections 73, 74 and 75, “to suffer abuse”, when used in reference to a child, means to be in need of protection within the meaning of clause 37(2)(a), (c), (e), (f) or (h).
- (2) *Duty to report that child in need of protection*. – A person who believes on reasonable grounds that a child is or may be in need of protection shall forthwith report the belief and the information upon which it is based to a society.
- (3) *Idem: professional or official duties, suspicion of abuse*. – Despite the provisions of any other Act, a person referred to in subsection (4) who, in the course of his or her professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information on which it is based to a society.
- (4) *Application of subs. (3)*. – Subsection (3) applies to every person who performs professional or official duties with respect to a child, including,
 - (a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;
 - (b) a teacher, school principal, social worker, family counsellor, priest, rabbi, a member of the clergy, operator or employee of a day nursery and youth and recreation worker;
 - (c) a peace officer and a coroner;
 - (d) a solicitor; and
 - (e) a service provider and an employee of a service provider. (1993, c. 27, Sched.)
- (5) *Definition*. – In clause (4)(b), “youth and recreation worker” does not include a volunteer.
- (6) *Duty of society*. – A society that obtains information that a child in its care and custody is or may be suffering or may have suffered abuse shall forthwith report the information to a Director.
- (7) *Section overrides privilege*. – This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with subsection (2) or (3) unless the person acts maliciously or without reasonable grounds for the belief of suspicion, as the case may be.
- (8) *Exception: solicitor client privilege*. – Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. (1993, c. 27, Sched.)

PRINCE EDWARD ISLAND - FAMILY AND CHILD SERVICES ACT⁽¹³⁰⁾

Sec. 14. Mandatory reporting of child abuse.

- (1) Every person who has knowledge or has reasonable and probable cause to suspect that a child has been abandoned, deserted or abused must forthwith report or cause to be reported the circumstances to the Director or to a peace officer who shall report it to the Director, and shall provide to a child care worker such additional information as is available to him or is known to him.
- (2) *Investigation.* – Upon receiving a report given pursuant to subsection (1), or where the Director has reasonable and probable cause to suspect that a child is otherwise in need of protection, the Director may cause an investigation to be made into the circumstances of the case and, where necessary, he shall provide child care services to reduce or eliminate any neglect or abuse of the child and he may make application for an order under section 34.
- (3) *Identity of reporter confidential.* – No person shall reveal or be compelled to reveal the identity of a person who has acted in accordance with subsection (1).
- (4) *Civil liability.* – A person who makes a report pursuant to subsection (1) or who does anything to assist in any investigation conducted pursuant to subsection (2) is not liable to any civil action in respect of any matter contained in the report or anything done in good faith in assistance in the investigation.
- (5) *Solicitor client privilege.* – Nothing in this section affects or abrogates any privilege that may exist because of the relationship between a solicitor and his client.

QUEBEC - YOUTH PROTECTION ACT⁽⁹³⁾

Sec. 39. [Bound to inform].

Every professional who, by the very nature of his profession, provides care or any other form of assistance to children and who, in the practice of his profession, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of section 38 or 38.1, must bring the situation to the attention of the director without delay. The same obligation is incumbent upon any employee of an institution, any teacher or any policeman who, in the performance of his duties, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of the said provisions.

Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is considered to be in danger within the meaning of subparagraph *g* of the first paragraph of section 38 must bring the situation to the attention of the director without delay.

Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of subparagraph *a, b, c, d, e, f* or *h* of the first paragraph of section 38 or within the meaning of section 38.1 may bring the situation to the attention of the director.

The first and second paragraphs apply even to those persons who are bound by professional secrecy, except to an advocate who, in the practice of his profession, receives information concerning a situation described in section 38 or 38.1. (1981, c. 2, s. 9; 1984, c. 4, s. 19; 1994, c. 35, s. 25.)

Sec. 43. Immunity.

No person may be prosecuted for acts done in good faith under section 39 or 42.

Sec. 44. Identity confidential.

No person shall reveal or be compelled to reveal the identity of a person who has acted in accordance with section 39 or 42, without his consent.

SASKATCHEWAN - CHILD AND FAMILY SERVICES ACT⁽¹³¹⁾

Sec. 12. Duty to report.

- (1) Subject to subsections (2) and (3), every person who has reasonable grounds to believe that a child is in need of protection shall report the information to an officer or peace officer.
- (2) Subsection (1) applies notwithstanding any claim of confidentiality or professional privilege other than:
 - (a) solicitor-client privilege; or
 - (b) Crown privilege.
- (3) No action shall be commenced against a person with respect to making a report pursuant to subsection (1) except with leave of the Court of Queen's Bench. (1996, c. 11, s. 2.)
 - (3.1) An application for leave shall be commenced by notice of motion served on the respondent and the minister in any manner set out in Part Three of the Queen's Bench Rules. (1996, c. 11, s. 2.)
 - (3.2) On an application for leave, leave shall be granted only if the applicant establishes, by affidavit evidence or otherwise, a *prima facie* case that the person made the report maliciously and without reasonable grounds for his or her belief. (1996, c. 11, s.2.)
 - (3.3) If leave is not granted, the court may order the applicant to pay all or any portion of the costs of the application. (1996, c. 11, s. 2.)
 - (3.4) An action against a person who makes a report pursuant to subsection (1) that is commenced without leave of the court is a nullity. (1996, c. 11, s. 2.)
- (4) Every peace officer who has reasonable grounds to believe that a child is in need of protection shall immediately report the information to an officer. (1996, c. 11, s. 2.)

NORTHWEST TERRITORIES - CHILD WELFARE ACT⁽¹³²⁾

Sec. 30. Definition of abuse .

- (1) For the purposes of this section, "abuse" means a condition of
 - (a) physical harm in respect of which a child suffers physical injury but does not include reasonable punishment administered by a parent or guardian.
 - (b) malnutrition or mental ill-health of a degree that if not immediately remedied could seriously impair growth and development or result in permanent injury or death; or
 - (c) sexual molestation.
- (2) *Reporting child abuse.* – Every person who has information of the abandonment, desertion or need of protection of a child or the infliction of abuse on a child shall without delay report the information to the Superintendent.
- (3) *Duty of professional.* – Notwithstanding any other Act, every person who has reasonable grounds to suspect in the course of his or her professional or official duties that a child has suffered or is suffering from abuse that may have been caused or permitted by a person who has or has had charge of the child shall without delay report the suspected abuse to the Superintendent.
- (4) *Confidentiality and privilege.* – This section applies notwithstanding that the information reported is confidential or privileged.
- (5) *Civil liability.* – No action shall be commenced against a person for reporting information to the Superintendent in accordance with this section unless it is done maliciously or without reasonable grounds to suspect that the information is true.

- (6) *Solicitor and client privilege.* – Nothing in this section shall abrogate any privilege that may exist between a solicitor and the solicitor's client.

Sec. 30.1. No liability.

- (1) Subject to subsection (2), no person authorized to act under this Act shall be liable for anything done or not done with regard to the welfare and the protection of a child, where that person is carrying out his or her duties in good faith under this Act.
- (2) *Application.* – This section does not apply to persons required to report under section 30.

YUKON - CHILDREN S ACT⁽¹⁰²⁾

Sec. 115. Reporting of child in need of protection.

- (1) A person who has reasonable grounds to believe that a child may be a child in need of protection may report the information upon which he bases his belief to the director, an agent of the director, or a peace officer.
- (2) [*Immunity*]. – No legal action of any kind, including professional disciplinary proceedings may be taken against a person who reports information under subsection (1) by reason of his so reporting, unless the reporting was done maliciously and falsely.
- (3) [*Malicious and false report*]. – Any person who maliciously and falsely reports to a peace officer, the director, an agent of the director, or to any other person facts from which the inference that a child may be in need of protection may reasonably be drawn commits an offence and is liable on summary conviction to a fine of up to \$5,000 or imprisonment for as long as six months, or both.

Appendix B

Interview Protocol

Introduction

Objective

The objective of this survey is to obtain information that will provide an overview of how a select number of hospitals deal with the identification, classification, and reporting of child abuse.

Focus

This component of the study focuses on how the institution responds to cases of suspected child abuse – not how you as an individual respond. Information from the survey will be aggregated and summarized, and you will be given the opportunity to review the relevant section of the report prior to finalization.

Written Documentation

If you have written descriptions or documentation relevant to any of the questions below, please fax them to Linda Bland at the Canadian Research Institute for Law and the Family (CRILF) at (403) 289-4887. If the documents are too long to fax, please call Linda at (403) 220-6653 and she will arrange for a courier pick up. If documentation is received prior to the interview, it should shorten the time needed for the interview.

- 1.0 **Does your hospital have a special child abuse unit** (defined as a dedicated internal resource)?
 - 1.1 How is this unit funded?
 - 1.2 How many positions are allocated to the unit?
 - 1.3 What disciplines are represented in the unit?
 - 1.4 What are the mandate and functions of the unit?
 - 1.5 Does the unit provide services internally (to the hospital) and/or externally (to external physicians and agencies)?
- 2.0 **Is your hospital involved with a child protection team** (defined as a multi-disciplinary, multi-agency group of professionals with resources being “pooled” from sources mainly external to the hospital)?
 - 2.1 What agencies and disciplines are represented on the team?
 - 2.2 Who chairs the team?
 - 2.3 What are the mandate and functions of the team?
- 3.0 **Does your hospital have specific protocols for dealing with cases of suspected child abuse?**
 - 3.1 What are the protocols for the identification, definition, and classification of child abuse?
 - 3.2 What types of child abuse cases do you deal with?
 - What are the operational definitions for those types?
 - Where are these definitions derived from (e.g., legislation, hospital policy, research)?
 - 3.3 What are the protocols for the investigation of suspected child abuse cases?
 - 3.4 What are the protocols for the treatment of child abuse cases?
 - 3.5 What other agencies are identified by the protocols (e.g., child welfare, police)?
 - 3.6 Is the liaison with the above agencies effective?
- 4.0 **Does your hospital provide specific training for dealing with child abuse?**
 - 4.1 What is the nature of the training (e.g., does it deal specifically with the identification and classification of child abuse) and are legal and institutional issues such as reporting and liaison dealt with?
 - 4.2 When is it given?

- 4.3 Who is trained?
- 4.4 Who provides the training?
- 4.5 Is training provided for health care professionals in the community?

5.0 Do you keep statistics on the number of suspected child abuse cases reported in your hospital and to child protection?

- 5.1 How long have you been compiling information on suspected child abuse cases?
- 5.2 Could you provide data on the number of child abuse cases, preferably broken down by types of abuse for the most recent year?
- 5.3 Approximately what percentage of suspected child abuse cases are reported in your hospital through:
 - Emergency?
 - The child abuse unit (if applicable)?
 - Units such as general pediatrics, child psychiatry or developmental pediatrics?
 - Other referral sources (please specify)?

6.0 Is (or has) anybody in your hospital conducting research regarding child abuse especially identification, reporting, and treatment of child abuse?

- 6.1 Who are these researchers? (names and contact numbers)
- 6.2 Are reports available?

7.0 Issues and problems

- 7.1 Is the legislation dealing with child abuse in your jurisdiction considered adequate?
- 7.2 Are there problems and/or concerns regarding the identification and reporting of child abuse?
 - For example:
 - Is there concern regarding uncertainty of the validity of abuse allegations?
 - Are staff reluctant to report, and why?
 - Is there concern regarding over reporting: malicious or unfounded reporting?
- 7.3 How could the reporting system be improved?

Appendix C

Sample Protocols

CRITERIA FOR REFERRAL

British Columbia Children s Hospital Child Protection Service Unit

Girls 13 years of age and under and boys 18 years of age and under are seen for concerns of sexual assault.

All children 18 years of age and under are seen for allegations of physical assault.

Referrals are from:

1. The family physician where a second opinion is requested.
2. The Ministry for Children and Families social worker or Police in Vancouver/Richmond only.
3. Outside Vancouver - the Ministry for Children and Families or Police may call to consult on complicated or unique situations.

It is preferred that the child has been interviewed by the Police/Ministry for Children and Families **prior** to the medical assessment.

British Columbia Children's Hospital Sexual Abuse Protocol

Prepared by:

Child Protection Service Unit

British Columbia Children s Hospital

Dr. Jean Hlady, Director

I. GENERAL INFORMATION:

1. Any child with an allegation of sexual assault in the previous 72 hr should be seen by the Emergency physician immediately. The CPSU physician on call should then be informed if there are any injuries to be documented.
2. All children thirteen years and under should be seen at Children’s Hospital.
 - Girls 14 years and over should be referred to the Sexual Assault Program at Vancouver Hospital.
 - Boys 18 years and under will be seen at BCCH for sexual assault.
3. The chart may become legal evidence - be sure that all statements are **objective accurate** and **legible**.
4. Provide maximum emotional support. Allow the child as much control as possible. Explain all steps of the examination.
5. Remember - It is not our function to be moralistic but to provide medical care as needed.
6. Do not use terms other than “alleged sexual assault”. “Rape” and “Sexual Assault” are legal terms not medical diagnoses.
7. In a case of suspected sexual assault, one of the following four doctors should be contacted:
(See CPSU on-call schedule)

Dr. Jean Hlady

Dr. Paul Korn

Dr. Margaret Colbourne

Dr. Barbara Fitzgerald

8. Consent for examination must be obtained from parent or legal guardian.

II. HISTORY:

1. The nurse should:

- (a) Triage the patient in the regular manner.
- (b) Have the patient wait in the clinic area (room 1 K82 if possible).
- (c) Obtain vital signs and obtain a urine sample.
- (d) Document any obvious trauma.
- (e) Record the patient's emotional state.
- (f) Document the condition of the clothing.
- (g) Have the patient assessed initially by the paediatrician in Emergency. The paediatrician will decide if the CPSU should be involved. The CPSU physician should be called if there are injuries to be documented.
- (h) If the CPSU physician is called, the nurse should assemble the necessary swabs and equipment and place these in Room I K82.
- (i) The sexual assault "kit" and "rape kit" are located in the third drawer of the filing cabinet in room I K85. The kits contain all the equipment and requisitions necessary for obtaining specimens for BCCH lab and police forensic lab. Speculums are kept in top shelf of filing cabinet in IK82 if needed.
- (j) See CPSU review re: kit. The kits are stocked by the CPSU nurse (Local - 7342).

2. The doctor should:

- (a) Obtain history of assault from parent, social worker, or police and corroborate pertinent data with the patient if possible. Use patients own words - what and when, not why and how.
- (b) Obtain a full direct medical history from parent and patient.

If an older child:

Inquire further regarding:

- (a) Areas "penetrated" during assault.
- (b) Menstrual, contraceptive, coital and V.D. history, and activity post assault (change of clothing, bathing, douching, etc.)
- (c) If menstruating, her wishes regarding hormonal pregnancy prevention and abortions must be taken into account.

III. PHYSICAL EXAMINATION:

The doctor should:

1. Have a nurse present at all times during the physical exam. If a parent is available, they too should be present during the exam.
2. Perform routine physical exam; include emotional status and general appearance of patient (and clothing).
3. Examine areas penetrated during the assault, e.g., vagina, mouth, rectum.
4. Document evidence of trauma (however slight) to any of the above areas. Obtain photographs if indicated (after obtaining proper consent).

IV. MEDICAL TESTS:

1. Culture body orifices involved for C&S, gonorrhoea, chlamydia. - Send to lab immediately during the day. (Microbiology 0800 - 1700). In off hours they are to be kept in a locked box and transported to the lab the following day, appropriately labelled. Specimens for chlamydia and herpes must be stored in a fridge or kept on ice. Specimens for gonorrhoea must be stored at room temperature for no longer than 16 hr.
2. Obtain VDRL and HIV Screens if indicated.
3. Urinalysis, culture.
4. Double check that labelling information is correct.

5. All specimens transferred to the Children's Hospital lab must be signed in the log book in Microbiology by the person delivering and the person receiving the specimens.

V. LEGAL TESTS:

1. **Wet Mount Preparation:** Obtain specimens for sperm/ semen from body areas involved. (Aspirated specimens are preferable to cotton swabs). If a young child, use a feeding tube flushed with saline. Instill saline into the vagina and aspirate. Place a drop of aspirate on glass slide. Examine immediately microscopically for five minutes under H.P.F. Document presence or absence of sperm and number of motile/non-motile sperm.
2. **Permanent Smears:**
 - a) Obtain in the same manner as the wet mount. If an adolescent, take smears from the posterior vaginal pool, rectum or pharynx as indicated. In a younger child, take a vaginal swab if possible or swab any obvious secretions. Rectal and pharyngeal swabs may be taken as indicated. Air dry the swabs, label and place in an envelope. Do not use cover slips.
 - b) Note on request from "Alleged Sexual Assault - please document presence or absence of sperm". Send two smears with the police and two to the Pathology Lab. If seen after hours, place two smears in the locked drawer.
3. **Protein 30** - one air dried swab (dried one hour) placed in a labeled envelope to go with the police.
4. **Further tests** to document identity of offender may be obtained if police request—pubic hair combing, scrapings from beneath finger nails, secretions for ABO, antigens. Place these specimens in individual marked envelopes found in the rape kit This evidence must be labeled and placed in the large brown envelope containing **all** forensic evidence for the police. Keep in the locked drawer along with the patient's clothing (if indicated) until police arrive.
5. **Clothing**, especially underwear, may be needed for evidence. Once removed, each item should be bagged separately in individual bags.
6. **All specimens transferred to the police** must be placed in a large brown envelope supplied in the rape kit. The list of contents and the signatures of the person delivering and the person receiving the envelope must be filled out at the time the specimens are put in the envelope and/or at the time of the transfer.

VI. TREATMENT:

- 1) **Injuries:** Treat and/or consult as indicated.
- 2) **In the older child: Pregnancy prophylaxis:** If patient is menarchal, without contraception and at risk in her cycle, use Ovral - 2 tablets stat and 2 in twelve hours. Explain side effects and efficacy. The victim should be informed of increased risk to fetus and assured of access to abortion if she misses a menstrual period. Do not prescribe if there has been no vaginal penetration or if there has been effective birth control during the cycle.

VII. FINAL DIAGNOSIS:

1. State whether findings indicate normal/abnormal exam.
2. If abnormal exam, indicate whether it is definite evidence or compatible with sexual assault.
3. Presence or absence of sperm.
4. Specific diagnosis of trauma, contusions, lacerations, etc.
5. Other pertinent medical diagnoses.

VIII. DUTY TO REPORT:

The Family and Child Service Act requires reporting of suspected sexual and physical abuse.

1. **During the day**, the Child Protection Service Unit social worker should be contacted regarding reporting to the Ministry for Children and Families.

2. **During the evening or weekend shifts**, the Child Protection Service Unit physician, if called, will be responsible for reporting.
3. **If the Child Protection Service Unit physician is not present**, the Emergency physician should contact the Ministry for Children and Families. After Hours Service - tel: 660-4927 - to report.

IX. FOLLOW-UP:

1. If **medical** follow up is required, the child can be seen by their family physician or by a Child Protection Service Unit Physician, in the Child and Family Clinic. The Child and Family Clinic appointments are booked through the Child Protection Service Unit social worker (875-3270).
2. **Emotional** support to the child and family is extremely important. The Emergency Physician should provide the Child Protection Service Unit's social worker's telephone number (875-3270) to the family and encourage them to make an appointment in the Child and Family Clinic.
3. **If follow-up with CPSU is planned** please leave the ER SSP form in CPSU envelope located in the Emergency Room. Ask the charge nurse for the exact location.

British Columbia Children's Hospital Physical Abuse Protocol

Prepared by:
Child Protection Service Unit
British Columbia Children's Hospital
Dr. Jean Hlady, Director

I. GENERAL INFORMATION:

- 1) See immediately, all children up to and including 18 years.
- 2) The chart may become legal evidence. Be sure all statements are **objective, accurate, and legible**.
- 3) Staff should provide maximum emotional support for the child and family. Explain all steps involved in the exam.
- 4) Consent for examination must be obtained from parent or legal guardian.

II. HISTORY:

- 1) **The nurse should:**
 - (a) Triage the patient in the regular manner.
 - (b) Have patient wait in clinic waiting area (IK82 if possible).
 - (c) Obtain vital signs.
 - (d) Document any obvious trauma.
 - (e) Have patient assessed initially by the paediatrician in Emergency. The paediatrician will decide if CPSU should be involved. The CPSU physician should be called if there are injuries to be documented.
 - (f) If CPSU is to be called - one of the 4 physicians on the team should be contacted (see CPSU on-call schedule). If there is a serious life threatening abuse situation, notify the Director of the CPSU.
- 2) **The doctor should:**
 - (a) Obtain an accurate history of the assault from parent, police person and social worker, and corroborate with the patient if possible.
 - (b) Obtain a medical history.

III. PHYSICAL EXAMINATION:

The doctor should:

- (a) Perform a complete physical examination in the presence of a nurse.
- (b) Accurately document all trauma on the Emergency Sheet and on the CPSU documentation sheets available in the Emergency Department.

- (c) Document the colour and sizes of bruises if any.
- (d) Obtain photographs if indicated after proper consent. May call Children's Hospital Biomedical Department or Police Identification Squad.

IV. MEDICAL TESTS:

- 1. If significant bruising - obtain CBC with differential, platelet count, PT, PTT.
- 2. Skeletal Survey or Bone Scan should be routinely performed in a child less than 2 years of age.

V. TREATMENT:

- 1. Treat all injuries as indicated.
- 2. Subspecialty consults (e.g., Plastic Surgery, Ophthalmology, Neurosurgery, Orthopaedics) may be required.

VI. FINAL DIAGNOSIS:

- 1. Indicate whether exam is normal or abnormal.
- 2. If abnormal: indicate whether it is definite evidence of non-accidental trauma or compatible with non-accidental trauma.

VII. DUTY TO REPORT:

The Child, Family and Community Service Act requires reporting of suspected sexual or physical assaults.

- 1) **During the day** the Child Protection Service Unit social worker, (at 875-3270) should be contacted re: reporting to the Ministry for Children and Families.
- 2) **During the evening and weekend shifts**, the Child Protection Service Unit physician, if called, will be responsible for reporting.
- 3) **If the Child Protection Service unit physician is not present**, the Emergency physician should contact the Ministry for Children and Families After Hours Service - tel: 660-4927 - to report.

VIII. FOLLOW-UP:

- 1. If **medical** follow-up is required, the child can be seen by their family physician or by a Child Protection Service Unit physician, in the Child and Family Clinic. Child and Family Clinic appointments are booked through the Child Protection Service Unit social worker (875-3270).
- 2. **Emotional** support to the child and family is extremely important. The Emergency physician should provide the Child Protection Service Unit's social worker's telephone number to the family and encourage them to make an appointment in the Child and Family Clinic.
- 3. **If follow-up with the CPSU is planned** please leave the ER SSP form in the CPSU envelope located in the Emergency Room. Ask the Charge Nurse for the exact location.

Calgary Regional Health Authority - Acute Care - Child Abuse and Neglect

RATIONAL

The intent of this policy is to ensure, in cases of suspected child abuse and/or neglect, that:

- the child and family receives quality health care; the child is protected and his/her family appropriately supported and assisted;
- the rights of the abused child are protected;
- appropriate communication among health, social services, police and other professionals occurs;
- compliance with Alberta Child Welfare Act occurs;
- health professionals are aware of their responsibility to report suspected child abuse and neglect; and
- clinical practice is consistent with the provisions of the Provincial Child Abuse Protocol.

GUIDING PRINCIPLES

The protection and safety of children is everyone's concern. While the primary responsibility for ensuring safety and well-being of children lies with each child's guardian, Child Welfare Services may intervene when guardians are unable or unwilling to fulfill their guardianship responsibilities.

The protection and best interests of children prevail over the interests of guardians or families when reports of child abuse or neglect are being made and investigated. Those who are involved with the child and family during an investigation will work together to facilitate a thorough investigation.

DEFINITIONS (From the Child Welfare Act)

Child Abuse: For the purposes of this policy, a child is in need of protective services if there are reasonable and probable grounds to believe that the survival, security or development of the child is endangered.

This can include active or passive harming of the child by the person(s) who is responsible for the child care; and illness, abandonment or desertion, with or without inflicted injury, stemming from situations in his/her environment which threaten a child's well being or survival. A child is defined as a male or female person under the age of 18 years. The child may be endangered by any of the following:

- the child has been abandoned or lost;
- the guardian of the child is dead and the child has no other guardians;
- the guardian of the child is unable or unwilling to provide the child with the necessities of life, including failing to obtain for the child or to permit the child to receive essential medical, surgical, or other remedial treatment that has been recommended by a physician;
- the child has been, or there is substantial risk that the child will be physically injured or sexually abused by the guardian of the child;

- the guardian of the child is unable or unwilling to protect the child from physical injury or sexual abuse;
- the child has been emotionally injured by the guardian of the child;
- the guardian of the child is unable or unwilling to protect the child from emotional injury;
- the guardian of the child has subjected the child to, or is unable or unwilling to protect the child from cruel and unusual treatment or punishment;
- the condition or behaviour of the child prevents the guardian of the child from providing the child with adequate care appropriate to meet the child's needs.

Emotionally Injured: If there is substantial and observable impairment of the child's mental or emotional functioning, that is evidenced by a mental or behavioural disorder, including anxiety, depression, withdrawal, aggression, or delayed development or poor physical growth, and if there is reasonable and probable grounds to believe that the emotional injury is a result of rejection; deprivation of affection or cognitive stimulation; exposure to domestic violence or severe domestic disharmony; inappropriate criticism, threats, humiliation, accusations, or expectations of, or towards the child; or the mental or emotional condition of the guardian of the child or chronic alcohol or drug abuse by anyone living in the same residence as the child.

Physically Injured: A child is physically injured if there is substantial and observable injury to any part of the child's body as the result of the non-accidental application of force or an agent to the child's body that is evidenced by a laceration, a contusion, an abrasion, a scar, a fracture or other bony injury, a dislocation, a sprain, hemorrhaging, the rupture of viscus, a burn, a scald, frostbite, the loss of alteration or consciousness of physiological functioning, or the loss of hair or teeth.

Sexual Abuse: A child is sexually abused if the child is inappropriately exposed or subjected to sexual conduct, activity or behaviour.

POLICY

1. General

- 1.1 Any person living in Alberta, including health professionals, is required by the Child Welfare Act to ensure all actual cases of suspected abuse or neglect of a child are reported to Alberta Family and Social Services (A.F.S.S.). In the Calgary Region, the report can be made by calling the Alberta Family and Social Services Response Team (Child Welfare):

Daytime: 270-5335

After hours: 270-5333

Fax: 297-7507

- 1.1.1 The Act protects people reporting suspected abuse or neglect from legal action unless "the reporting is done maliciously or without reasonable and probable grounds" (Child Welfare Act, Section 3, Subsection 4).
- 1.1.2 Any person who has reasonable and probable grounds to make a report and who does not, is guilty of an offense. A professional may be reported to their professional college/association for failure to comply with this reporting responsibility under the Child Welfare Act.
- 1.2 A health professional who, in treating an adult patient, hears about a child who may be in need of protective services is required to report the matter to Child Welfare, Alberta Family and Social Services.
- 1.3 Child abuse often evokes strong negative feelings toward the perpetrators; health professionals must be aware of these feelings and transfer care to a colleague if necessary.

1.4 Often the health professional may not be sure if their concern is sufficient to meet the requirements of reporting according to the Child Welfare Act. The professional will consult with colleagues who may include Social Work staff, staff with the Child Abuse Program at Alberta Children's Hospital (229-7886), or Child Abuse Team at the Peter Lougheed site or other colleagues who have an identified expertise or responsibility for Child Welfare matters or liaison. Direct consultation with a Child Welfare worker will clarify if the situation requires a formal report.

2. Communication

- 2.1 Any concern related to suspected or proven child abuse or neglect will be discussed with the attending physician and the service or site Social Work staff, and/or consult staff of the Child Abuse Program, Alberta Children's Hospital.
- 2.1.1 The health professional who believes he/she has reasonable and probable grounds to believe that a child requires protective services is obligated by law to report to Child Welfare. This is best done in collaboration with the attending physician or other health care team members.
- 2.1.2 Health professionals recognize the strong emotions child abuse elicits and acknowledge the different views the members of the health care team may possess. Even if others are in disagreement, the concerned health professional has an obligation to report if they believe there are reasonable and probable grounds to suspect abuse and/or neglect. When in doubt it is recommended that the Social Services Response Team be consulted for advice as to whether the circumstances warrant a report. This can be done without identifying the child or family and such consultations are welcomed by Child Welfare workers.
- 2.1.3 A health professional's obligations are not discharged until such a report is made.
- 2.1.4 In recognition of the complexity of team functioning, a health professional (attending physician, nurse, social worker) may be delegated to make the report to Child Welfare on behalf of those involved.
- 2.1.5 The Child Abuse Program at the Alberta Children's Hospital is available for consultation during office hours. After hours crisis workers are available for consultation and can be contacted through the ACH Hospital Switchboard.

3. Reporting

- 3.1 Thorough and precise documentation is necessary in all matters of suspected abuse or neglect. The health professional may be required to give evidence in a court of law at a later date.
- 3.1.1 Documentation should be made available on the Health Record in a timely manner.
- 3.2 A disclosure made by a child, or alleged abuse reported by an adult should be documented as accurately as possible.
- 3.3 The professional, upon receiving a child's disclosure, should maintain support of the child but should refrain from interviewing the child about the alleged abuse. A report to a Child Welfare worker should occur immediately. Only a Child Welfare worker is mandated to determine if protective services are necessary.
- 3.4 If the clinical management of the child/family in the Emergency Department indicates that no immediate involvement of other Crisis, Social Work, Child Abuse Program or Advisory Committee personnel is required at this time, later involvement is still possible. A copy of the documentation should be forwarded without delay to the appropriate clinical service for review.
- 3.5 When reporting a case of actual or suspected abuse to the Child Welfare worker, the health professional is to provide the following information:
- 3.5.1 child's name, address, DOB
- 3.5.2 names of other family members

- 3.5.3 name and address of the alleged perpetrator, if known
 - 3.5.4 details of the disclosure
 - 3.5.5 a description of other indicators, signs or symptoms leading the health professional to believe the child is in need of protective services
 - 3.5.6 any additional concerns regarding the child's safety and/or development
- 3.6 The Child Welfare worker, upon investigation of the report of actual or suspected abuse, will notify the police if he/she thinks an offense has been committed.

4. Confidentiality

- 4.1 The responsibility to report under the Child Welfare Act outweighs any confidentiality requirements under other acts or professional regulations. The only person not required to report to Child Welfare is the legal counsel for the family.
- 4.1.1 Reports of child abuse will be kept confidential by A.F.S.S., but health care providers should be aware that any case might proceed to court where records will be open to the court.

5. Release of Information

- 5.1 Consistent with the Provincial Child Abuse Protocol, CRHA staff will act as partners with other agency staff when responding to Child Abuse investigations. For further information as to the appropriate release of information, please contact either the Legal Affairs Office or the Child Abuse Program Manager.

6. Discharge Against Medical Advice

- 6.1 If there is clear concern that removal of the child from the acute care site would put the child at immediate risk, the following procedure should be followed:
- 6.1.1 Immediately contact Child Welfare
 - 6.1.2 If Child Welfare is not able to respond quickly, contact the City of Calgary Police.

7. Child Neglect and Obstetrical Patients

- 7.1 Members of the health care team should initiate consultation with the attending physician and the Social Worker after observation or concern related to:
- 7.1.1 A mother displaying inappropriate or unexplainable ambivalence toward her pregnancy taking into account:
 - marital and family circumstances
 - cultural dynamics and customs
 - physical condition of mother.
 - 7.1.2 Lack of interest and/or response to baby in delivery room followed by inappropriate ante or post partum behaviours, i.e. refuses to interact or care for baby.
 - 7.1.3 Continued lack of interest and interaction with baby.
 - 7.1.4 Complex pre and/or post partum emotional or social problems.
 - 7.1.5 Fetal alcohol syndrome.
 - 7.1.6 Past history of drug abuse or prenatal drug abuse by mother.
 - 7.1.7 Lack of prenatal care during pregnancy.
- 7.2 In addition to appropriate clinical interventions and referrals, the health professional should consider if a report to Child Welfare is required.

8. Interviewing Guidelines

- 8.1 Detailed questioning of the child for purposes of evidence should be left to the Child Welfare Worker and Police to pursue although clinical information relevant to the child's treatment should be obtained.

9. Photographs

- 9.1 Where possible photographs should be taken, either by the hospital photographer if available, the police, if involved or by another health professional.
- 9.1.1 A doctor's order is required. Where possible, consent by the parent/legal guardian should be obtained but is not required.
 - 9.1.2 During the off hours, contact the Switchboard. A photographer will come in if required and available.

PROCESS

1. Role of the Physician

- 1.1 Examination of the child should include:
- 1.1.1 obtaining a complete medical and abuse history
 - 1.1.2 completing physical examination and clinical investigations, as appropriate.
- 1.2 Treatment of the child, as appropriate.
- 1.3 When a physician has reasonable and probable grounds to believe the child may require protective services, the physician will report the concerns directly to a Child Welfare Worker (A.F.S.S.).
- 1.4 Referrals to other professionals and services, as appropriate. These referrals may include referrals to other physicians, Social Work, Crisis Services, Child Abuse Program (ACH), Child Abuse Advisory Committee (PLC), etc.

2. Role of Other Health Professionals

- 2.1 To complete an assessment of the child, as appropriate.
- 2.2 Assure the immediate safety of the child and initiate treatment as necessary.
- 2.3 Report to Child Welfare (A.F.S.S.) if a report has not already been made and the professional has reasonable and probable grounds to believe that protective services are required.
- 2.4 If doubt exists about the appropriateness of a report, consultation with others with clinical expertise in the area of Child Abuse, e.g. Social Work, Child Abuse Program, should occur.
- 2.5 Provide appropriate clinical support to the child and family according to the professional expertise of each discipline.
- 2.6 Make appropriate referrals to other services and agencies to ensure appropriate follow-up care. A team meeting is advisable prior to discharge.

REFERENCES:

- Province of Alberta, Child Welfare Act 1985, Section 3(1)
- Province of Alberta, Alberta Hospitals Act
- Provincial Child Abuse Protocol

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