

CHILD PROTECTION REFERRAL ISSUES  
FOR GENERAL PRACTITIONERS / FAMILY PHYSICIANS

by

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### Abstract

The purpose of this research was to investigate why GPs/FPs are having difficulty collaborating with other health and human service professionals on matters of child protection. Since the symptoms of a child in need of protection are often hidden and can easily be minimized or attributed to something else, an assertiveness to rigorously investigate ambiguous symptoms is required. This research applied Organizational Citizenship Behaviour theory to understand some of the barriers and facilitators to assertive collaboration.

The research survey of 190 GPs/FPs in Vancouver BC, showed that the referral process in child protection cases is lengthy (often a few hours over several weeks), and the GP/FP is rarely remunerated for this time. Most GPs/FPs believe that it takes longer to refer to non-MDs than to MDs. GPs/FPs who refer to non-MDs have more interprofessional education (mentoring, CCFP certification), and work in group practices more often than in solo practices. GPs/FPs who are paid by fee-for-service refer to non-MDs less often than those who are paid by other methods (e.g., salary).

Abundant additional information was collected beyond the basic research question, mainly for future research. Some of these data are striking: many GPs/FPs have never referred a child/family for a child protection concern; most child protection referrals are to pediatricians and then to psychiatrists; the GPs/FPs who stated that non-MD referrals take longer than MD referrals referred more to pediatricians and psychiatrists than to non-MDs; the GPs/FPs who refer to non-MDs stated that it took the same amount of time to refer to non-MDs or MDs. Another distinctive finding was that the survey comments showed strong GP/FP frustration with the lack of help for children and their families, including some alarming examples.

The work reported here provides data about MD/non-MD collaboration, discusses practice implications, and offers suggestions about how to encourage child protection referrals from GPs/FPs particularly to non-MD health and human service professionals. GPs/FPs may be the province's most accessible, powerful professional resource for children and their families, and the least motivated to take action.

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## Chapter 1: Background

### Introduction

Better early intervention in child protection cases is needed - it does not occur enough (Gove, 1995). Health and human service professionals are not pooling known information about families, and often do not individually realize the magnitude of particular problems. Consequently, they often miss early and late opportunities to take decisive action (Gove, 1995). Collaboration needs to be more effective and efficient between General Practitioners (GPs) / Family Physicians (FPs) and other health and human service professionals (e.g., nurses, psychologists, and social workers). The Gove Inquiry did not explore the structural and organizational issues for GPs/FPs which could be barriers to collaboration. Structural barriers (e.g., legal concerns surrounding confidentiality) and organizational issues (e.g., unclear roles, time limitations, lack of remuneration for their time) appear to significantly impede GPs/FPs from collaborating. The research reported in this thesis focuses on these organizational issues from a theoretical and practical perspective. Organizational Citizenship Behaviour (OCB) theory, which addresses time limitations and fairness, is applied. OCB theory suggests that if GPs/FPs believe that child protection collaboration is an "extra role" activity, organizational issues will influence the extent to which it is done. The objectives of the research were to learn whether collaboration patterns were accounted for by the behaviour described in OCB theory, and to use outcomes to suggest further research for practice implications.

### The Role of the General Practitioner / Family Physician

As the "gatekeepers" of the Canadian health care system (Gass, 1997), GPs/FPs treat most patients themselves, and refer some to other health and human service professionals,

mainly other MDs. Some patients visit GPs/FPs solely to acquire these referrals, as required by the BC Medical Services Plan (MSP). Visits are for many reasons, often involving psychosocial issues (McWhinney, 1989). Family practice residents currently receive training in the management of psychosocial problems, in addition to their more traditional bio-medical training. They are taught that these two areas often overlap. Nevertheless, GPs/FPs appear to under-treat psychosocial distress.

“The prevalence of psychosocial problems in primary care is estimated to be high.

Various studies, including several that asked physicians to estimate the burden of psychosocial distress in their own practices, indicate that between 20 % and 47 % of patients visiting family or general practitioners are suffering from significant emotional or psychological problems. Despite this high prevalence and physicians' apparent awareness of it, the amount of time devoted to treatment of psychosocial problems in daily practice tends to be low; in several surveys, family physicians themselves estimated that they do psychotherapy, counseling, or "therapeutic listening" in less than 5 % of all patient visits. Nor is the disparity between prevalence and treatment accounted for by high referral rates. Studies indicate that family physicians refer an average of only 5 % of patients with diagnosed psychosocial problems to any mental health resource and that only 1 % of all family physicians' referrals are to non-medical community resources. There could be many reasons for these low referral rates; lack of time, inadequate community resources, poor previous experience, assumptions about patient wishes, and negative attitudes about referral have all been cited. Few studies have attempted to assess family physicians' knowledge of social services” (Craven, Kates & Raso, 1990, p 443).

Clearly there is a need for research that will examine whether concerns about child protection are one of the psychosocial problems on which GPs/FPs spend little time, and if so why that is the case.

GPs/FPs are in a unique position to assist children in profound ways, particularly when more than one family member attends the practice, and when relationships can be built over time. It is frequently the case that the GP/FP may be one of a few people known to the child, who has the opportunity, legitimacy and the power to intervene.

According to the Child, Family, and Community Services Act, 1997 (see Appendix I), all suspicions of child abuse must be reported immediately. The Canadian Incidence Study of Reported Child Abuse and Neglect states that health professionals (defined as hospital- and clinic-based physicians and nurses, and public health nurses) report 5 % of the cases reported to child welfare services (Trocmé et al., 2001, p. 92 and 93).<sup>1</sup>

There are often other situations that may represent abuse-related symptoms, however, which are not clearly *reportable* (e.g., a child with chronic nightmares and/or stomach aches). In such instances, options open to the GP/FP include:

- minimizing the concern that symptoms may be related to child abuse and doing nothing;
- waiting until the child/family provides the opportunity to collect more data;
- seeking-out other professionals who know the child/family and discussing concerns with them; and
- referring the child and family to another professional.

It is not known how often each of these options is executed. What is clear, however, is that the public outcry following the death of Matthew Vaudreuil, the focal point of the Gove Inquiry, showed that society expects all health and human service professionals, including physicians, to do far more to protect children.

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<sup>1</sup> The proportion of physicians versus nurses could be calculated separately, as the survey itself distinguishes between the two (Trocmé et al., 2001, p. 124).

"In five and one-half years Matthew had at least 60 doctor's office visits, and was taken to emergency wards at least 20 times, usually for non-emergencies.

Examinations of Matthew appear to have been performed professionally, and the medical records often identify (his mother) as a major source of Matthew's difficulties. Each procedure seems to have been done adequately, but in almost all cases they were isolated interventions. The immediate concern was addressed but Matthew's overall safety and well-being were not" (Gove, 1995, p. 150).

How the GP/FP can collaborate with other health and human service professionals more effectively is unclear. While 118 recommendations were made following the Gove Inquiry (Morton, 1996) none of them describe specific actions GPs/FPs might or should take to improve collaboration. The recommendations repeatedly insist that collaboration needs to be improved, but examples are only given for government offices and for ideal government-organized community centres, not for practitioners in solo or small group practice. Note, for example, the vagueness of Recommendation 61: "Members of the medical profession need to work with other child welfare professions and service organizations to improve cross-disciplinary approaches to training and development" (Morton, 1996). Also, the recommendations do not acknowledge that some physicians are reluctant to report even clear cases of children in need of protection, and even more reluctant to act on cases of greater ambiguity (e.g., anonymous personal communication, October 15, 1998; Vulliamy, 1998).

If a GP/FP chooses to collaborate with other professionals, forming alliances can be difficult. In some communities, other professionals often are not as accessible as they are in structured locations, such as hospitals. Alliances formed in hospital settings are

frequently not transferable into the community, since most non-MDs seldom work in both environments. There are no organized mechanisms for individual practitioners to connect with each other in larger communities, such as cities. Connections are frequently limited to social encounters on a casual basis, or may be non-existent.

Whether the role of the GP/FP includes responsibility for other members of the health and human services team is also unclear and problematic. The belief that medical doctors are responsible for the work of the entire professional team is widely held. For example, Merton, Reader and Kendall (1957) state that: "The physician must collaborate with others of the medical team rather than dominate them (nurses, social workers, technicians). But, he has the final responsibility for the team and must see to it that his associates meet high standards" (p. 75). A competing belief is that each professional is an equal team member. This misunderstanding was demonstrated recently when a medical student in a role play simulation at The University of British Columbia stated emphatically that she was "in charge" to the 12 other health and human service students on her team. Her belief was questioned afterwards by those in the other professions, including a nursing faculty member. The medical student was puzzled and stated that this is what she had been taught (personal communication, October 8, 1998).

Responsibility within collaborative teams currently appears to vary, particularly when it is not clear who is a team member (i.e., when members do not practice in the same location). Any team member can be in charge, and the role may rotate. The most suitable person to be in charge may, for example, be the most experienced professional; or the one who knows the family best; or the one with the best rapport with the family; or the one with the strongest team building skills; or the one who saw the family the most recently;

or even a family member. Conversely, leadership may be assumed by no one, a state that may go unnoticed for years (as with the case of Matthew Vaudreil and his family). It is unclear whether anyone from any of the professions wants to assume the daunting role of leading the entire team themselves, or conversely to fully respect the leadership of someone else. Not having a team leader, however, has proven to be dangerous for children and their families (Gove, 1995).

### The Benefits of Collaboration

The BC Ministry for Children and Families has identified several reasons why interprofessional collaboration is particularly advantageous to children and families:

“Children and families have a wide range of often complex and inter-related needs.

These needs cannot be adequately addressed by individual service providers working in isolation. While the correct range of services may be provided, they can prove ineffective. For example, when service providers work in isolation, clients may have to deal with many different professionals who may or may not be in contact with each other; information about a case may be missed; information may have to be repeated by client and provider; time may be wasted, and minor but vital links between services may be overlooked” (BC Ministry for Children and Families [BCMCF], 1997).

More specific advantages, according to Anglin and Artz (1998, p. 7) are:

- “1. better case assessment and planning through coordination and collaboration of inputs from different disciplines;
2. the development of joint initiatives;
3. more informed decisions through greater information and multiple perspectives;
4. a higher level of productivity;

5. increase staff satisfaction and professional stimulation;
6. more effective use and exchange of resources;
7. more holistic perspective and understanding of client and situation;
8. more creative thinking about client and situation;
9. can deal more effectively with complex and broad issues and questions;
10. ability to solve problems beyond the scope of any one discipline;
11. enhanced competence of team members;
12. shared responsibility cushions the effect of failure;
13. power parity and equity amongst team members; and
14. emotional support for other team members.”

#### The Availability of Collaborators

The large number of health and human service professionals who work with children and their families, appear to be readily available to GPs/FPs in many locations (see Table 1).

In Vancouver, there are dozens of professional service options for families. For example, The Red Book Directory of Services for the Lower Mainland has been published annually since 1958 (Information Services, 1998, p iii). The 1998 edition lists 107 agencies as resources for families (p. 684-687), and several hundred more for various related subjects (p. 581-849). Additionally, it includes 120 private practitioners separately; 28 of them indicate that they specialize in family issues and/or family violence (p. 945). Each practitioner is further described individually with common headings: professional accreditation, services offered, theoretical orientation, areas of special interest, availability, fees, description of services, and special services. There are

other resources, which are not listed in the Red Book (e.g., additional private practitioners listed in The Yellow Pages, programs offered through the Vancouver Richmond Health Board such as “Nobody’s Perfect”).

Table 1a

Health and Human Service Professionals Who Work With Children/Families in the Community

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Professionals

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Audiologists

Child and Youth Care Workers

Counsellors/Psychologists

Dentists

Dietitians

Medical Doctors

Mental Health Workers

Nurses

Physical Therapists

Social Workers

Speech/Language Pathologists

Teachers

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Table 1b

Locations of Health and Human Service Professionals Who Work With  
Children/Families in the Community

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Locations

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agencies (private and public)  
 daycare centres (private and public)  
 clinics (private and public)  
 family services teams (public and private)  
 group practices  
 health departments  
 schools  
 solo practices  
 universities

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The recommendations from the Gove Inquiry, suggest that resources, such as those described above are underutilized (Morton, 1996), although the reason is unclear. Reasons may include the need for patients to pay for some of these services themselves, or a perception that these services are reserved for acute cases only. More importantly, for some professionals, an impersonal disregard towards clients as suggested in the following statement regarding child protection in BC may be the reason:

“Relationship, long thought to be at the heart of helping, is hard to develop when no preventive or early-support services are offered and the ministry is reduced to policing

child maltreatment and adjudicating whether there is sufficient risk to warrant removal" (Sullivan, 2000, A11).

### Referrals

It is not known how often or how easily GPs/FPs refer children and families to other health and human service professionals in the community for any reason, much less specifically for child protection. The following related data, however, suggest that the referral rate is low:

1. "...family physicians refer an average of only 5 % of patients with diagnosed psychosocial problems to any mental health resource and only 1 % of all family physicians' referrals are to non-medical community resources" (Craven et al., 1990, p 443).
2. "Epidemiological data suggest that approximately 20 % of children seen by primary care physicians either meet criteria for psychopathological disorders or disturbance of role functioning. Physicians appear to identify approximately one half of these children as having psychosocial problems" (Lynch, 1981, p. 273).
3. "A survey of 255 family physicians and general practitioners in the Hamilton-Wentworth area, revealed that knowledge of social services and community treatment programs was often poor: 65% of 122 respondents did not know about one or more points of access to social services information, and 26 % reported that they knew of appropriate social services for less than half of 13 psychosocial problems commonly encountered in family practice" (Craven et al., 1990, p. 443).
4. "...pediatricians did not appear to know whether or not the child was safer because they had reported" (Vulliamy, 1998, p. 70).

Studies such as these, suggest that GPs/FPs are not responding well to children who need protection.

Some of the poor response by GPs/FPs to children in need of protection can be attributed to the difficulty in identifying children in need of protection. For example:

- "...parents fail to disclose psychosocial concerns to physicians, even when they are asked by physicians" (Lynch, 1981, p. 278); and
- "...signs of possible abuse or neglect, ... particularly those of a behavioural nature, may be signs of other problems" (BCMCF, 1998, p. 10).

Even if they do identify a child who may need protection, many GPs/FPs do not appear to have a viable action plan ready.

#### Medical Service Plan Coverage

Because the Medical Services Plan of BC does not pay for patient visits to most non-MD health and human service professionals, a decision to refer is frequently not taken, even though limited funding is sometimes provided through clinics and government supported community agencies. If a GP/FP perceives that such agencies are meant only for children in acute distress, or only for children who need to be apprehended, the GP/FP may mistakenly believe that there are not available resources for a child with a more ambiguous risk status. Since many families cannot afford to pay for specialized non-MD services privately (e.g., for visits to a nurse, psychologist, or social worker in private practice), this may encourage a GP/FP to either refer children and their families to pediatricians or psychiatrists (who are funded by the MSP), or to minimize the need for support (i.e., do nothing).

## Chapter 2: Supporting Literature

### Health Collaboration

The literature repeatedly documents difficulties in collaboration between health and human service professionals (e.g., Gilbert et al., 2000; Lynch, 1981; Poulton & West, 1996; Szasz, 1969; Weisbord, 1976). "Bainbridge and Matthews (1996) found that practitioners did not feel prepared for effective interprofessional teamwork" (Gilbert et al., 2000, p. 224).

Most of these difficulties, however, have been studied in large, structured settings (e.g., hospitals, large rehabilitation clinics). Community interactions have been less well observed – it is therefore unclear how hospital-based findings might be applied in community settings.

Issues associated with collaboration were reviewed in five empirical research studies. Four are published studies: two document physician to physician referrals (Langley, MacLellan, Sutherland, & Till, 1992; Langley, Minkin, & Till, 1997); one documents physician-social worker experiences in hospital settings (Abramson & Mizrahi, 1996); a fourth describes interviews with six general practice teams (Field & West, 1995). A fifth study is an unpublished Master's Degree thesis on pediatrician experiences of reporting child abuse (Vulliamy, 1998). Although data from these projects do not directly address referrals between GPs/FPs and other health and human service professionals in the community for purposes of child protection, these data allow for the generating of hypotheses.

Langley and MacLellan et al. (1992) surveyed 41 GPs/FPs and 20 consultants in Nova Scotia about nonmedical factors affecting referrals for consultation (1992) – the

professional identity of the consultants is not, however, revealed in the article. It is presumed that by “referral” the authors mean referrals by GPs/FPs to medical doctors (MDs) who are not GPs/FPs. They conclude that the most influential factors leading to referral and cited in unprompted interviews are (in descending order of prevalence): patient wishes, FP capabilities, style of practice, FP wishes, availability of consultant, family’s wishes, difficulties with travel, medicolegal issues, the FP’s geographic location, and FP-patient relationship (p. 663). It can be assumed that some (or all) of these factors may also influence GP/FP decisions to refer to non-MD health and human service professionals.

Langley and Minkin et al. (1997) surveyed 125 GPs/FPs in 5 geographic regions in Nova Scotia to determine the extent of regional variation of non-medical factors that affect the decisions of GPs/FPs to refer to another health care provider. In this study, the consultants were described as *specialists*, a term which in the context of the medical literature generally means non-GP/FP MDs. They concluded that:

“Three factors affecting referral showed unequivocal variation across the 5 groups.

Access to hospital facilities and remoteness from specialist care, leading to local styles of practice or treatment policies, and the FP’s relationship with specialist consultants appeared to be important nonmedical factors affecting referral decisions. For similar case scenarios the physicians living in rural areas would refer only half as often overall as those living in urban areas with tertiary care hospitals; for some cases, such as a severe asthma attack, the difference was more than 7-fold” (Langley & Minkin, 1997, p. 265).

On the basis of these findings it might be presumed that similar factors may influence GP/FP decisions to refer to non-MD health and human service professionals.

Abramson and Mizrahi (1996) identified additional issues that come into play when MDs collaborate with non-MDs. Fifty three social workers and 50 physicians in 12 hospital settings were interviewed about their best and worst experiences collaborating on a case. The participants were not randomly selected, and the dynamics in the hospital setting may be very different than those found in a community setting. Nevertheless, the conclusions reached in this study suggested topics for investigation in this research:

“Differences between the two professions were greatest on the interactional factors, with social workers valuing them much more than physicians did. Communication appeared to be the only intrinsic or universal aspect of collaboration equally important to both groups in both types of cases” (Abramson & Mizrahi, 1996, p. 270).

Most of the concerns about collaboration were similar for both social workers and the physicians. Both were concerned about their dissimilar perspectives. There were four categories in which social workers and physicians interviewed differed by a factor of more than 10 out of 30 importance intervals in their ranking – thus (p. 274):

1. your capability not acknowledged (more of a concern to social workers than to physicians);
2. disrespectful treatment by collaborator (more of a concern to social workers than to physicians);
3. collaborator's feedback not timely (more of a concern to physicians than to social workers); and

4. collaborator did not do paperwork (more of a concern to physicians than to social workers) (Abramson & Mizrahi, 1996).

Field and West (1995) identified an even larger number of issues when more than two professions were asked about collaborating together. Ninety six members of primary health care teams in six practices were interviewed in a study "...designed to explore attitudes to change, team-working, and team-building" (p. 123). Amongst other conclusions, the following barriers to team-building were identified by the three practices which had not worked on their team-building (Field & West, 1995, p. 126):

- "1. (team-building activities scheduled during) their off duty time;
2. lack of understanding of the need for team-building;
3. skepticism about the quality of the initiatives offered;
4. difficulty in finding suitable time...to attend;
5. doubt about the usefulness of events involving only half a team;
6. fears regarding the process;
7. perception that practice problems are too deep-seated to be helped by a workshop;
8. doctors perceived as not wanting to change; and
9. receptionists feeling that they are too old to make a contribution.

Vulliamy (1998, 2000) studied issues relating to collaboration that were specific to child protection. 50 pediatricians in Vancouver BC were asked their opinions regarding reporting abused children to The Ministry of Children and Families. Their documented concerns included: lack of confidence in the social workers, disruption to the family, and loyalty to the child's parent (Vulliamy, 1998, 2000). For example, 86 % of the 21

respondents had negative comments about social workers. Their comments (1998, p. 73) included the following:

1. *"Notably, sometimes I seem to have to convince them they should look into things even with physical evidence reported";*
2. *"Initially I was frustrated that the worker would not do anything as "it would not stand up in court"; and*
3. *"The social worker over-reacted, despite my every efforts to prevent this."*

Pediatricians were surveyed rather than GPs/FPs, and clearly reportable, rather than ambiguous, cases were studied. The results of this study clearly suggested that further research should be conducted with GPs/FPs, in particular, research that would probe the confidence of GPs/FPs in other health and human service professionals.

#### A Provincial Inquiry, Forums, and a Focus Group

The purpose of the Gove Inquiry (Gove 1995) was to investigate the circumstance that led to the death of 5-year old Matthew Vaudreuil, caused by his mother, even though Matthew and his mother had visited a large number of health and human service professionals in the several years preceding his death. The inquiry made 118 recommendations targeted at prevention of such tragedies in the future. One of those recommendations was to teach health and human service professionals how to collaborate with each other (Morton, 1996). To further this recommendation, the Ministry of Advanced Education subsequently funded an interprofessional team from The University of BC (UBC) and The University of Victoria (UVic), of which I was a member, whose task was to develop curricula focusing on child protection for students and practitioners. Parts of the curricula were successfully piloted in April, 1999 and the entire curriculum

(Harrison et al., 1999) was subsequently distributed for implementation to educational institutions throughout the province. Implementation, however, has been difficult. Some disciplines cite academic topics of higher priority or an inability to schedule a common time convenient for students from several disciplines to learn together (personal communication, August 15, 2000). Many other recommendations made by the Gove Inquiry are also progressing slowly (Willcocks, 2000).

In the process of developing the above mentioned curricula, the UBC/UVic team conducted two forums and a focus group in 1997-98. Almost 100 educators from across the province attended the forums, and approximately one dozen front-line health and human service professionals attended the focus group. One of the many concerns expressed, particularly by focus group members, was the unwillingness of many GPs/FPs to collaborate outside of hospital settings with non-MD health and human service professionals. Participants suggested that this unwillingness to collaborate was primarily due to two factors: GP/FP concerns about the legal requirements to maintain patient confidentiality, and the reluctance of GPs/FPs to collaborate without remuneration.

Focus group members voiced frustration about their inability to obtain crucial information from GPs/FPs about the families with whom they were working. They were also frustrated about "not being treated respectfully as a fellow professional" (anonymous personal communication, June 10, 1998). Focus group participants were particularly supportive of my research interest.

This health and human services research provides a practical perspective to the issue of interprofessional child protection collaboration. Research from commerce and sociology provides a theoretical perspective.

### Organizational Theories

Organizational behaviourists and sociologists have explored various facilitators and barriers to collaboration in the workplace, which are applicable to GP/FP collaboration. According to Peter Robertson (1998): "In general terms, collaboration refers to the process through which two or more actors intentionally work together to accomplish a specified objective....Four main prerequisites (are) necessary for organizations and their members to collaborate: incentive, willingness, ability, and capacity" (p. 70). It is not known to what extent GPs/FPs possess each of these prerequisites. As health and human service professionals can minimize their collaboration with each other if they wish (since GPs/FPs are not required to work with non-MDs in the community), some insight may be found in a theory which looks at "extra-role" behaviour - Organizational Citizenship Behaviour theory.

### Organizational Behaviour Theory

Organizational Citizenship Behavior (OCB) was developed in a School of Business doctoral thesis (Smith, 1983) and in a subsequent article (Smith, Organ & Near 1983). Smith summarized OCB as "...innovative and spontaneous activity that goes beyond role prescriptions", which is actually essential to the operation of the organization (Smith et al., 1983, p. 653). This concept was subsequently studied extensively by W. Dennis Organ (Bateman & Organ, 1983; Farh, Podsakoff & Organ, 1990; Hui, Organ & Crooker, 1994; Konovsky & Organ, 1996; Moorman, Niehoff & Organ, 1993; Organ, 1988; Organ, 1990; Organ, 1994; Organ & Konovsky, 1989; Organ & Lingl, 1995; Organ & Moorman, 1993; Organ & Ryan, 1995; Smith, Organ & Near, 1983). Although much of Organ's research attempted to describe factors which facilitate or impede OCB, the conclusions

he reached were somewhat mixed. The most important findings relate to positive job attitudes and sub-categories that include perceptions of workplace fairness and organizational commitment. Some of the other hypotheses include personal issues, organizational incentives, and issues of leadership.

In the first description of OCB, Smith et al. (1983) credits the contribution of Katz (1964) with inspiring the development of OCB. Katz acknowledged that one of the basic types of behaviour essential for a functioning organization, is behaviour which Smith summarized as: "...innovative and spontaneous activity that goes beyond role prescriptions....Every factory, office, or bureau depends daily on a myriad of acts of cooperation, helpfulness, suggestions, gestures of goodwill, altruism, and other instances of what we might call citizenship behavior" (Smith et al., 1983, p. 653).

Smith also credits Roethlisberger and Dickson (1964) with introducing the term *cooperation*, and differentiating it from *productivity*. Smith (Smith et al., 1983, p. 653) summarizes this distinction:

"Cooperation thus included the day-to-day spontaneous prosocial gestures of individual accommodation to the work needs of others (e.g., co-workers, supervisor, clients in other departments), whereas productivity (or efficiency) was determined by the formal or economic structure of the organization."

Several authors have identified antecedents to OCB; for example, Altruism, Social Exchange Theory, Social Psychology, and Equity Theory:

#### 1) Altruism

"Mood state influences the probability of prosocial gestures. Subjects in whom a mood of positive affect had been induced – whether by prior success on a

challenging task, the good fortune of receiving some windfall, or simply quiet meditation on past enjoyable experiences – were more likely to behave altruistically”(Smith et al., 1983, p. 654).

## 2) Social Exchange Theory

“To the extent that a person’s satisfaction results from the efforts of organizational officials and such efforts are interpreted as volitional and nonmanipulative in intent, the person will seek to reciprocate those efforts” (Bateman & Organ, 1983, p. 588).

## 3) Social Psychological Experiments

“Social psychological experiments strongly support the contention that prosocial gestures are most likely to occur when a person experiences a generalized mood state characterized by positive affect. To the extent that job satisfaction, as conventionally measured, reflects this positive affective state, it is likely that more satisfied persons display more of the prosocial, citizenship behaviors” (Bateman & Organ, 1983, p. 588).

## 4) Equity Theory

“Both early and more recent work on equity theory has shown that employee job performance may increase or decrease in relation to perceptions of inequitable outcomes” (Moorman, 1991, p. 845).

Smith synthesized several of these antecedents and concluded that “Citizenship behaviours are important because they lubricate the social machinery of the organization. They provide the flexibility needed to work through many unforeseen contingencies; they enable participants to cope with the otherwise awesome condition of interdependence on

each other” (Smith et al., 1983, p. 653-4). Smith contended that “Good citizenship behaviour could be accounted for by characteristic mood state and the extent to which certain environmental forces and individual difference variables could independently predict citizenship behavior (Smith et al., 1983, p. 656).

Smith studied 422 bank employees. She concluded that *leader supportiveness* and *job satisfaction* facilitated OCB. She was unable to reach conclusions, however, about the effects of education, urban/rural origin, generalized compliance, task interdependence, extraversion, belief in a just world, or birth order. These preliminary findings led her to conclude that OCB was worthy of further study (Smith et al., 1983).

OCB theory was in an initial, exploratory phase, from 1983 until 1993-1995, and was summarized by Organ in three review articles (Organ, 1994; Organ & Moorman, 1993; Organ & Ryan, 1995). In 1993, he concluded that “fairness, rather than job satisfaction, accounts for OCB” (Organ & Moorman, 1993, p. 5). In 1994, he concluded that “a review of the research on personality measures and OCB does not support the case for dispositional affectivity as an important determinant of OCB. A stronger case emerges for the role of some variant of conscientiousness” (Organ, 1994, p. 465). In 1995 he compiled a meta-analysis of 55 OCB articles and concluded that:

“The relationship between job satisfaction and OCB is stronger than that between satisfaction and in-role performance, at least among nonmanagerial and nonprofessional groups. Other attitudinal measures (perceived fairness, organizational commitment and leader supportiveness) correlate with OCB at roughly the same level as satisfaction. Dispositional measures do not correlate nearly as well with OCB, with the exception of conscientiousness” (Organ & Ryan, 1995, p. 465).

He also warned that self- versus other-ratings of OCB differ widely (Organ & Lingl, 1995).

### Organizational Citizenship Behaviour Research

Few studies of OCB were published immediately following Smith's thesis and article (perhaps reflecting the fact that she died prior to publication and received her degree posthumously). Several studies, however, have been published recently, which suggests that investigators are developing an interest in the theory of OCB as a useful descriptive framework.

At least 18 studies have been published which have investigated the application of OCB. I focus on six that centre on: identification of extra-roles (Morrison, 1994; Latham, Millman & Karambayya, 1997), fairness (Farh et al., 1990; Moorman, 1991; Niehoff & Moorman, 1993) and time limitations (Hui et al., 1994). Other studies characterize: leadership (Deluga, 1994; Morrison & Phelps, 1999; Van Yperen, van den Bert & Willering, 1999), organizational commitment (Williams, 1991; Gregerson, 1993), organizational incentives (Deckop, Mangel & Cirka 1999; Skarlicki & Latham, 1995; Werner, 1994), and personal issues (Organ & Konovsky, 1989; Pearce & Gregersen, 1991; Eastman, 1994; Witt & Silver, 1994). These numerous characteristics of behaviour likely can also be applied to the decisions made by GP's/FP's to initiate referrals. The characteristics: extra-roles, fairness, and time limitations were selected for study because they appeared most relevant to GPs/FPs.

The identification of extra-roles is a logical starting point.

### The Identification of Extra-Roles

The literature warns that the distinction between a prescribed role and an extra-role is often unclear. Employees, managers, and researchers define numerous activities differently.

In a survey of 317 clerical workers, Morrison (1994) reported that employees differed in what they defined as *in-role* and *extra-role* behavior. Differences were related to commitment and social cues (i.e., employees were more likely to display OCB if they defined the behavior as in-role rather than extra-role). The results of this study indicate that "the boundary between in-role and extra-role behavior is not clearly defined and that OCB is a function of how broadly employees define their job responsibilities" (Morrison, 1994, p. 1543).

Latham et al. (1997) also found confusion of the definition associated with particular extra-role behaviours - employees are unclear about which activities constitute extra-role behaviour, as are their managers, and investigators of OCB.

"59 researchers, scholars, managers, and union employees were surveyed ...using scales designed to measure OCB, altruism, collectivism, and organizational commitment. The results showed that only OCB researchers could distinguish OCB items from the other three content domains. Managers were only able to distinguish OCB items from altruism. Union members perceived the OCB scale items to be as indicative of altruism, collectivism, and organizational commitment as they are of OCB. (Scholars) perceived OCB items to be as indicative of collectivism and organization commitment as they are of OCB. Thus it would appear that items that

purportedly measure OCB are not perceived as falling in a unique content domain” (Latham et al., 1997, p. 206-7).

This investigation calls into question all OCB studies which do not rigorously address these different perspectives. It is therefore essential that investigators who use OCB theory, acknowledge that in-role and extra-role behaviours are often defined differently. This difference in definition leads to an inconclusiveness in results.

The second OCB characteristic selected for study is fairness.

### Fairness

In addition to the review by Organ and Moorman (1993), three studies focusing on fairness and OCB concluded that fairness was a key component of job satisfaction which led to OCB (Farh et al., 1990; Moorman, 1991; Niehoff & Moorman, 1993).

Farh et al. (1990) found that fairness was distinct from satisfaction. She studied leader fairness in relation to satisfaction and task scope, and its influence on OCB in 195 Taiwanese Ministry of Communications workers. “Overall, the data do not support the view that satisfaction is in any sense a direct cause or antecedent of either Altruism or Compliance....Leader fairness and task characteristics are the relevant causal variables” (Farh et al., 1990, p. 716-717).

Fairness was also the most important component of job satisfaction leading to OCB according to Moorman (1991). Moorman assessed 225 employee self-ratings and ratings from their managers, in two painting industry companies. When perceptions of fairness were measured separately from job satisfaction, job satisfaction was not related to OCB (Moorman, 1991, p. 845).

Niehoff and Moorman (1993) supported the finding of fairness as a key issue. They studied the impact of performance monitoring on OCB in 213 employees of a national movie theatre company. Both negative and positive effects on OCB were documented. Monitoring restricted employees from performing some extra duties, but also increased the perception of workload fairness which increased performing extra duties overall (Niehoff & Moorman, 1993, p. 527).

The third OCB characteristic selected for study is time limitations.

### Time Limitations

The effect of time limitations on OCB behaviour has not been well studied, despite their logical connection (i.e., how can anyone do anything extra without having extra time?). Only one study was found which addressed time limitations (Hui et al., 1994).

Hui et al. (1994) conducted a study of 77 undergraduate students, in which time pressure was manipulated in a laboratory task. The objective of the study was to test whether time limitations and personality contributed to OCB. Participants were asked to complete a personality questionnaire, and to perform a calculation. Half of the participants performed the calculation under time pressure, and the other half performed the calculation without time pressure. After each participant was thanked and left the test area, s/he was asked by a stranger in the hall to complete a seemingly unrelated survey. Completing this survey for the stranger was deemed to be a demonstration of OCB. Three variables were studied:

- Type A personalities versus Type B personalities. "Type A scorers exhibit an attentional style that fixes upon stimuli central to their assigned task.

Compared to their opposites (Type B scorers), they show less sensitivity to

peripheral cues....Type A persons have a higher threshold for sensing, or even caring about what is not relevant to their tasks at hand” (Hui et al., 1994, p. 201);

- Time pressure versus no time pressure; and
- Completing the seemingly unrelated survey or not.

The results of this study indicated that Type A scores did not correlate with completing the seemingly unrelated survey less often; but time pressure did correlate with completing it less often. The authors concluded that time pressure, rather than personality, facilitates OCB.

#### OCB Research Summary

The OCB literature is still developing and some of the findings in that literature are difficult to reconcile. While a matrix of complex contributing factors and implications is exciting to contemplate, a well-defined matrix does not yet exist. In 1997, Latham et al. warned that “OCB is currently in danger of degenerating into a contentless construct to the extent that it defines everything and anything and hence cannot advance our understanding of employee behaviour” (Latham et al., 1997, p. 207). Although three review articles by Organ attempted to consolidate the research findings, a more focused theory needs to be developed.

Studies to date are also limited because only a segment of the workforce has been studied. Organ acknowledges this limitation in the main conclusion of his most recent meta-analysis: “job attitudes are robust predictors of OCB ... at least among nonmanagerial and nonprofessional groups” (Organ & Ryan, 1995, p. 775). Few attempts to study managers and professionals have been made, and those that have are weak. For

example, surveys of executive MBA students, while a convenient population to sample, are not representative of managers (e.g., Williams & Anderson, 1991; Morrison & Phelps, 1999).

Despite its limitations, OCB may be applicable in understanding GP/FP referrals to non-MD health and human service professionals for child protection concerns. For example, it may be the case that GPs/FPs who make these referrals are better organizational citizens than those who do not make such referrals, or perhaps those who have learned to reduce the time demands of these referrals and those who are fairly remunerated for this time make these referrals more often.

Determining whether the pursuit of child protection issues is considered to be an extra-role or an in-role behaviour for GPs/FPs is difficult. Most GPs/FPs are likely to respond that it is their legal responsibility to report suspicious cases, and therefore it is an in-role behaviour. But, the symptoms of a child in need of protection are often nonspecific and can easily be minimized or attributed to something else. This requires an assertiveness to rigorously investigate symptoms which may not immediately cause concern. This assertiveness would be an extra-role behaviour for a GP/FP.

This assertiveness was not investigated in this research, as it is impossible to quantify in a self-administered survey (i.e., are GPs/FPs able to judge their individual level of assertiveness?). Rather, the factors which support extra-role behaviour were investigated.

### Chapter 3: Research Methodology

The time required of the GP/FP to refer concerns about child protection and related issues, were the focus of this research. A research question, propositions, concepts, hypotheses, and a survey were developed over a 2 year period. The survey was implemented during the summer of 2000.

#### Research Question

In this research I asked whether time and related issues are significant factors in the decision of GPs/FPs to refer or not refer children and their families to health and human service professionals for concerns about child protection. Posing this question allowed simultaneous collection of demographic and descriptive data associated with referral patterns.

#### Propositions

1. When referring children and their families to non-MD health and human service professionals for concerns about child protection, a significant amount of time is required for most GPs/FPs to complete the referral process.
2. When referring children and their families for concerns about child protection, more time is required for the process when GPs/FPs refer to non-MD health and human service professionals than when referral is made to other MDs.
3. When referring children and their families to non-MD health and human service professionals for concerns about child protection, interprofessional education facilitates the referral process.
4. Group practice settings facilitate the referral process for GP/FP referrals to non-MD health and human service professionals for concerns about child

protection.

5. Fee-for-service payment does not sufficiently compensate GPs/FPs for the time required to refer children and their families to non-MD health and human service professionals for concerns about child protection.

### Definitions

1. General practitioners: general practitioners have graduated from medical school but have not passed the certification examination of the Canadian College of Family Physicians (CCFP).
2. Family physicians: family physicians have graduated from medical school and have passed the CCFP certification examination. Most have graduated from a family practice residency program; others study independently in various ways for the examination.
3. Child protection: advocating an individual child's legal rights, according to the Child, Family and Community Service Act (see Appendix II).
4. Concerns: defined by each individual GP/FP.
5. Health and human service professional: a licensed or certificated professional in one of the health or human service professions.
6. Refer: to arrange for another health and human service professional to see a particular child/family.
7. Referral process: a series of components including:
  - deciding to which professional a child/family should be referred;
  - asking the professional if they would be willing/able to see the child/family;
  - encouraging the family to see another health and human service professional;

- providing the professional with adequate background information; and
  - learning the initial opinion of the professional (e.g., through a report from the professional or a conversation with the professional).
8. Interprofessional: weaving professional expertise, recognizing that this weaving is not executed side-by-side but rather by sharing knowledge with each other, and recognizing that each profession draws from many disciplines.
  9. Interprofessional Education: includes three types:
    - a. preparing for the College of Family Physicians of Canada certification examination (CCFP): usually by attending a family practice residency program; others study independently in various ways for the examination (the family practice residency programs include some interprofessional education);
    - b. training: formal training, further defined by each GP/FP; and
    - c. mentoring: demonstrating wisdom/skills by an experienced and trusted advisor.

### Hypotheses

1. When GPs/FPs refer children and their families for concerns about child protection, the process takes less than 30 minutes.
2. There is no significant difference in perception of the time required for the referral process when GPs/FPs refer children and their families to another MD or to a non-MD health and human service professional.
3. There is no significant correlation between interprofessional education and referrals to non-MD health and human service professionals for child protection concerns.

4. There is no significant correlation between practice setting and GP/FP referrals of children and their families to non-MD health and human service professionals for concerns about child protection.
5. There is no significant correlation between payment by fee-for-service versus other methods of payment, and GP/FP referrals of children and their families to non-MD health and human service professionals.

### Survey Development

The survey and its cover letter incorporated suggestions from two pilot tests, and from several UBC professors in different disciplines. Pilot tests were conducted on general practitioners, family physicians, and social science researchers (six participants in total). The survey was restricted to two double-sided pages, to respect time constraints on physicians, and used language consistent with the education of physicians and with conventional medical terminology (see Appendices III - V). The survey responses were designed for coding into the computer program SPSS.

The survey was difficult to develop. Initially, case studies were developed to limit interpretations of "a child protection concern". The first pilot test showed that the case studies confused respondents and diverted attention from the key research questions. For example, half-page case studies could not provide all of the details needed for objective assessment (i.e., respondents replied: "can't answer - not enough information"). Another issue is that case studies which clearly provoke concern, by law must be reported to the Ministry of Children and Families (see Appendix I). Therefore, the case studies inadvertently focused on whether the case was *reportable* rather than on *referrable* to another health and human service professional.

Asking questions about how respondents collaborated with other health and human service professionals (e.g., by telephone, in writing, in person) was a second approach which was abandoned. This method proved to be too complex for this particular survey because of the diversity of circumstances of patients and service providers. For example, sometimes the families are well-known to both service providers or not known at all; sometimes the service providers know each other well or not at all; sometimes service providers share office space or are on the other side of town from each other. These examples could form the basis for future research questions.

Every revision of the survey increased my understanding of the issues, and the difficulties associated with applying quantitative research methodology to such variable questions. Most of the questions I wanted to ask proved to be ambiguous and circumstantial, despite the most careful wording, as in the example: "Which concerns do you refer to non-MDs; which concerns do you refer to MDs?" Therefore, my survey might easily have frustrated respondents and lead to meaningless results. I therefore focused on those pieces of information which were quantifiable across the large sample.

A qualitative approach was considered, particularly because several illuminating individual interviews with GPs/FPs were conducted during the design phase. Because many of the perceptions of the GPs/FPs were so different each from the other, my interest in learning about the patterns of referrals rather than individual circumstances was reinforced and a qualitative approach was also abandoned.

The solution for the survey was to use broad wording which would accommodate different respondent interpretations and circumstances. For example, the final version of the survey allowed the phrase "child protection" to be defined by each respondent.

Another example was the utilization of the phrase: “if you had protection concerns about a child” rather than providing case studies.

The second pilot survey was successful and therefore formed the basis of this study.

### Survey Sampling

It was difficult to obtain an accurate sampling frame, as confidentiality restrictions limit access to lists of active physicians in the province. The 1999-2000 BC Medical Directory offered the best starting point. The Directory lists physicians by location and specialty, but does not differentiate physicians who do not see patients. For example, many physicians listed occupy administrative, teaching or research roles. In addition, the Directory goes quickly out of date. Many physicians listed in the Directory, therefore, would be ineligible or no longer at the address listed. The Ministry of Health (MoH) agreed to delete inactive names if I submitted a list to them. Therefore, I sent the MoH a list of those physicians in the 1999-2000 BC Medical Directory who:

1. were listed as practicing in the City of Vancouver (p. 192-228);
2. did not have a specialty indicated next to their names (Family Medicine is no longer identified as a specialty in the Directory); and
3. were not listed on the Temporary Register.

I identified 1,084 such names, entered them onto an Excel spreadsheet in alphabetical order, and sent the spreadsheet to the MoH in the spring of 2000. The MoH deleted 163 names. I numbered the remaining 921 alphabetically, and listed in ascending order. I randomly selected 600 of the 921 numbers, using the computer program SPSS. When more than one address was listed for the physician selected, the first address listed was used.

I chose a sample size of 600 for a conservative estimation of the response rate, and to allow for limitations imposed by the UBC Ethics Committee. I estimated a 22% response rate, and estimated that 25 % of those who responded would be ineligible (e.g., those who do not see patients at all, those who do not see children). Therefore, out of the sample size of 600, I anticipated 134 responses, with 33 being ineligible, for a total of 101 eligible responses. This ensured that I would receive the 100 responses necessary for the statistical analysis I had planned. The low anticipated response rate considered the historically low response rates of social science surveys, the high volume of requests received by GPs/FPs, and the requirements of the UBC Ethics Committee that restricted me to two contacts with physicians, contrary to standard survey methodology (e.g., Gray & Guppy, 1994). My inability to send a follow-up postcard between a first and second mailing, make a follow-up phone call after the second mailing, and conduct a third mailing to those expressing interest during the phone call, considerably reduced the probability of a high response rate (see Appendices VI -IX).

#### Survey Data Collection

The survey was sent on June 1, 2000 and again on July 31, 2000. A special stamp was affixed to each outgoing envelope, as studies have shown that using such a device increases survey responses (Dillman, 1991). The stamp was a colourful Boys and Girls Club stamp portraying three smiling children. Business reply envelopes were provided, and were directed to The Office of the Coordinator of Health Sciences at UBC. These reply envelopes included a code number on the outside indicating the originating respondent, to reduce the size of the second mailing. The code numbers were written in black ink on the first mailing envelopes and in blue ink on the second mailing envelopes,

to be able to record from when the response originated. Surveys were separated from their envelopes immediately upon receipt, well before the data was entered, to ensure the confidentiality of the respondents. If a survey envelope was returned by Canada Post indicating return to sender, an attempt was made to obtain a more recent address and re-send the survey whenever possible (e.g., I looked up the physician in the Telus telephone book for a more recent address).

Expenses for the survey were approximately \$1,000 plus the use of office equipment, and were shared by The Office of the Coordinator of Health Sciences at UBC and The UBC Department of Family Practice.

#### Survey Participants

##### Response Rate

The survey response was more than double that anticipated (47.8 % vs. 22 %).

Table 2

Response Rate

Mailing	# Sent	# Received	% Received
1 <sup>st</sup> Mailing	600	185	30.8 %
2 <sup>nd</sup> Mailing	413	92	15.3 %
Unknown*		7	1.7 %
Total	1013	284	47.8 %

Note. Fifteen surveys were returned by Canada Post; one was successfully resent.

\*Seven surveys were not returned in a coded reply envelope, and therefore I was unable to determine which mailing the response was from.

More responses were ineligible than anticipated (33.1 % versus 25 %).

Table 3

Ineligible Responses

Reason for Ineligibility	Number (percent)
No direct contact with patients in a community office practice ever	46 (16.2 %)
Had not seen at least one child in the past month	37 (12.7 %)
Other (e.g., left section blank, stated "no time for surveys")	12 ( 4.2 %)
Total Ineligible	94 (33.1 %)

There were 190 eligible responses, well above the 100 responses required for the statistical analysis planned. Many respondents did not answer every question, however, and therefore most of the results reported in the following tables do not account for all of the 190 respondents (i.e., the totals are frequently less than 190).

### Demographics

The demographics of the eligible respondents were diverse. There were more male respondents than female: 105 male (55.3 %); 83 female (43.7 %).

The age of respondents ranged from 29-76 years old and all local areas were represented.

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Table 4

### Respondent Age

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25-34	35-44	45-54	55-64	65 plus
23 (12.1 %)	53 (27.9 %)	64 (33.7 %)	32 (16.8 %)	15 (7.9 %)

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Table 5

Respondent Local Area

Low Income		Medium Income		High Income	
Strathcona	7(3.7%)	Renfrew	5(2.6%)	South Cambie	1(0.5%)
Granview	15(7.9%)	Sunset	2(1.1%)	Oakridge	4(7.4%)
Mt. Pleasant	11(5.8%)	Victoria	13(6.8%)	Arbutus	2(1.1%)
Downtown	16(8.4%)	Fairview	16(8.4%)	W. Point Grey	7(3.7%)
West End	7(3.7%)	Kilarney	2(1.1%)	Dunbar	5(2.6%)
Marpole	2(1.1%)	Riley Park	2(1.1%)	Kerrisdale	3(1.6%)
Kensington	2(1.1%)	Kitsilano	22(11.6%)	Shaughnessey	3(1.6%)
Hastings	3(1.6%)				

Note. Local area names are those used by Statistics Canada.

Income area based on the 1996 Statistics Canada Census (see Appendix X).

The number of years in practice ranged from 2 – 45 years.

Table 6

Respondent Years in Practice

1-10	11-20	21-30	31-40	41 plus
63(33.2%)	64(33.7%)	43(22.6%)	14(7.9%)	3(1.6%)

Most respondents saw less than 100 patients 18 years of age or under, in the month prior to completing the survey.

Table 7

Approximate Number of Children Seen in the Past Month

1-99	100-199	200-299	300-399	400 or more
131(68.9%)	32(16.8%)	15(7.9%)	5(2.6%)	5(2.6%)

## Chapter 4: Results

### Time Required for the Referral Process

The survey asked the following question: If you had protection concerns about a child, and decided to refer the child and his/her family..., approximately how long do you estimate it would take you to do all of the following:

- decide which professional to refer the child/family to;
- ask the professional if they would be willing to see the child/family (if necessary);
- encourage the family to go;
- provide the professional with adequate background information; and
- learn the initial opinion of the professional (e.g., through a report from the professional or a conversation with the professional).

Physicians were asked to respond in two circumstances:

1. if the referral was to another MD; and
2. if the referral was to a health and human service professional who was not an MD.

Few respondents indicated that the referral process takes less than 30 minutes (9.5% for referrals to MDs and 7.4% for referrals to non-MDs). The median referral time was between 30 minutes and 2 hours, although respondents also indicated that referrals to non-MDs required more time than referral to MDs. This was statistically significant ( $\Pr \geq |S| = 0.0010$ ) according to the Wilcoxon signed rank test for pairs (an analogue for the t test, for related non-parametric measures such as this categorical data utilizing an ordinal scale, which compares pairs of data by each respondent).

Table 8

Time Required for the Referral Process

Amount of Time	For Referrals to MDs	For Referrals to Non-MDs
< 30 minutes	18( 9.5%)	14( 7.4%)
≥ 30, < 60 minutes	60(31.6%)	48(25.3%)
≥ 1, < 2 hours	54(28.4%)	54(28.4%)
≥ 2, < 3 hours	16( 8.4%)	24(12.6%)
≥ 3, < 4 hours	4( 2.1%)	5( 2.6%)
4 hours or more	22(11.6%)	28(14.7%)
missing	16( 8.5%)	17( 8.9%)

Interprofessional Education and Referrals

The survey looked at three different types of interprofessional training and referrals: preparing for the College of Family Physicians of Canada certification examination (CCFP), formal training related to non-MD referrals, and mentorship.

Preparing for the CCFP

Most respondents had passed the CCFP examination (59.5 %), but a substantial number had not (40.5 %). Those who had passed the examination referred to non-MDs *more often* than those who had not passed ( $r = .30, p < .01$ ).

Table 9

CCFP Examination and Non-MD Referrals

Refer to Non-MDs	Passed CCFP Exam	Not Passed CCFP Exam
yes	80(72.7%)	32(42.7%)
no	30(27.3%)	43(57.3%)

Formal Training

Some physicians (16.8 %) received a few hours of formal training (number of hours on file) on referrals to non-MD health and human service professionals. This training occurred either during medical school (7.7 %), during family practice residency training (7.4 %), during their careers (6.1 %), or during more than one of these.

Those with a few hours of formal training did not refer to non-MDs more often than those without formal training.

Table 10

Training on Referrals to Non-MDs and Non-MD Referrals

Non-MD Referrals	A Few Hours of Training	No Training
yes	20(62.5%)	94(60.3%)
no	12(37.5%)	62(39.7%)

### Mentoring

Almost half of the physicians (47.3 %) had mentors who referred children to non-MD health and human service professionals. This mentoring occurred either during medical school or family practice residency (38.4 %), during their professional career (31.4 %) or during both.

Mentorship at any time *increased* referrals to non-MDs ( $r = .15, p < .05$ ).

Table 11

### Mentorship and Non-MD Referrals

Non-MD Referrals	Had Mentorship	No Mentorship
yes	59(67.8%)	52(53.6%)
no	28(32.2%)	45(46.4%)

### Practice Settings and Referrals

Most respondents worked in group practices (63.7 %) while approximately one-third worked in solo practice settings (32.1 %). The types of group practices included: GP/FP groups (50.5 %), various MD groups (3.7 %), and multidisciplinary groups (9.5 %).

GPs/FPs who worked in multidisciplinary groups did not refer to non-MDs significantly more often than those in solo practice. However, those in any one of the three types of group practices collectively did refer *more often* ( $r = .20, p < .01$ ).

Table 12

Practice Settings and Non-MD Referrals

Non-MD Referrals	Group Practice	Solo Practice
yes	81(66.9%)	28(45.9%)
no	40(33.1%)	33(54.1%)

Method of Payment and Referrals

The primary method of payment was overwhelmingly fee-for-service (87.9 %). Only 10.5 % received a different form of payment.

Those who were paid by fee-for-service referred to non-MDs *less often* (57.5 %) than those who were paid in other ways (85.0 %), ( $r = .17$ ,  $p < .05$ ).

Additional Information

Extensive additional information was obtained in process of obtaining the data for the research question. Some of them are included here to benefit future research.

Types of Referrals for Child Protection Concerns

Respondents indicated that they had referred to a range of individual professionals and to professional teams, for concerns about child protection, throughout their careers. They referred to pediatricians and psychiatrists most often.

Table 13

Number of Referrals to Whom

Rank	Referrals to	Number of Referrals	At Least One Referral
1	Pediatrician	1517*	85
2	Psychiatrist	891*	61
3	Social Worker	460.5*	39
4	Child Protection Team	343.5	34
5	Psychologist	198*	36
6	Mental Health Team	175.5*	51
7	School Counselor	168*	35
8	Family Services Team	119.5*	40
9	Community Health Team	111.5	34
10	Nurse	91*	11
11	Child & Youth Care Worker	3	1

Note. \*These numbers would be higher if 22 respondents had not used a word describing the number of referrals in these categories, rather than an approximate number as requested (e.g., "hundreds", "over 100", "many").

GPs/FPs Who Have Never Referred

Thirty percent (57/189) of the respondents indicated that they had never referred to anyone (MD or non-MD) for concerns about child protection.

Table 14

Demographics of GPs/FPs Who Have Never Referred Versus Those Who Have

Demographic	Category	Never Referred	Have Referred
Sex	Male	35(62.5%)	69(52.7%)
	Female	21(37.5%)	62(47.3%)
Age	25-34	7(12.5%)	16( 8.4%)
	35-44	9(16.1%)	44(23.2%)
	45-54	21(37.5%)	43(22.6%)
	55-64	13(23.2%)	19(10.0%)
	65 plus	6( 3.2%)	8( 4.2%)
Years in Practice	1-10	18(32.1%)	45(34.4%)
	11-20	17(30.4%)	47(35.9%)
	21-30	16(28.6%)	27(20.6%)
	31-40	5( 8.9%)	10( 7.6%)
	41 plus	0( 0 %)	2( 1.5%)
Children Seen/Month	1-99	44(77.2%)	86(66.2%)
	100-199	7(12.3%)	25(19.2%)
	200-299	5( 8.8%)	10( 7.7%)
	300-399	1( 1.8%)	4( 3.1%)
	400 plus	0( 0 %)	5( 3.9%)

### Referrals by the Income of Local Areas

The survey asked respondents to identify their Local Area. Local Areas are terms used by Statistics Canada for categorizing the census, and were used in the survey instead of another measure, such as postal code, to be able to cross-tabulate the findings with the census. I stratified Vancouver's 22 Local Areas into three average income categories using data from the 1996 Canadian census and labeled them as low income, medium income, and high income (see Appendix X).

The low and medium income areas were equally represented by respondents (33.7 % and 32.6 % respectively); the high income area was represented approximately half as often (17.9 %).

Comparing referrals from the three income areas, there were more referrals overall from the low income area. Also, referrals to non-MDs decreased as area income increased (i.e., the lower the income area, the more referrals to non-MDs; the higher the income area, the more referrals to MDs).

Table 15

### Referrals by Income Area

Income Area	Referrals to Anyone	Referrals to Non-MDs
low	49/64(76.6%)	41/64(64.1%)
medium	39/62(62.9%)	37/62(59.7%)
high	23/34(67.6%)	17/34(50.0%)

### Survey Comments

The last survey question was a request for comments. Comments were added by 14 % of the respondents. Nine comments were further descriptions of their practice settings; eleven were miscellaneous comments, and seven were the following:

1. *"MDs are more understanding. Non MDs work in programs to which access is limited. I find I am quizzed much more by non MDs."*
2. *"Many children are referred to these teams by their psychiatrists or pediatricians."*
3. *"Often non MDs are not covered by MSP and patients cannot afford them."*
4. *"It is very difficult to be aware of all the community resources available - the "Red Book" is helpful but difficult to use due to it's (sic) organization."*
5. *"None of the non MD professionals have ever paid a visit to my office to advise on child protection services....Indeed, in this office (and in others as verified by discussion with colleagues) there appears to be a "run on your own attitude"...".*
6. *"My experience in dealing with Community Health Services is that, other than the nursing profession, one rarely if ever receives any informal or formal report on referrals of any type. Nearby Community Health Clinic and no professional from there has paid a visit."*
7. *"Few (GPs) know who to refer to....Huge waiting lists. I did refer one family, where my pt a 15 yo girl was being knowingly abused, I referred to social services & NOTHING came out of this. The abuser & abused continue to live in the same house!!"*

## Chapter 5: Discussion and Conclusions

### Discussion

Better early intervention in child protection cases is needed. The welfare of children is multi-factoral and challenging – a conclusion reached by the Gove Inquiry (Gove, 1995). Significant contributions are therefore needed from many different health and human service professions (as well as many other groups. e.g., families, communities and governments). When no single resource is comprehensive, unless there are obstacles to collaboration, it would appear intuitively correct. This thesis does not support or refute the premise of collaboration; rather, it accepts it as a given. A survey of a sample of Vancouver General Practitioners (GPs) and Family Physicians (FPs) was developed to investigate some possible obstacles to effective and efficient collaboration.

### The Data Overall

Data from the survey are imprecise. Despite the large sample (600) and a 48 % response rate (showing considerable interest in the topic), it is probable that responses are likely to be from those most interested in the topic. The 52 % of the sample who did not respond may have a very different perspective.

Respondent bias and the generality of the findings are of concern. In particular, the key responses are a retrospective estimation only. In some cases, for example, respondents were recollecting select cases out of thousands of patients, over a time span of more than 40 years – estimates are therefore approximate. The estimates are informative, however, since no similar data appear to exist.

How well respondents understood the questions asked, particularly given the likelihood that the physicians were busy and probably read the questions quickly, is also of concern. Despite carefully chosen, pilot tested wording, it is possible that individual physicians varied in their interpretation of some questions. For example, in the question: “Have you ever referred a child and his/her family to any of the following licensed health and human service professionals for a child protections concern: ...”, it is not known

which box they indicated when reporting a concern to the BC child protection system. Were those reports categorized as referrals to a child protection team, to a social worker, or were they not included at all? This lack of clarity was identified prior to mailing the survey. The question was reconstructed numerous times, sometimes indicating which option to choose for reporting, sometimes adding specific institutions/agencies into the list of professionals, sometimes adding an "other" selection, and sometimes it was left open ended (i.e., several blank lines for respondents to fill in their own wording preferences). Ultimately, a limited choice of select professionals was provided, to focus attention on professionals and professional teams rather than on institutions/agencies.

The Vancouver-centric perspective of the respondents was also of concern. It is possible that a province-wide survey might show very different results from rural communities, and even other urban areas. Referral practices might differ widely in each community. The Vancouver respondent sample does, however, provide a perspective from BC's largest city.

In summary, the data are approximations. Interprofessional collaboration and child protection are both difficult, unwieldy topics and difficult to study individually. Combining them in a quantitative research study was therefore particularly ambitious. Given the highly variable circumstances of families and physicians, and so much interpretive terminology, it was inevitable that results would be limited. This was accepted *a priori* as partially unavoidable. Nevertheless, the value of these results, however broad, was recognized to be sufficiently important to withstand some predictable criticism. The survey and its results does not purport to be definitive. The results suggest possible trends with consequent hypotheses that can be tested in future research.

### Research Questions

One primary and four secondary hypotheses were tested in this research. Results obtained from a written survey showed that when GPs/FPs refer patients to non-MD health and human service professionals for child protection, such referrals:

- 1) take a significant amount of time;
- 2) take more time than referrals to MDs;
- 3) occur more often when the GP/FP has had interprofessional education than without interprofessional education;
- 4) occur more often when the GP/FP works in a group practice setting rather than a solo practice; and
- 5) occur more often when the GP/FP is not paid by fee-for-service.

### Time Required for the Referral Process

The primary research hypothesis was based on the theoretical possibility that GPs/FPs may perceive the pursuit of ambiguous concerns about child protection as not clearly within their mandate for patient care (i.e., an "extra-role" according to Organizational Citizenship Behaviour theory). The amount of time required to perform an extra-role is a pivotal factor in the decision for or against performing that extra-role. The primary objective of the survey was thus to assess the amount of time required for GPs/FPs to engage in the referral process in instances of child protection.

The referral process for child protection takes most GPs/FPs between 30 minutes and 2 hours (62 %). Some respondents stated that it took more than 4 hours (14 %). This is an exceptionally large amount of time for a GP/FP, considering the most common billing option is for visits which average approximately ten minutes in length. A second billing option, Counseling Visits, are longer at 20 minute visits but are limited to 4 visits per year according to the Medical Services Commission Payment Schedule (BC Ministry of Health and Ministry Responsible for Seniors [BCMHMRS], 1999). A several hour unpaid task therefore requires a considerable commitment from the referring physician.

Consultations, a third billing option, do not include verbal consultations, consultations for child protection concerns, or consultations with most health and human service professionals.<sup>2</sup> Therefore, GPs/FPs who are paid by fee-for-service are not paid for the time required to collaborate with nurses, psychologists, or social workers (e.g., verbal consultations with them, referral notes/letters to them, or meeting attendance with them).

The extensive time required for the referral process and the lack of financial compensation for this time possibly discourages GPs/FPs from pursuing child protection concerns.

#### Time Required to Refer to a non-MD versus an MD

A further possible deterrent to pursuing concerns about child protection is the additional time required to refer to a non-MD compared to an MD. GPs/FPs undoubtedly realize that referring to a non-MD may often be an appropriate next step, but possibly have reservations about the additional time required to refer. This is supported by the data and by several written comments:

- “MDs are more understanding”
- “I find I am quizzed much more by non-MDs”
- “Other than the nursing profession, one rarely if ever receives any informal or formal report on referrals of any type”.

Those who refer to non-MDs indicated that it took the same amount of time to refer to non-MDs as MDs. This is the most meaningful finding of the survey; that is, GPs/FPs who refer to non-MDs, seem to know how to work with them efficiently. The 44 % of the respondents who indicated that referral to non-MDs takes longer, may refer their child

<sup>2</sup> “A consultation applies when a physician, or a registered midwife (for obstetrical or neonatal related consultations), or a non-physician practitioner (chiropractor, for orthopaedic consultations; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication) in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a physician competent to give advice in this field. The service includes the initial services of a consultant necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring physician/practitioner/midwife. A consultation must not be claimed unless it was specifically requested by the attending physician/practitioner/midwife and unless the written report is rendered.” (BCMHMRS, 1999, p. 1.13).

protection concerns to pediatricians and psychiatrists because they believe that such referral is a faster route to resolution of the family's problem.

### Interprofessional Education and Referrals

Particular types of training and all mentoring related to non-MD referrals, increases referrals to non-MDs. A few hours of lecture does not increase referrals to non-MDs, while residency training in Family Practice does increase referrals. This is of particular interest to medical schools. Relying upon "an hour lecture on the Redbook (sic)"<sup>3</sup> (one survey comment) is inadequate. Medical students and family practice residents clearly need training demonstrating non-MD interaction and mentorship on how to refer to non-MDs. This training might be achieved through clinical placements in interdisciplinary settings, and courses with interactive exercises between students from other professions, taught by a team of interprofessional practitioners/professors (e.g., Gilbert et al., 2000).

It is likely that most MDs who have passed the College of Family Physicians of Canada certification examination (CCFP) have had clinical placements in interprofessional settings, since most will have graduated from a family practice residency program. However, some certificants are "practice eligible" without formal residency training; they will prepare for the examination in various ways. General practitioners (those who have not passed the CCFP examination) may not have received any training/mentoring regarding non-MD referrals, since medical schools tend to delay such training until residency. Because of this, many GPs and their patients, are deprived of considerable non-MD expertise. Interprofessional education as core content in undergraduate medical education would add to the experience gained in the now compulsory family practice residency programs that must be completed for general licensure.

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<sup>3</sup> The Red Book Directory of Services for the Lower Mainland lists community agencies and professionals (See Chapter 1).

### Practice Settings and Referrals

Group practice settings increase GP/FP referrals to non-MDs. One can speculate that such settings develop a culture of collaboration across professional boundaries.

It is unlikely that pre-existing "collaborative-type" personalities explain group practice culture, since many other factors drive GPs/FPs into group practices. For example, some GPs/FPs may prefer to work alone, but find they cannot afford the additional overhead of a solo practice (they may be just starting to build their practice, or they may not be able to generate enough "business" on their own). Those raising a young family may prefer to work part-time, which is difficult in a solo practice. A GP/FP may work in a local area with a small medical centre rather than solo offices.

Demographics, however, may significantly influence choices to work in a solo practice and subsequent decisions not to refer to non-MDs. Those in solo practices may be older, more established at a later stage in their careers and may be unaware of the competency of non-MD professionals.

The data analysed did not provide insight into these possibilities, as only one question on the survey related to type of practice.

A sub-group analysis of the group practices showed no statistical difference in referrals between each type of group practice and solo practices (i.e., the result only became significant when all three types of group practices were compared together against solo practices). Initially, it was surprising that the sub-set of multidisciplinary practices (where at least one practitioner is not an MD) did not refer to non-MDs more often than solo practices. I would have thought that the proximity of an independently paid, non-MD professional would remind physicians of the existence of independently paid, non-MD professionals. However, many multidisciplinary practices include non-MD professionals who are not independently paid (e.g., the salaries of most office nurses are paid out of the MD's Medical Services Plan payments). The survey did not differentiate the various financial arrangements within the multidisciplinary practices.

It remains unclear why group practice settings encourage referrals to non-MDs for concerns about child protection.

#### Method of Payment and Referrals

Method of payment also influences referrals. Fee-for-service is based on a flat rate per patient visit and is the standard method of payment by The Medical Services Plan of BC (MSP). It encourages physicians to see more patients each for the shortest period of time, therefore, lengthy visits are avoided. A child who requires a few hours of physician time is thus very "costly" given that most physicians could bill for dozens of other visits during that time period. As the referral process to non-MDs is reported to require more time from most GPs/FPs than the referral process to MDs, it is not surprising that those who receive payment via other payment formats refer more to non-MDs.

Other methods of payment, such as salary, encourage referrals to non-MDs for concerns about child protection.

#### Other Deterrents to Referrals

The survey did not address two other key issues which may well be even greater barriers to collaboration than those studied. They are noted here to encourage further research:

1. visits to non-MDs are not covered by the MSP; and
2. some GPs/FPs have legal concerns about collaborating with non-MD professionals.

#### Additional Information and Future Research

The survey produced much that was not analyzed. Comprehensive demographic data was obtained in the hope that it could be used by future researchers. However, additional information is needed to interpret most of it. For example, I cannot determine whether the respondents were representative of the Vancouver GP/FP population without knowing the demographics of the entire Vancouver population (e.g., how many Vancouver GPs/FPs

are male/female, their ages, their average number of years in practice, how many work in each local area).

Some cross-tabulations were conducted that lead to some suggested preliminary research questions, as listed below:

1. Thirteen percent (36/284) only see adults in a community office practice. How extensive are sub-specialties within Family Practice? Is child protection a sub-specialty within Family Practice?
2. Thirty percent of those who do see children (57/189), have never referred a child and his/her family to anyone for a concern about child protection. Are many GPs/FPs missing opportunities or are the families in some practices "low risk"?
3. Most referrals are to pediatricians and then to psychiatrists (see Table 8). Do GPs/FPs prefer to deal with "their own kind" or does the MSP structure dictate referrals to other MDs? Are other MDs the best qualified to treat child protection concerns? What are the cost implications of referrals to MDs versus non-MDs versus care teams?
4. There are more referrals from the low income area versus the medium and high areas (77 %, 63 %, and 68 % respectively). This disparity is also evident in The Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé et al., 2001).<sup>4</sup> Are there more problems in the low income area or are the problems better hidden in the higher income areas? Is available help more prominently advertised and promoted in lower income areas than in higher income areas?
5. Referrals to non-MDs decreased as income area increased (64 % low, 60 % medium, 50 % high). Are there fewer non-MDs available in higher income areas? Do high income earners prefer appointments with MDs? Are MDs seen as more

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<sup>4</sup> "(In reported) child maltreatment investigations, ...thirty-six percent involved children from families that received social assistance or some other form of benefits, an additional 10 % involved children who lived in families relying on part-time employment/multiple jobs or seasonal employment, ...and in 2% no reliable source of income was reported" (Trocmé et al., 2001, p. xxvi).

competent? Is it less embarrassing to visit an MD than a non-MD for a concern about child protection? Are non-MDs available at no charge in lower income areas but not in higher income areas?

6. The range of professionals referred to suggests an inconsistent relationship between GPs/FPs and other health and human service professionals regarding concerns about child protection (i.e., concerns are channeled through numerous different routes). Are more children likely to be overlooked without standardized referrals routes? Is there a best route?
7. The comments strongly suggest GP/FP frustration and danger to children with the status quo. For example: "Few (GPs) know who to refer to. ...huge waiting lists. I did refer one family, where my pt a 15 yo girl was being knowingly abused, I referred to social services & NOTHING came out of this. The abuser & abused continue to live in the same house!!" What do the GPs/FPs suggest? What do children and families suggest?

#### Implications for Improving Practice

Methods should be explored to assist GPs/FPs to collaborate with non-MD professionals on matters of child protection. Additional research is needed to make professional policy recommendations. In particular, service providers and service users need to be consulted (e.g., holding focus groups of GPs/FPs, nurses, social workers, psychologists, child and youth care workers, children, and families). The results of this survey suggest several options that need further study. They include:

1. provide the necessary services from non-MD health and human service professionals, funded by the provincial government, which are timely and affordable for children and their families, and are not seen to be child apprehension services. The development of credible, reliable teams of professionals could be funded by the savings incurred by fewer referrals to solo pediatricians and psychiatrists;

2. revise the preamble in the Medical Services Commission Payment Schedule regarding "consultations" in the General Practice section, to include:
  - a. consultations for "family concerns"
  - b. consultations with nurses, psychologists, and social workers, and
  - c. verbal consultations, meeting attendance, and written reports.
3. implement measures to reduce GP/FP administrative time for referrals;

For example:

- A regular newsletter from the regional health board describing: available professional services for children and their families in the region, which children and families are eligible, how GPs/FPs can contact them, and whether children and families need referrals from GPs/FPs for MSP coverage;
  - A local phone number for GP/FP receptionists (and children and families) to call to receive information contained in the newsletter. The phone number could be on a sticker applied to the receptionist's phone; and
  - Referral forms (with a signed consent section from the patient) and progress report forms for practitioners to exchange, which meet the needs of several professions.
4. incorporate the well-piloted 2-day interprofessional workshop (Gilbert et al, 2000), in all of BC's university-based teaching programs for health and human service programs. The interactive exercises between students/practitioners/faculty from several professions, and use of the child protection case option are particularly important;
  5. conduct further research on referral patterns from group practices compared with solo practices;
  6. fund more GPs/FPs by salary; and

7. seek support for these ideas, and solicit additional ideas, from The British Columbia Association of Social Workers, The BC Medical Association, The BC Psychological Association, The Registered Nurses Association of BC, and an organization which represents Child and Youth Care workers.

### Conclusions

The purpose of this research was to investigate why GPs/FPs are having difficulty collaborating with other health and human service professionals on matters of child protection. Since the symptoms of a child in need of protection are often ambiguous and can easily be minimized or attributed to something else, an assertiveness to rigorously investigate possible symptoms of child abuse is required. This research applied Organizational Citizenship Behaviour theory to understand some of the barriers and facilitators to assertive collaboration.

The research survey of 190 GPs/FPs in Vancouver BC, showed that the referral process in child protection cases is lengthy (often a few hours over several weeks), and the GP/FP is rarely remunerated for this time. Most GPs/FPs believe that it takes longer to refer to non-MDs than to MDs. GPs/FPs who refer to non-MDs have more interprofessional education (mentoring, Family Practice residency), and work in group practices more often than in solo practices. GPs/FPs who are paid by fee-for-service refer to non-MDs less often than those who are paid by other methods (e.g., salary).

Additional information was collected beyond the basic research question, that can be utilized for future research. Some of these data are striking: many GPs/FPs have never referred a child/family for a child protection concern; most child protection referrals are to pediatricians and then to psychiatrists; the GPs/FPs who stated that non-MD referrals take longer than MD referrals referred more to pediatricians and psychiatrists than to non-MDs; the GPs/FPs who refer to non-MDs stated that it took the same amount of time to refer to non-MDs or MDs. Another distinctive finding was that the survey comments

showed strong GP/FP frustration with the lack of help for children and their families, including some alarming examples.

Six years ago, in presenting the results of his Inquiry, Judge Gove wrote:

“If the physicians who attended to Matthew had been governed by protocols for the handling of cases of suspected abuse, and if they had had access to child abuse experts or had been working in a multi-disciplinary environment, Matthew’s need for protection would have been identified” (Gove, 1995, p. 151).

Since then, it is not clear that much has changed. “...Children’s Advocate Joyce Preston and others have warned repeatedly that the ministry has failed to meet the needs of families and children, with staff shortages, poor training and inadequate management support leaving thousands of children at risk” (Willcocks, 2000, p. A14).

The work reported here provides data about MD/non-MD collaboration, discusses practice implications, and offers suggestions about how to encourage child protection referrals from GPs/FPs particularly to non-MD health and human service professionals. GPs/FPs may be the province’s most accessible, powerful professional resource for children in need of protection and their families, while limited in their utilization of trained professionals outside the medical profession.

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## Appendix I

Duty to Report Need for ProtectionChild, Family and Community Service Act (1997) Section 14

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 (l)(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.

## Appendix II

Definition of A Child in Need of ProtectionChild, Family and Community Service Act (1997) Section 13

1. (a) if the child has been, or is likely to be, physically harmed by the child's parent;
- (b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
- (c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
- (d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
- (e) if the child is emotionally harmed by the parent's conduct;
- (f) if the child is deprived of necessary health care;
- (g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refused to provide or consent to treatment;
- (h) if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
- (i) if the child is or has been absent from home in circumstances that endanger the child's safety or well-being;
- (j) if the child's parent is dead and adequate provision has not been made for the child's care;

- (k) if the child has been abandoned and adequate provision has not been made for the child's care;
  - (l) if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.
2. For the purpose of subsection 1(e), a child is emotionally harmed if the child demonstrates severe
- (a) anxiety
  - (b) depression
  - (c) withdrawal
  - (d) self-destructive or aggressive behaviour.

**SECTION  
A****Your Contact  
with Children**

1. How long have you had direct contact with patients in a community office practice?

\_\_\_\_\_ years

If zero, please discontinue the survey now and mail it back in the return envelope.

2. Approximately how many of your community office practice patient visits in the past month were with patients 18 years of age or under?

☐ none: please discontinue the survey now and mail it back in the return envelope.

☐ 1 - 99

☐ 100 - 199

☐ 200 - 299

☐ 300 - 399

☐ 400 or more

**SECTION  
B****Referrals**

Have you ever referred a child and his/her family to any of the following licensed health and human service professionals for a child protection concern. ("referral" is defined as recommending another professional to a child/family; "child protection" is defined by you):

	approximate # of times	Never
3. Child protection team	_____	<input type="checkbox"/>
4. Community health team	_____	<input type="checkbox"/>
5. Family services team	_____	<input type="checkbox"/>
6. Mental health team	_____	<input type="checkbox"/>
7. Nurse	_____	<input type="checkbox"/>
8. Pediatrician	_____	<input type="checkbox"/>
9. Psychiatrist	_____	<input type="checkbox"/>
10. Psychologist	_____	<input type="checkbox"/>
11. School counsellor	_____	<input type="checkbox"/>
12. Social worker	_____	<input type="checkbox"/>
13. Someone with a degree in "child and youth care"	_____	<input type="checkbox"/>

14. If you had protection concerns about a child, and decided to refer the child and his/her family to another MD, approximately how long do you estimate it would take you to do all of the following:

- decide which professional to refer the child/family to
- ask the professional if they would be willing to see the child/family (if necessary)
- encourage the family to go
- provide the professional with adequate background information
- learn the initial opinion of the professional (e.g.: through a report from the professional or a conversation with the professional).

- ☐ less than 30 minutes
- ☐ 30 minutes or more, but less than 60 minutes
- ☐ 60 minutes or more, but less than 2 hours
- ☐ 2 hours or more, but less than 3 hours
- ☐ 3 hours or more, but less than 4 hours
- ☐ 4 hours or more.

15. If you had protection concerns about a child, and decided to refer the child and his/her family to a licensed health and human service professional who was not an MD, approximately how long do you estimate it would take you to do all of the following:

- decide which professional to refer the child/family to
- ask the professional if they would be willing to see the child/family (if necessary)
- encourage the family to go
- provide the professional with adequate background information
- learn the initial opinion of the professional (e.g.: through a report from the professional or a conversation with the professional).

- ☐ less than 30 minutes
- ☐ 30 minutes or more, but less than 60 minutes
- ☐ 60 minutes or more, but less than 2 hours
- ☐ 2 hours or more, but less than 3 hours
- ☐ 3 hours or more, but less than 4 hours
- ☐ 4 hours or more.

<b>SECTION</b> <b>C</b>	<b>Demographics</b>
----------------------------	---------------------

16. When were you born? 19 \_\_\_\_\_.

17. Please indicate your sex:

- ☐ male  
☐ female

18. Please indicate the local area of your current community office practice:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arbutus Ridge            | <input type="checkbox"/> Kilarney            | <input type="checkbox"/> Riley Park          |
| <input type="checkbox"/> Downtown                 | <input type="checkbox"/> Kitsilano           | <input type="checkbox"/> Shaughnessy         |
| <input type="checkbox"/> Dunbar-Southlands        | <input type="checkbox"/> Marpole             | <input type="checkbox"/> South Cambie        |
| <input type="checkbox"/> Fairview                 | <input type="checkbox"/> Mount Pleasant      | <input type="checkbox"/> Strathcona          |
| <input type="checkbox"/> Grandview Woodlands      | <input type="checkbox"/> Oakridge            | <input type="checkbox"/> Sunset              |
| <input type="checkbox"/> Hastings-Sunrise         | <input type="checkbox"/> Renfrew-Collingwood | <input type="checkbox"/> Victoria-Fraserview |
| <input type="checkbox"/> Kensington-Cedar Cottage | <input type="checkbox"/> West End            | <input type="checkbox"/> West Point Grey     |
| <input type="checkbox"/> Kerrisdale               |  |  |

19. What is your primary method of payment for your community office work with children and families?

- ☐ "fee for service"  
☐ other

20. Which type of practice is the community office in which you spend the majority of your time?

- ☐ solo practice  
☐ family physician group practice  
     (2 or more family physicians sharing office space)  
☐ family physician/specialist group practice  
     (2 or more MDs sharing office space)  
☐ multidisciplinary practice  
     (2 or more licensed health and human service professionals sharing office space, from at least 2 different disciplines, and at least one is not an MD).  
☐ other: \_\_\_\_\_

21. Are you practice eligible CCFP by exam?

- ☐ yes  
☐ no

22. Have you ever had any formal training relating to referrals to non-MD licensed health and human service professionals?

☐ no: please go on to question # 26

☐ yes ⇒ 23. Was the formal training during Medical School?

☐ no

☐ yes, \_\_\_\_\_ hours in total

24. Was the formal training during a Family Practice Residency?

☐ no

☐ yes, \_\_\_\_\_ hours in total

25. Was the formal training during your professional career?

☐ no

☐ yes, \_\_\_\_\_ hours in total

26. How many "mentors" have you had who referred children to licensed non-MD health and human service professionals during any of your training? (Mentor is defined as an experienced and trusted advisor who demonstrates wisdom/skills).

☐ 0

☐ 1 - 3

☐ more than 3

27. How many "mentors" have you had who referred children to licensed non-MD health and human service professionals during your professional career?

☐ 0

☐ 1 - 3

☐ more than 3

28. Please add any comments you may have:

**Thank you for your co-operation. We are confident that this information will assist us to understand more about child protection issues in the Vancouver community.**



The University of British Columbia  
Office of Research Service  
Behavioural Research Ethics Board  
Room 323 - 2194 Health Sciences Mall, Vancouver, BC V6T 1Z3  
Phone: (604) 822-8584 Fax: (604) 822-5083

# Appendix VI First UBC Ethics Committee Submission

78

For Administrative Use Only

Protocol Number:

Date Received:

## REQUEST FOR ETHICAL REVIEW

The Principal Investigator must have a UBC Faculty Appointment.

1. Principal Investigator / Faculty Advisor  
Surname: Gilbert  
Given Name(s): John  
Academic Rank: Professor  
UBC Faculty / Department: Health Sciences

2. Co-Investigator / Student  
Surname: Cole  
Given Name(s): Carol Diane  
Academic Rank: MSc Candidate  
UBC Faculty / Department: Interdisciplinary Studies

3. Source of Funds: The UBC Office of the Coordinator of Health Sciences and The UBC Department of Family Practice

4. Project Period (YY-MM-DD): From: 00-06-01 To: 31-01-08

5. Indicate the Institutions where the Research will be Carried Out:

☒ UBC Campus ☐ VHHSC ☐ SPH ☐ BCWH ☐ BCCH ☐ BCCA ☐ Other:

6. Mailing Address for Correspondence:

☐ Principal Investigator / Faculty Advisor ☒ Co-Investigator / Student

Phone Number: 822-8021

Fax Number: 822-2495

E-Mail Address: ccole@interchange.ubc.ca

UBC, The Office of the Coordinator of Health Sciences  
#400-2194 Health Sciences Mall  
Vancouver, B.C. V6T 1Z3

7. Title of Project: Family Physician Motivation to Initiate Early Child Protection Support

8. Summary of Purpose and Objectives of Project

This project is designed to begin to understand the perspective of the Family Physician (FP) in the community, who is considering initiating early child protection support. In 1995, the report of the Gove Inquiry into Child Protection identified the lack of collaboration between health and human service professionals. It did not report on the current logistics of this collaboration nor did it recommend specific ways in which it could be improved. It did, however, recommend that collaboration skills be taught during professional training programs and to practitioners. Educational materials have subsequently been developed but only a few students and practitioners have received them, as they are not part of their required training. More importantly, students and practitioners they are not required to implement what is advocated in the materials, nor is it clear whether they could in the current organizational structure in the community.

Furthermore, community collaboration will be unsuccessful if practitioners are not motivated to participate. In particular, if Family Physicians are not motivated to participate collaboration will continue to be poor, as Family Physicians are pivotally placed in the organizational structure of health care.

This research project only addresses some of the many factors contributing to Family Physician motivation to participate in interprofessional, early child protection support. A starting point is the research question: Is the perceived time required to complete the referral process a significant factor in the FP's decision to refer or not refer families to community health and human service professionals for early child protection support. This issue will be studied through a self-administered survey of Vancouver FPs and will yield descriptive results as well.

☒ Research for a Graduate Degree

All Information Requested in this Form must be Typewritten in the Space Provided.

Note: If the project is limited to one of the following, please check the appropriate box and complete and submit the original plus three copies of pages 1 and 2 (sections 1-17 inclusive) of this form:

☐ Observation without intervention, i.e. no tests, interviews, or questionnaires;

☐ Interviews of professional colleagues in the fields of law or business (not education) in which no invasion of an individual's personal privacy or possible jeopardy of employment status is involved. Summarize interview / questionnaire content in item #12 or attach a copy. Also attach copies of the introductory letter or consent form;

☐ UBC course or programme evaluation.

12. Summary of Methodology and Procedures. Note: If your study involves deception, you must also complete page 7, the 'Deception Form'.

A self-administered questionnaire (attached) will be sent to a randomized sample of family physicians/general practitioners. The survey has been developed over a one year period and has incorporated suggestions from pilot tests of two general practitioners, one family physician, and three social science researchers, and from suggestions from several UBC professors. Every effort is planned to maximize the response rate, including descriptions of the support from several UBC departments and the importance of the research. It has been kept short, to respect the time limitations of family physicians. It also uses language which is consistent with the intelligence and terminology of physicians. Business reply envelopes will be provided and up to 5 contacts with each physician are planned: initial mailing, reminder postcard, second mailing, reminder phone call, and a third mailing.

300 general practitioners/family physicians will be sent surveys (see item 14 below). At least 193 responses are anticipated, a response rate of approximately 64 %. Of these 193, 25 % are anticipated to be ineligible, however, in that they will be from physicians who do not have direct contact with children in a community office practice. Therefore, 48 are anticipated to be ineligible, leaving 145 surveys eligible for detailed analysis. This allows sufficient additional data to complete the analysis (as 100 surveys are required for most of the statistical calculations planned), should the response be less. Therefore, a 33 % eligible response rate would be acceptable, but an eligible response rate of approximately 60 % is possible.

Data analysis will include univariate, bivariate, and multivariate analysis. Data will be entered by the co-investigator onto an SPSS spreadsheet. Statistical calculations will include frequency tabulation, cross-tabulation, and linear regression tabulation. Extensive interpretation will be conducted and reported.

#### Description of Population

13. How many subjects will be used? **300** How many in the control group? **0**

14. Who is being recruited, and what are the criteria for their selection?

A few thousand physicians are listed alphabetically in the 1999-2000 BC Medical Directory, as being located in the City of Vancouver. 1097 do not have a specialty indicated next to their names (Family Medicine is no longer identified in this category), and are listed as not on the Temporary Register. Therefore these 1097 are considered to be either General Practitioners or Family Physicians. Each of these 1097 names will be numbered, in alphabetical order, from 1 - 1097. 300 of these numbers will then be selected using a Table of Random Numbers. The names corresponding to these numbers will be selected to be surveyed.

15. What subjects will be excluded from participation?

Specialists and those on the Temporary Register will be excluded.

16. How are the subjects being recruited? If the initial contact is by letter or if a recruitment notice is to be posted, attach a copy. Note that UBC policy discourages initial contact by telephone. However, surveys which use random digit dialing may be allowed. If your study involves such contact, you must also complete page 8, the 'Telephone Contact' form.

Selected physicians will be contacted up to 5 times, depending upon how quickly they reply:

1. An Initial letter (attached)
2. A reminder postcard
3. A second mailing
4. A phone call asking if they received the survey
5. A third mailing

17. If a control group is involved, and their selection and/or recruitment differs from the above, provide details:

NA

18. Where will the project be conducted (room or area)? **IRC #407B, Office of ... Health Sciences**

19. Who will actually conduct the study and what are their qualifications?

**The Co-Investigator, Carol Cole will actually conduct the study. Her qualifications are:**

**Extensive experience as an RN for 25 years:**

- 6 years working with children and families in a Vancouver Family Practice
- 9 years working with Family Physicians and specialists as a research coordinator and as a regional research monitor
- 3 years coordinating the development of several interprofessional courses for UBC students and BC practioners as the Coordinator of the UBC Division of Interprofessional Education. Three of these courses have been: A Youth Health Curriculum, Interdisciplinary Practice with Children and Families, Interprofessional Teamwork Workshops.

**Extensive education including health sciences, research, statistics, organizational behaviour, conflict resolution, and sociology courses.**

20. Will the group of subjects have any problems giving informed consent on their own behalf? Consider physical or mental condition, age, language, and other barriers.

**NA**

21. If the subjects are not competent to give fully informed consent, who will consent of their behalf? **NA**

22. What is known about the risks and benefits of the proposed research? Do you have additional opinions on this issue?

**NA**

23. What discomfort or incapacity are the subjects likely to endure as a result of the experimental procedures?

**NA**

24. If monetary compensation is to be offered to the subjects, provide details of amounts and payment schedules.

**NA**

25. How much time will a subject have to dedicate to the project? **20 minute survey**

26. How much time will a member of the control group, if any, have to dedicate to the project? **NA**

27. Who will have access to the data?

**Only the co-investigator and investigator will have access to the data.**

28. How will the confidentiality of the data be maintained?

**The surveys will be kept in a locked office, and none of them include any identifying questions.**

**A separate spreadsheet will kept for tracking purposes only, and will not include any of the survey responses. The Tracking Spreadsheet will be based upon code numbers written on the survey return envelopes. When the envelopes are received, the surveys will be separated immediately.**

29. What are the plans for the future use of the raw data beyond that described in this protocol? How and when will the data be destroyed?

**The surveys will be destroyed when all of the data has been entered, analysed, and compiled into a report. The surveys will be shredded in the summer of 2001.**

30. Will any data which identifies individuals be available to persons or agencies outside the University?

**No**

31. Are there any plans for feedback to the subject?

**Aggregate summaries will be available to subjects upon request.**

32. Will your project use:

- ☒ Questionnaires (Submit a copy);
- ☐ Interviews (Submit a sample of questions);
- ☐ Observations (Submit a brief description);
- ☐ Tests (Submit a brief description).

## 33. Funding Information

Agency / Source of Funds:

☒ Internal ☐ ExternalFunds Administered by: ☒ UBC ☐ VHHSC ☐ SPH ☒ BCWH ☒ BCCH ☐ BCCA

UBC or Hospital Account Number:

Status: ☐ Awarded ☒ PendingPeer Review: ☐ Yes ☒ No

Start Date (YY-MM-DD): 00-06-01 Finish Date (YY-MM-DD): 01-08-31

## Informed Consent

34. Who will consent?

☐ Subject.☐ Parent or Guardian. (Written parental consent is always required for research in the schools and an opportunity must be presented either verbally or in writing to the students to refuse to participate or withdraw. A copy of what is written or said to the students should be provided for review by the Committee.)☐ Agency Officials.

35. In the case of projects carried out at other institutions, the Committee requires written proof that agency consent has been received. Please specify below:

☐ Research Carried Out at a Hospital - Approval of hospital research or ethics committee.☐ Research Carried Out at a School - Approval of school board and/or principal. Exact requirements depend on individual school boards. Check with Faculty of Education committee members for details.☐ Research Carried Out in a Provincial Health Agency - Approval of Deputy Minister.☐ Other - Specify:

## Questionnaires (Completed by Subjects)

36. Questionnaires should contain an introductory paragraph or covering letter which includes the following information. Please check each item in the following list before submission of this form to insure that the instruction contains all necessary items.

☒ UBC Letterhead.☒ Title of Project.☒ Identification of the Investigators, including a phone number.☒ A Brief Summary that Indicates the purpose of the project.☒ The Benefits to be derived.☒ A Full Description of the Procedures to be carried out in which the subjects are involved.☒ A Statement of the Subject's Right to Refuse to Participate or Withdraw at any time without jeopardizing further treatment, medical care or class standing, as applicable. Note: This statement must also appear on explanatory letters involving questionnaires.☒ The Amount of Time required of the subject.☒ The Statement that if the questionnaire is completed it will be assumed that consent has been given. This is sufficient if the research is limited to questionnaires; any other procedures or interviews require a consent form signed by the subject.☒ An Explanation of how to return the questionnaire.☒ Assurance that the Identity of the subject will be kept confidential and a description of how this will be accomplished; e.g. "Don't put your name on the questionnaire".☒ For Surveys circulated by mail, a copy of the explanatory letter as well as a copy of the questionnaire.

## Consent Forms

37. UBC policy requires written consent in all cases other than those *limited* to questionnaires which are completed by the subject. (See item #36 for consent requirements.) Please check each item in the following list before submission of this form to ensure that the written consent form attached contains all necessary items. If your research involves initial contact by telephone, you do not need to fill out this section.

- ☐ UBC Letterhead.
- ☐ Title of the Project.
- ☐ Identification of investigators, including a telephone number. Research for a graduate thesis should be identified as such and the name and telephone number of the faculty advisor included.
- ☐ Brief but complete description in lay language of the purpose of the project and of all procedures to be carried out in which the subjects are involved. Indicate if the project involves a new or non-traditional procedure whose efficacy has not been proven in controlled studies.
- ☐ Assurance that the identity of the subject will be kept confidential and description of how this will be accomplished, i.e. describe how records in the principal investigator's possession will be coded, kept in a locked filing cabinet, or under password if kept on a computer hard drive.
- ☐ Statement of the total amount of time that will be required of a subject.
- ☐ Details of monetary compensation, if any, to be offered to subjects.
- ☐ An offer to answer any inquiries concerning the procedures to ensure that they are fully understood by the subject and to provide debriefing, if appropriate.
- ☐ A statement that if they have any concerns about their rights or treatment as research subjects, they may contact Dr. Richard Spratley, Director of the UBC Office of Research Services and Administration, at 822-8598.
- ☐ A statement of the subject's right to refuse to participate or withdraw at any time and a statement that withdrawal or refusal to participate will not jeopardize further treatment, medical care or influence class standing, as applicable. Note: This statement must also appear on letters of initial contact. For research done in the schools, indicate what happens to children whose parents do not consent. The procedure may be part of classroom work but the collection of data may be purely for research.
- ☐ A statement acknowledging that the subject has received a copy of the consent form including all attachments for the subject's own records.
- ☐ A place for signature of subject consenting to participate in the research project, investigation, or study and a place for the date of the signature.
- ☐ Parental consent forms must contain a statement of choice providing an option for refusal to participate, e.g. "I consent / I do not consent to my child's participation in this study." Also, verbal assent must be obtained from the child, once the parent has consented.
- ☐ If there is more than one page, number the pages of the consent, e.g. page 1 of 3, 2 of 3, 3 of 3.

## Attachments

38. Check items attached to this submission, if applicable. Incomplete submissions will not be reviewed.

- ☒ Letter of Initial Contact. (Item 16)
- ☐ Advertisement for Volunteer Subjects. (Item 16)
- ☐ Subject Consent Form. (Item 37)
- ☐ Control Group Consent Form. (If different from above)
- ☐ Parent / Guardian Consent Form. (If different from above)
- ☐ Agency Consent. (Item 35)
- ☒ Questionnaires, Tests, Interviews, etc. (Item 32)
- ☒ Explanatory Letter with Questionnaire. (Item 36)
- ☐ Deception Form, including a copy of transcript of written or verbal debriefing.
- ☐ Telephone Contact Form.
- ☐ Other - Specify:

12. Summary of Methodology and Procedures. Note: If your study involves deception, you must also complete page 7, the 'Deception Form'.

A self-administered questionnaire (attached) will be sent to a randomized sample of family physicians/general practitioners. The survey has been developed over a one year period and has incorporated suggestions from pilot tests of two general practitioners, one family physician, and three social science researchers, and from suggestions from several UBC professors. Every effort is planned to maximize the response rate, including descriptions of the support from several UBC departments and the importance of the research. It has been kept short, to respect the time limitations of family physicians. It also uses language which is consistent with the intelligence and terminology of physicians. Business reply envelopes will be provided.

600 general practitioners/family physicians will be sent surveys (see item 14 below). At least 180 responses are anticipated, a response rate of approximately 30%. Of these 180, 25 % are anticipated to be ineligible, however, in that they will be from physicians who do not have direct contact with children in a community office practice. Therefore, 45 are anticipated to be ineligible, leaving 135 surveys eligible for detailed analysis. This allows sufficient additional data to complete the analysis (as 100 surveys are required for most of the statistical calculations planned), should the response be less. Therefore, a 22 % eligible response rate would be acceptable.

Data analysis will include univariate, bivariate, and multivariate analysis. Data will be entered by the co-investigator onto an SPSS spreadsheet. Statistical calculations will include frequency tabulation, cross-tabulation, and linear regression tabulation. Extensive interpretation will be conducted and reported.

#### Description of Population

13. How many subjects will be used? **600** How many in the control group? **0**

14. Who is being recruited, and what are the criteria for their selection?

A few thousand physicians are listed alphabetically in the 1999-2000 BC Medical Directory, as being located in the City of Vancouver. 1084 do not have a specialty indicated next to their names (Family Medicine is no longer identified in this category), and are listed as not on the Temporary Register. Therefore these 1084 are considered to be either General Practitioners or Family Physicians. According to the Ministry of Health, 163 of these MDs are not currently in active practice. The remaining 922 names will be entered into SPSS, and a random sample of 600 names will be generated.

15. What subjects will be excluded from participation?

Specialists and those on the Temporary Register will be excluded.

16. How are the subjects being recruited? If the initial contact is by letter or if a recruitment notice is to be posted, attach a copy. Note that UBC policy discourages initial contact by telephone. However, surveys which use random digit dialing may be allowed. If your study involves such contact, you must also complete page 8, the 'Telephone Contact' form.

Each selected physician will be contacted up to 2 times:

1. An initial letter and survey(attached)
2. A second mailing, if they have not already responded.

17. If a control group is involved, and their selection and/or recruitment differs from the above, provide details:

NA

## Appendix X: Average Income of Local Areas

1996 Statistics Canada Census and My Stratification

Low Income		Medium Income		High Income	
Strathcona	18,895	Renfrew	45,825	South Cambie	60,562
Granview	32,398	Sunset	45,959	Oakridge	62,621
Mt. Pleasant	32,888	Victoria	47,275	Arbutus	67,426
Downtown	34,497	Fairview	48,957	W. Point Grey	82,658
West End	34,397	Kilarney	49,414	Dunbar	87,132
Marpole	43,318	Riley Park	51,615	Kerrisdale	87,267
Kensington	44,337	Kitsilano	53,877	Shaughnessey	131,148
Hastings	45,630				