PHYSICIANS' EXPERIENCES WITH THE CHILD PROTECTION SYSTEM AS A FACTOR IN THEIR DECISION TO REPORT CHILD ABUSE

By

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Abstract

Victims and perpetrators of child abuse will typically not self-report to child protection services (CPS) so responsibility for detection and reporting of suspected child abuse must fall to others. Since physicians are often the first to treat serious injuries in children, they are in an ideal position to report abuse allegations to CPS social workers who are delegated with the responsibility to protect children. Research shows that although physicians are generally aware of mandatory reporting legislation, they are often non-compliant. A recurrent theme which has not been fully explored in Canadian research is the lack of confidence in CPS as an organizational barrier to reporting. To that end, a short questionnaire was distributed to pediatricians at British Columbia's Children's Hospital (BCCH) requesting feedback about their previous reporting experiences to CPS. Results of this study provide useful feedback to organizations such as CPS and the College of Physicians and Surgeons. Recommendations include the use of interdisciplinary training and guidelines about collaboration between organizations.

TABLE OF CONTENTS

LIST OF TABLES

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Introduction

Most social workers who have been doing child protection work for as long as I have, can say they have at least one case that troubles them. In 1995, I was involved in a case where a 14-month-old baby was shaken and smashed into a hard object at about 50 miles per hour by someone who has never been charged. At the hospital, I was told that the top of his skull had become detached and he had some other broken bones, but he appeared flawless because of the white bandage around his forehead. Although the attending pediatricians made many attempts to insert an intravenous line into his veins, all had collapsed due to the lack of blood pressure. He was already on life support systems and when they were removed shortly after my visit, he officially died.

Due to confidentiality, I cannot go into details about the case but there are indications that this child was known to both child protection social workers and to physicians and probably would be alive today if adequate interagency collaboration had taken place. The death of this little boy has compelled me to write the following thesis and to actively pursue improved interactions between two large organizational systems, specifically the hospital system which employs physicians and the child protection system which employs social workers.

A report about child deaths presented to B.C. CPS managers after the

Gove Inquiry (1995) into the death of 5-year-old Matthew Vaudreuil stated: "failures in professional communication were cited in every Inquiry report just as they are in the Gove Report" (Hume, 1995, p. 20). I have tried to write this thesis in a non-judgmental way, so as not to blame either organization or profession, with the ultimate goal being the improvement of child protection services by physicians and child protection social workers.

For the purposes of this research it should be noted that the title of the provincial governing body for child protection services in British Columbia is the Ministry for Children and Families (MCF). Since this frequently changes, the reference was made to the more generic term "child protective services" (CPS) throughout this work.

A survey participant in Kalichman and Brosig's (1992) study of mental health professionals stated:

> I have difficulty reporting suspected abuse to overburdened, underpaid, and often inexperienced social service workers. Too often reports are made, social services come into a family, make charges, write a report and proceed to do nothing for children. The therapy process is disrupted due to reporting and this can be damaging to families. Reporting abuse does not seem to always be the best solution to abuse - but it is the law in my state. (cited in Kalichman, 1993, p. 123)

This research explored the experiences of pediatricians who have reported child abuse to CPS and the influence of these experiences upon future reporting behaviours. It also examined pediatricians' opinions of the reasons some physicians may be reluctant to report.

Previous research indicates that parents and victims will not typically

self-report to CPS (Warner-Rogers, Hansen, & Spieth, 1996), therefore responsibility for the detection and reporting of suspected child abuse must fall to others. Because physicians are often the first to see and treat any serious trauma in children, they are in an ideal position to report suspicious injuries to CPS social workers.

The Child, Family and Community Service Act (1996) (CFCSA) legislates that physicians, like all other people in British Columbia, must report suspected child abuse to CPS social workers who have been given the role of investigation of abuse and protection of children. Studies also show that, although physicians are generally aware of mandatory reporting legislation, they are often non-compliant (Compaan, Doueck, & Levine, 1997; Warner & Hansen, 1994; Zellman, 1990).

Some key reasons cited by physicians for failing to report include: definitional or evidentiary confusion (Besharov, 1990; Deisz, Doueck, George, & Levine, 1996; Kalichman, 1993; Zellman, 1990); ethical considerations such as confidentiality (Kalichman, 1993); costs to the reporter such as time spent making reports and court attendance (Zellman, 1990); and systemic concerns such as CPS or police ineffectiveness (Kalichman, 1993; Zellman, 1990). Lack of confidence in CPS was cited in the literature as a leading barrier to reporting by professionals and others (Beck & Ogloff, 1994; Kalichman, 1993; Warner-Rogers & Hansen, 1994; Zellman, 1990).

Although research has concentrated on various other professionals'

reasons for non-compliance, there is a dearth of Canadian literature specific to physicians' reporting practices. Reasons for non-reporting by medical professionals in the U.S. and other countries have also been explored using variables such as definitions of child abuse, training differences, demographic differences, and diversity issues (Giovannoni & Becerra, 1979).

In B.C., the College of Physicians and Surgeons and the Ministry for Children and Families (MCF) recently acted on a Gove recommendation and developed a protocol in an attempt to increase reporting by physicians to CPS social workers. It plainly states:

> Physicians, like other health professionals, are required by law to report situations which indicate that a child may need protection....The physician's primary responsibility is the clinical management of the patient's (child's) situation. In the course of such management and treatment, the need to report may be identified as part of the treatment plan. There should be no delay in reporting concerns of abuse. Concerns must be report [sic] immediately. (College of Physicians & Surgeons of B.C., 1997, pp. 1, 7)

However, over the years neither legislation, nor threat of criminal or professional sanctions have drastically improved reporting behaviours. As Hallett and Birchall (1992) wrote, "organisations [sic] are unlikely to take up cooperation with one another simply because someone says it would be a good idea for them to do so" (Hallett & Birchall, 1992, p. 35).

Organizational, systems, and exchange theories provided the context for this study which explored pediatricians' experiences reporting child abuse to CPS, and the influence of these transactions upon future reporting

decisions. Historically, long-standing organizational constraints have provided endorsement for traditional hierarchies, monopolization of domain, and closed systems. Solutions are costly and require creative communication. Because information is not being shared, children are left in unsafe situations, often with dire consequences.

Chapter I

Policy and Literature Review

Child Abuse Reporting Legislation: History

The formation of the Society for the Prevention of Cruelty to Children (1874) was based upon the case of a young girl named Mary Ellen, who was severely abused and was reported to the New York Society for the Prevention of Cruelty to Animals (Coleman, 1995). However, the following describes an earlier, lesser-known case which stands out as the first child abuse report which was acted upon through the courts.

In April, 1866, Henry Bergh established the American Society for the Prevention of Cruelty to Animals. Critics questioned what they considered to be his misplaced advocacy for animals when children were also thought to be at risk in society, as illustrated here in a letter addressed to the New York Telegram in 1868:

> ...But there is a field in which we believe Bergh might labor with more thanks for his pains and more success as his reward. The children of New York are sadly in want of a champion....Children are more precious than turtles or turkeys, calves or car horses. If he will only open his large heart to the little ones, and insist that as all the happiness of life centers in them, so all its joys, pleasures and blessings should be showered upon their dear heads without sting and without grumbling, he will be entitled to and will receive the praise of all mankind - aye, and of all womankind as well. (Lazoritz & Shelman, 1996, pp. 236, 237)

In 1871, a woman walked into Henry Bergh's office to report that 8-year-

old Emily Thompson was being severely beaten on an ongoing basis and requested that he do something about it. Although Bergh stated that these cases "were not in his particular line" (Lazoritz & Shelman, 1996, p. 236), the press had been critical of him so he investigated nonetheless. He found the child to be black and blue and, through the courts, had her guardian, Mrs. Larkin, charged, in spite of the fact that young Emily refused to corroborate the neighbour's allegations. Unfortunately, because of Emily's lack of testimony and her fear of being removed from Mrs. Larkin's care, she was sent home. Although Bergh's case was resolved unsatisfactorily, the newspapers followed this case closely, and eventually, because of their continued interest, the case came to the attention of a distant but natural relative who rescued Emily from Mrs. Larkin.

In 1925, Dr. John Caffey, a pediatrician and director of the New York Babies Hospital X-ray Department, became curious about the unexplained injuries which would appear from time to time on charts. He juxtaposed the X-rays with the clinical findings of the children's injuries, and discovered that the injuries were due to trauma. He could not convince his colleagues of this finding but 21 years later, in 1946, wrote an article entitled "Multiple Fractures in the Long Bones of Infants Suffering from Chronic Subdural Haematoma" which captured some interest from other medical professionals. In the article, he hypothesized that long-bone fractures could be the result of trauma, much like subdural haematomas, which, at the time, were seen to be a

result of possible trauma (cited in Helfer & Kempe, 1988). The relevant point is that it was an effort to convince his medical colleagues that parents could inflict severe trauma upon their children.

Years later, in 1951 when Dr. Frederic N. Silverman, a radiologist, emphasized the "intentional infliction of these injuries" (cited in Helfer & Kempe, 1988, p. 19) more doctors began to take notice. Woolley and Evans (1955) reviewed eight years of radiographic findings and concluded that even if the history given was not consistent with the findings, the children were victims of traumatic forceful injury. They concluded that "the environmental factors surrounding the infants with the radiographic changes frequently included grossly undesirable and hazardous circumstances" (cited in Helfer & Kempe, 1988, p. 215). Silverman (1988) wrote:

> The radiographic signs of the battered child are surprisingly specific. They speak for the child who is unable or unwilling to speak for himself and serve to alert the physician to a hazard of considerable magnitude which threatens the life and limbs as well as the emotional and intellectual potentialities of the child. Although they may reflect the time of the injury with considerable accuracy and permit extremely accurate deductions concerning the nature of the forces producing the injury, they provide no information whatsoever concerning the circumstances surrounding the injury or the motivation of the individuals responsible. (cited in Helfer & Kempe, 1988, p. 241)

It was not until 91 years after Emily Thompson's concerned neighbour first reported her concerns to Henry Bergh that Dr. Henry Kempe (1962) published "The Battered Child", and any serious thought was given to the concept of mandatory reporting. At that time, child abuse became a public

rather than a private concern (Coleman, 1995).

How Child Abuse is Defined

The definition of child abuse is fundamental to the exploration of the topic of reporting. Some studies have shown that the concept of child abuse is viewed differently by diverse professions and lay people based on their own perceptions of abuse, their values, and the values and social structures of the society in which they live (Giovannoni & Becerra, 1979). As stated in the introduction, definitional confusion is one of the leading reasons given by physicians for failing to report abuse (Besharov, 1990; Deisz, et al., 1996; Kalichman, 1993; Zellman, 1990).

As it seems that the definition of abuse is rather contentious, I will attempt to limit the descriptions to those which are most typical. The United Nations Convention on the Rights of the Child, Article 19, states that:

> States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child. (cited in the draft Child Abuse Handbook, unpublished, 1996, p. 69)

In British Columbia, the relevant child protective legislation, the Child, Family and Community Service Act (1996), stipulates that under Section 13 a child may need protection under the following circumstances:

(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 refuses 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. (CFCSA, 1996, S. 13)

In terms of operationalizing the term "child abuse" for this thesis, I referred to the direction given by the College of Physicians and Surgeons of B.C. in the Child Abuse and Neglect Guidelines (1997). These guidelines refer physicians to a very lengthy summary of clinical presentations of physical, sexual, and emotional abuse, and neglect presented in the B.C. Handbook for Action on Child Abuse and Neglect (1998) which describes child abuse as follows:

> Physical Abuse is a deliberate, non-accidental physical assault or action by an adult or significantly older or more powerful child that results or is likely to result in physical harm to a child. It includes the use of unreasonable force to discipline a child or to prevent a child from harming him/herself or others. The injuries sustained by the child may vary in severity and range from minor bruising, burns, welts or bite marks to major fractures of the bones or skull,and in its most extreme form, the death of a child.
>
> Sexual abuse generally means any sexual use of a child by an adult or a significantly older or more powerful child. There are many criminal offences related to sexual activity involving children. The Criminal Code prohibits:
> · any sexual activity between an adult and a child under the age of 14 - a child under 14 is incapable in law of consenting to sexual activity (s. 150.1 of the Criminal Code). The criminal law recognizes that consensual "peer sex" is not an offence in the following situation: If one child is between 12 and 14 years and the other is 12 years or more but under the age of 16, less than two years older, and not in a position of trust or authority to the other.
> · any sexual activity between an adult in a position of trust of authority towards a child between the ages of 14 and 18 years.
> · any sexual activity without the consent of a child of any age. (Depending on the activity, non-consensual sexual activity may constitute the criminal offence of sexual assault).
> · Use of children in prostitution and pornography.
>
> The Ministry for Children and Families states that sexual abuse is any behaviour of a sexual nature toward a child, including one or more

of the following:
· touching or invitation to touch for sexual purposes, or intercourse (vaginal or anal)
· menacing or threatening sexual acts, obscene gestures, obscene communications or stalking
· sexual references to the child's body or behaviour by words or gestures
· requests that the child expose their body for sexual purposes
· deliberate exposure of the child to sexual activity or material.

The Ministry for Children and Families states sexual exploitation includes permitting, encouraging or requiring a child to engage in:
· conduct of a sexual nature for the stimulation, gratification, profit or self-interest of another person who is in a position of trust or authority, or with whom the child is in a relationship of dependency
· prostitution
· production of material of a pornographic nature.

Sexual aspects of organized or ritual abuse should be considered a form of sexual exploitation.

Emotional abuse is the most difficult type of abuse to define and recognize. It may range from habitual humiliation of the child to withholding life-sustaining nurturing. It can include acts or omissions by those responsible for the care of a child or others in contact with a child, which are likely to have serious, negative emotional impacts. Emotional abuse may occur separately from, or along with, other forms of abuse and neglect. Emotional abuse can include a pattern of:
· scapegoating;
· rejection;
· verbal attacks on the child;
· threats;
· humiliation.

When emotional abuse is persistent and chronic, this can result in emotional damage to the child. A child is defined...as emotionally harmed if they demonstrate severe:
· anxiety;
· depression;
· withdrawal; or
· self-destructive or aggressive behaviour.

Neglect involves an act of omission on the part of the parent or

> guardian that results or is likely to result in physical harm to the child. It generally refers to situations in which a child has been, or is likely to be physically harmed through action or inaction by those responsible for care of the child. This may include failure to provide food, shelter, basic health care, or supervision and protection from risks, to the extent that the child's physical health, development or safety is harmed or is likely to be harmed. This also includes failure to thrive....Not always intentional, neglect may be a result of insufficient resources or other circumstances beyond a person's control. (The B.C. Handbook for Action on Child Abuse and Neglect, 1998, p. 7 - 9)

Physicians not only need to have the ability to define and diagnose child abuse, but to make that information available to the child protection system in order to fulfil their obligation under Section 14 of the CFCSA.

Reporting Legislation

The Province newspaper had a recent news item (April 14, 1998) which describes the death of 22-month-old Jason Loverock 21 years ago. The pathologist, Dr. Rodney Brammell testified in 1977 that the baby died of a significant blow to his abdomen which likely caused death by rupturing his small bowel. He also noted the 35 bruises of various sizes and types all over Jason's body. The family doctor, Dr. Kurt Gottschling, also testified at that trial, stating that he had seen Jason only the month before his death and had noted severe bruising. He described the bruising: "Sad to say this bruising was the worst I have ever seen in my entire practice" (Province, 1998, p. D32). Dr. Gottschling said he had asked the mother about the bruises but she "solemnly denied having laid a hand on the child". He said that, since he had

known the mother since she was four years old, he believed her. By the time Jason was killed, Dr. Gottschling had been mandated by legislation to report for almost a decade (Amendment, Protection of Children Act, S. 7.2, 1968). The article reported that, after all these years, the mother had just been charged with Jason's murder.

Legislation and policies have been put in place in almost all jurisdictions to ensure that child protection agencies are made aware of cases of child abuse. However, these apparently unambiguous policies are not preventing cases from falling through the cracks.

Giovannoni and Becerra (1979) asserted that the reason for the original enactment of reporting laws in the early 1960's was to improve the problem of physicians refusing to report suspected cases of abuse. Physicians were treating traumatic injuries medically, but were not following up by having the children protected by the appropriate systems afterwards. Ray Helfer (1974) complained about pediatricians:

> Physical, nutritional, and emotional abuse is one of the most common maladies of the young child...The medical profession has exhibited almost a complete lack of interest in this problem until recent years ...Pediatrics still lags behind certain social and legal agencies in providing leadership, service, understanding and even research in the field of child abuse. We in pediatrics have found ourselves in the position of saying, "We must hurry and catch up for we are their leader [sic]." It is the responsibility of the medical profession to assume leadership in this field. (cited in Giovannoni & Becerra, 1979, p. 71)

After the original laws in the U.S. legislated physicians to report, similar laws for other professional groups were enacted which eventually expanded to

include almost everyone in most states. The original laws focused on physical abuse but gradually all types of child abuse reports were required.

Reporting Legislation in Canada and British Columbia

In Canada, there were no mandatory reporting laws until the 1960's. In British Columbia, the duty to report did not become law until 1968 when an amendment was made to the provincial Protection of Children Act which stated:

> ...every person having information of the abandonment, desertion, physical illtreatment or need for protection of a child shall report the information to the Children's Aid Society or to the Superintendent of Child welfare or his duly appointed representative". (cited in Geddes, p. 2, 1983)

A central registry of child abuse which had been established in 1965 in B.C. to collect data to measure the incidence and nature of child abuse complaints was formalized in 1969 and CPS and other relevant agencies were required to document all cases of child abuse to the registry. The reasons for the registry were to alert CPS workers to previous incidents of abuse, to monitor how children were being protected in the province, to prevent duplication of services, to provide research statistics, and to help with budgetary and program planning.

In October, 1981 after Ombudsman, Karl Friedmann, had received many complaints around the area of civil rights, the registry was closely scrutinized and eventually restructured. Concerns from the public included the fear of

unauthorized access to the registry, registrants not being informed of their identification on the registry, and lack of ability to expunge one's name from the registry once it was submitted, even if the complaint was unfounded. Changes made in February, 1983 included a change in record-keeping and formalized notification to registrants. Unfounded reports would no longer be registered. Modifications continued to be made to the registry until 1984, when the classifications "uncorroborated" and "substantiated" were removed and the registry became inoperative. Reports became classified according to the level of service which would be offered to a family and were classified as family service cases. The central location was disbanded and all file information was decentralized to district offices (Geddes, 1983; Robbins, 1998).

Canada was preceded by the United States in reporting legislation, with almost all states having enacted similar laws by 1966 (Martz, 1995). The American Medical Association opposed these laws because they felt that physicians should be able to use their discretion, and that parents would neglect medical concerns by failing to seek treatment for children's injuries out of fear of being reported. Coinciding with this opposition came the enactment of laws to ensure protection of reporters from civil action (Martz, 1995).

The CFCSA, under Section 14, legislates physicians, like all other people in British Columbia, to report suspected child abuse to CPS social workers

who have been given the role of investigation of abuse and protection of children. Studies also show that, although physicians are generally aware of mandatory reporting legislation, they are often non-compliant (Compaan, Doueck, & Levine, 1997; Warner & Hansen, 1994; Zellman, 1990).

Although many states and countries define mandated reporters specifically, Canadian law does not differentiate between professionals and other people in the duty to report; both have equal responsibility. Nor are particular groups of professionals, like doctors, named in the reporting laws. Under B.C.'s previous law, the Family and Child Service Act (1980), and under the current CFCSA, professional groups such as doctors are not specified to report.

In her book about child abuse in Canada, Mary van Stolk (1978) addressed three major similarities in legislation among the provinces. She found that the purpose for all provincial reporting laws was the same: to identify victims so they may be protected by the state. She also found that no province specifies "physician" in the reporting legislation; all refer to "person" which encompasses physicians. The last similarity she found was that reporting is mandatory, and not discretionary (van Stolk, 1978).

The Language of Reporting Legislation

British Columbia has what appear to be very clear policies around reporting, with stiff penalties for failure to comply. These are apparently not

adhered to, not only by the community at large, but by those who are charged with the responsibility of looking after children. Professionals who are in touch with children on a day to day basis, for example doctors, teachers, social workers, police, psychologists, nurses, counsellors, and child care workers, will often blatantly disregard reporting laws (Compaan, Doueck, & Levine, 1997; Warner & Hansen, 1994; Zellman, 1990).

Civil immunity in B.C. is afforded under the CFCSA (Section 14.5) to persons who report child abuse in good faith. Overzealous reporting is not an offense and is not penalized. In addition, clause 14.5 addresses the exoneration of reporters for making false but well-intentioned allegations: "No action for damages may be brought against a person for reporting false information under this section unless the person knowingly reported false information" (CFCSA, 1980). The previous legislation, the Family and Child Service Act FCSA (1980), did not guarantee immunity unless the informant had "reasonable grounds" to suspect abuse (S. 7.3) . This put the informant in the position of having to decide if the child was abused. In the current legislation, under Section 14.4, the informant needs to "knowingly report...false information" before it becomes an offense (CFCSA, 1996, S. 14.5).

Across Canada all jurisdictions, with the exception of the Yukon, have child protection legislation which includes mandatory reporting provisions (Martz, 1995). The main difference between current legislation in B.C. and the remainder of Canada is the threshold in the CFCSA (1996) at which people are

required to report. B.C. has taken a large step towards the detection of child abuse by changing the wording from the previous legislation, the FCSA (1980) which was reflective of most other jurisdictions. The FCSA (1980) stated in Section 7.1 that "a person who has reasonable grounds to believe that a child is in need of protection shall forthwith report the circumstances to the superintendent or a person designated by the superintendent to receive such reports". There was also freedom from liability under Section 7.3 as long as the person was not reporting "maliciously or without reasonable grounds for his belief".

That terminology was similar to current legislation in other jurisdictions in Canada and the United States, specifically in the use of the phrases: "reasonable grounds" and "in need of protection". When reasonable grounds were evident, and when a child was seen to be in need of protection, a social worker could be called, and the social worker would have legal authority to intervene.

The wording was unfortunate because, although there was protection from liability, it put pressure on the informant to decide whether they would be free from liability should their ideas of reasonable grounds and being in need of protection differ from the court's.

The latest piece of legislation, the CFCSA (1996) uses the phrase, "reason to believe", which takes some of the onus from the reporter to have proof of the abuse in order to report. Legal counsel for the Ministry of

Social Services, Jerry McHale, spoke to the Gove Inquiry (1995):

> The removal of any reference to 'reasonable grounds' also reduces the likelihood of technical legal analysis of the duty through the application of case law from other legal contexts. It has further been suggested that the new test sets a lower threshold for the activation of the duty. (cited in Martz, 1995, p. 7)

Martz concludes that the new language in the Act could be seen as a way to increase reporting.

Unfortunately, unlike the New Brunswick and NWT legislative phraseology of "without delay", the new CFCSA uses the term "promptly" which does not imply sufficient urgency. It is a positive step, however, that the term "forthwith" from the FCSA has been replaced with plain language.

The College of Physicians and Surgeons of B.C. increases the likelihood of reporting when it instructs its members to report "immediately" in all instances:

> ...where a child (person under age 19) needs or is likely to need protection. These circumstances include physical harm, sexual abuse, sexual exploitation, emotional harm, neglect, abandonment and inadequate provision for the child's care and deprivation of required health care. (College of Physicians & Surgeons of B.C., 1997, pp. 2, 7)

There is no "statute of limitations" in the B.C. child abuse legislation. Most clauses involving physical and sexual abuse, and neglect use the term "...if the child has been or is likely to be...". Only those clauses involving emotional abuse, medical neglect, abandonment, and parental death do not include past abuse as a factor.

Penalties for Failure to Comply

In June, 1997, Alberta radiologist Dr. Jack Miller was found liable for several hundred thousand dollars for medical malpractice for failing to report a child who was seriously shaken although the parents said she fell off a couch. Justice Marceau concluded "Common sense, hospital policy and precise legislation mandate that the medical profession go beyond pure diagnosis and report" (Province, 1997, p. A14).

In B.C., failure to comply with reporting legislation is still an offense as it was with the previous Act but the penalty is specified now within the CFCSA, with a $10,000 fine, six months in prison, or both. This may have been seen as a method of encouraging compliance. The historical lack of prosecutions of those not complying with the previous Act leads us to believe that prosecution would be surprising. In some provinces (Ontario and New Brunswick) noncompliance is only an offense for professionals. However, the definition of "professional" can also be somewhat confusing; for example in Colorado, the mandatory reporter list includes commercial film developers (Martz, 1995).

Some professional organizations in Canada include noncompliance with reporting laws as grounds for disciplinary measures (Martz, 1995). This formal use of sanctions gives a clear message to members about the expectations of the organization. For example, the College of Physicians and

Surgeons of B.C. has a policy where, after the first complaint of an infraction of failing to report, they would attempt to educate the physician. If warranted by more misconduct, further recommendations for discipline would include a committee of inquiry to hear charges of unprofessional conduct. To this date there have been no cases in this province where, at the request of CPS, a physician has been disciplined by the College for failing to report, or where physicians have been charged with non-compliance under the CFCSA (Martz, 1995; personal communication, Matheson, 1998).

Ethical Considerations

One of the key reasons given by physicians and other professionals for failing to report child abuse are ethical considerations, including confidentiality (Kalichman, 1993). In fact, the College of Physicians and Surgeons of B.C. (the College) has included the ethical guidelines of the Canadian Medical Association (CMA) in its directive to physicians about reporting:

> Respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance or confidentiality would result in a significant risk of substantial harm to others or to the patient if the patient is incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached. (College of Physicians and Surgeons of B.C., 1997, p. 2)

The CMA Code of Ethics also includes the statement: "Consider first the well being of the patient" (College of Physicians and Surgeons of B.C., 1997, p.

2). The guidelines clearly identify the "patient" to be the child when they describe: "... [the] management of the patient's (child's) situation" (p. 7). The College includes a section explaining to physicians their requirement under the law to report their concerns about a child should they believe the child may be in need of protection. They are also clear about the role of CPS to investigate these concerns after a report is made.

The guidelines are very clear and, in fact, are very directive about physicians' responsibility to report. One would think there could be no doubt about what is expected of physicians when faced with possible child abuse. For example, the following passage is included in the "Confidentiality" section of the guidelines:

> Where an individual discloses to a physician that he or she has been abusing a child, the individual should be advised of the physician's duty to report and consent should be obtained where possible. However, failure to obtain consent does not negate the duty to report. (College of Physicians & Surgeons of B.C., 1997, p. 4)

Other Relevant Legislation

The Infants' Act.

The Infants' Act provides those under the age of 19 with the ability to consent to treatment providing there is an ability to understand the situation. The physician in these cases may be told by their young patient that they do not consent for the physician to disclose abuse to CPS. The Attorney General of B.C. has directed that in these cases, the Infants' Act will be overridden by

the CFCSA Section 14 and the case will be reported to CPS whether or not the patient so chooses.

Legislation Surrounding CPS' Right to Information.

CPS has a right to information which relates to a child protection concern under Section 96 of the CFCSA if that information is in the custody or control of a public body, for example, a doctor working in a hospital who has information about a child. Under Section 96, physicians who are part of a public body must share information with or without consent of the patient (or guardian) in order to protect a child.

Section 96 clause (1) of the CFCSA states that:

> "A director has the right to any information that:
> (a) is in the custody or control of a public body as defined in the Freedom of Information and Protection of Privacy Act, and
> (b) is necessary to enable the director to exercise his or her powers or perform the duties or functions under this Act. (CFCSA, 1996)

However, Section 96 does not override those who are not members of public bodies, such as doctors who are in private practice. If a CPS social worker needs information from a non-public body such as a private physician's office or private medical clinic, an application has to be made through the courts under the CFCSA Section 65 to gain access to that information.

This has recently been argued successfully at the B.C. Provincial Court level when Judge Auxier made a court ruling about the College of Pharmacists of B.C. refusing to disclose information to the CPS worker (Case No. 97-10054,

1998). The worker deemed this to be necessary information in a child protection investigation but the College of Pharmacists, claiming privacy of the individual, refused to disclose the information from their records.

Judge Auxier ruled that the PharmaNet Committee (which held the relevant information) was a public body and therefore was covered under Section 96. Judge Auxier described Section 96 as having "few constraints" on the CPS worker because it is"one of the first rungs on the investigative ladder and permits a director to act quickly" (Case No. 97-10054, 1998, p. 7). Thus, it is up to the CPS worker's discretion to determine what is necessary to facilitate an investigation and the public body must turn the information over to CPS.

This case is relevant to the concept of physicians reporting because although there are clear guidelines and laws in place to regulate information-sharing between public bodies and CPS workers, this did not occur and, in fact, was taken to court and now is under appeal. The court ruling provided excellent insight into how legislation interacts with social work practice and formally clarified for other systems the importance and urgency of the CPS investigative process. Although formal and informal systems are in place to protect children, the organizational boundaries prevent this from occurring as it should. Judge Auxier also mentioned in her ruling that Vancouver Hospital and some school boards have taken the same position as the College of Pharmacists in refusing to disclose information under Section 96.

Significantly, although this case was judged fairly and logically, the College of Pharmacists continues to appeal the case.

Judge Auxier also makes the point that it is the CPS worker who is to determine what information is shared, although the College of Pharmacists argued that the public body should make the decision as to what information to share. She also stated that the CPS worker need not justify to the public body why the information is necessary as this would put the CPS worker in breach of privacy restrictions. Rather than collaborating in the effort to protect children, it appears that some other organizations are becoming increasingly protective of their information and, as I will describe in the next chapter, of their domain. The College of Pharmacists court case is an example of the reluctance of some organizations to give up any domain and to look at a systems approach to resolving the difficult situations CPS social workers deal with when they conduct child protection investigations. The development and formation of case law around these sections of the Act will have a significant effect on the sharing of child abuse information between systems.

The Enigmatic Nature of Child Protection.

In resolving the case of a drowned and malnourished baby in early 1989, the B.C. Coroner included a recommendation to the College of Physicians and Surgeons, Registered Nurses Association of B.C., and the B.C. Association of

Social Workers that "there was a lack of interdisciplinary teamwork and coordination by the professions involved in this case which should be addressed by their professional associations" (Coroner's Recommendations, 1995, p. 26).

There appears to be some mystery about what occurs once a child protection report is made. Recent studies have shown that a lack of interdisciplinary awareness and misperceptions by other professionals of the social worker's role can cause conflict (Carpenter & Hewstone, 1996; Compaan, Doueck, & Levine, 1997).

The child abuse literature is replete with articles about how a lack of awareness of CPS' roles contributes to negative feelings toward CPS workers. Compaan, Doueck, & Levine (1997) studied the association between satisfaction and exchange of information and found that reporters were most satisfied when they reported and the action taken was what they expected it to be. They hypothesized that this was due to the awareness these mandated reporters had of what CPS would or could do with a case. They found that reporters were most disappointed when they had high expectations that an outcome would occur and then something different transpired. This was found to be due to their unrealistic expectations of CPS. The researchers concluded there is a need for more communication between reporters and CPS about the true nature and constraints of the role of CPS social workers.

Carpenter & Hewstone (1996) encouraged the eradication of interdisciplinary barriers between physicians and social workers:

> Well worn stereotypes, mostly negative (doctors are 'arrogant', social workers' dithering') are invoked at times of interprofessional conflict. Ignorance of each others' roles, skill and duties is thought to be widespread...(p. 240)

They cited Sweden as an example of a progressive training ground where first-year medical students took a social and behavioural science course in mixed groups with other professionals, including community care workers. Remarkably they also cited an older study by Szasz (1969) about the University of B.C. beginning a program (which is still in existence, and which now includes social work) involving medicine, dentistry, nursing, pharmacy, home economics and others (cited in Carpenter & Hewstone, 1997). The UBC program showed, at least tentatively, that students needed structured opportunities to collaborate and classroom time was best spent on joint problem-solving activities. If the structure was not provided, it was found that the students would not interact much with the other groups and felt their time was wasted.

Hallett and Stevenson (1980) researched professionals' perceptions of other professions and found widespread stereotyping, and a lack of understanding and tolerance when one group was surveyed about the other (cited in Hallett & Birchall, 1992). Others specifically studied social workers' role misperceptions by other professionals and found these misperceptions

to be problematic to the point that others did not know what the social workers did in the workplace (Watt, 1985; Carniol, 1984; Auluck, 1990).

Some studies have examined the area of role clarity for social workers and other professionals. Watt (1985) favoured role clarity, in otherwords, role differentiation (cited in Hallett & Birchall, 1992). Others, like Helfer and Kempe (1976) felt role overlaps could also be a useful affiliation to provide a more collaborative model for working with clients. Some like Hey (1989) recommended doing away with the usual boundaries between professions, and encouraged the team approach and the use of "metaprofessions" with new skills (cited in Hallett & Birchall, 1992).

When Ducanis and Golin (1979) surveyed an interprofessional group of doctors, nurses, social workers, and physical therapists, they found that most of the people in the study felt the others were encroaching on their roles. The majority found the doctors were the most invasive (cited in Hallett & Birchall, 1992). In a literature review by Horder and Bosanquet (1986) positive changes in doctors' work (noticed by those around them in the workplace) were seen to be caused by working closely with other types of professionals (cited in Hallett & Birchall, 1992).

Some researchers looked at closed hierarchal systems in hospitals which discouraged exchange of information both within and outside the organization. For example, Auluck (1990) looked at a hospital where maternity room nurses refused to refer cases to hospital social workers

because they did not know the social workers' roles and therefore had a negative perception of them. Once they became aware of the range of services the social workers could offer, their negative views changed. Auluck suggested that once the lack of knowledge and negative stereotyping stopped, more openness could occur between the groups of professionals (Carniol, 1984; Iles & Auluck, 1990). Sheppard (1986) studied doctors' perceptions of social worker' roles in a hospital and found that when doctors lacked an awareness of the social workers' role, they felt they did a poor job (cited in Iles & Auluck, 1990).

Dingwall's research (1980) suggested that there was a greater risk of conflict between what he called the "holistic" sectors of medicine, which include pediatricians and general practitioners, and other types of professionals. Ironically, he also noted that in spite of this adversarial relationship, it is the holistic physicians who are most likely to encounter child abuse (cited in Hallett & Birchall, 1992).

Lisa Martz (1995) wrote in her submission to the Gove Inquiry: "The effect of the enactment of a mandatory duty to report is to remove from mandated reporters the discretion to decide whether or not they wish to play a role in child protection" (Martz, 1995, p. 3). The legislation is meant to delineate responsibility and simplify things.

It is the child protection worker who needs to be called by the pediatrician who sees a child injured by unknown or unexplained trauma or

who fits other definitions of child abuse or neglect. It is therefore the role and responsibility of the pediatrician to make the decision to place the call to the child protection worker to initiate a child protection investigation.

What Happens After a Child Abuse Report is Received?

When a report is received by CPS social workers, the steps they are legislated to follow are laid out in a series of policy manuals and are put into established practice standards. The steps to accepting and assessing the report are a formalized set of rules which are fully documented by the social worker onto a computer form which can then be monitored by the supervisor and other authorized parties who may require access to the file.

The first thing the social worker does upon a receiving a child abuse report is assess the information to decide what to do next. The social worker will investigate a case if there is reason to believe a child may need protection. If the worker assesses that the case does not involve child protection, they may offer support services to a family or decide to do nothing.

Although the safety of children is the responsibility of many people in the community, the decision whether or not a child requires protection under the CFCSA lies solely with the CFCSA "director" or those who are delegated by the director (normally, child protection social workers).

At the point when the CPS social worker assesses that a child may be in

need of protection, an investigation must begin to determine if there are grounds to believe the child may be at risk and to decide what steps need to be taken to protect the child. Depending on the degree of risk, the investigation may begin anywhere from immediately to five days.

When a CPS social worker begins an investigation, a decision is made whether the child is at immediate risk and, if so, a safety plan must be developed for the child. CPS must also report the case to the police if there appears to be a criminal offence committed. The child and other children who may be involved will need to be seen and interviewed depending on the ability of the child and the circumstances. Other collaboration may also occur, for example with some aboriginal agencies, religious groups, schools, or doctors.

Other steps must be taken during the initial investigation, such as checking previous records from CPS or hospitals. The parents, witnesses, or any other relevant informants may need to be contacted or interviewed. Evidence or photographs may need to be obtained. If the abuse is serious or medical evidence is needed, a doctor's examination or treatment may be necessary.

Eventually CPS makes a decision after assessing risk to the child, sometimes in collaboration with other professionals such as physicians or police, about the child's safety. A safety plan is established which can include many options. If the child is determined to be unsafe and, depending

on the circumstances, consideration is given to the least disruptive option to the child with choices ranging from the child staying at home with an alternate caregiver to removal to an out-of-home placement. The social worker is required in policy to provide feedback after the investigation is complete to the person who reported the abuse, unless safety and confidentiality become factors. Without adequate information from community members, a complete assessment of a child's risk is not likely.

Are there Any Good Reasons Not to Report?

Pediatricians were found to be less reliable reporters than many other professionals in spite of their expertise. Giovannoni & Becerra (1979) used questionnaires with vignettes to elicit reporting practices and attitudes of four different professions including pediatricians, police, social workers, and lawyers. They found that the pediatricians, though reporting more frequently than the lawyers, did not identify child abuse as often as police or social workers even when it was extreme. They hypothesized that if the participants did not identify abuse, they obviously would not report it.

The literature is saturated with reasons to avoid reporting child abuse. Physicians' variations in the definition of child abuse was seen to cause different thresholds at which reporting would take place (Giovannoni & Becerra, 1979). Hampton and Newberger (1985) looked at racial and economic differences and found these to be factors when hospitals reported (cited in

Warner & Hansen, 1994). Woolf, Taylor, Melnicoe, Andolsk, Dubowitz, De Vos, and Newberger (1988) explored lack of relevant medical training as a factor in child abuse identification (cited in Warner & Hansen, 1994).

Although little research has been done in Canada regarding physicians reporting, some has been done on the reporting practices of other professionals. For example, two recent studies by Beck and Ogloff (1991) and Beck, Ogloff and Corbishley (1994) at Simon Fraser University examined the child abuse reporting practices of local psychologists and teachers. Using analog methods (vignettes) they found that a lack of confidence in CPS rated very high as a reason for failing to report child abuse. Both psychologists and teachers rated definitional and diagnostic confusion as the primary reason for failing to report. Next, they cited the possibility of a negative effect on the child or negative effect on the therapeutic relationship. They found the third most common reason for not reporting child abuse was a lack of confidence in CPS.

Disenchantment with CPS

Research done in the U.S., Europe, and Australia has all been consistent with the notion that physicians are not generally very satisfied with the process of reporting child abuse to CPS (Compaan, Doueck, & Levine, 1997; Crenshaw, Bartell, & Lichtenberg, 1994; Finkelhor & Zellman, 1991; Kalichman, 1993; Van Haeringen, Dadds, & Armstrong, 1998; Warner & Hansen, 1994;

Zellman, 1990).

Warner-Rogers, Hansen and Spieth (1996) compared reporting practices of medical students to experienced physicians. In one of their vignettes they found that when the physicians had reported previously, they would be less likely to report again. This was found to result from a lack of adequate response from CPS.

Some researchers argued that reporting child abuse only brings it to the attention of the authorities who are accused of doing little to ameliorate the problem. Some raised doubts about the ability of CPS as "an overworked and underfunded...system to fulfil its role of providing protection and successful remediation to abusive families" (Crenshaw, Bartell, & Lichtenberg, 1995, p. 17) and advocated for more discretion in reporting for some professionals. They argued that child protection services should be sought only when it would benefit the family and child, rather than simply following mandatory legislation. Others found that, in spite of mandatory laws, reporters use their own judgement to weigh the seriousness of cases and use discretionary judgement before reporting to CPS (Zellman, 1990).

Family Loyalty - Who Is the Patient?

In a study of the identification and reporting of physical abuse at the Suspected Child Abuse and Neglect Team (SCAN) Clinic at Toronto's Hospital for Sick Children (Parkhill & Huyer, 1997), approximately one third of doctors

took the possible disruption of a family into account when making their decision whether to report. Parkhill recommended further research to interview physician-reported families about the extent they felt their relationship with their physician was actually jeopardized.

Those findings are consistent with other types of professionals who were surveyed about their satisfaction levels in making reports to CPS. For example, Helfer (1975) and Levine, Anderson, Terretti, Sharma, Steinberg, & Wallach (1991) studied the concerns of psychologists and other professionals who have ethical dilemmas when families they are treating are suspected of abusive behaviour. Although the professionals felt reporting would have negative effects on their clients, the researchers found that reporting actually had very few negative effects and was often beneficial (cited in Kalichman, 1993).

Many like Douglas Besharov (1990) have criticized CPS for traumatic intrusions into families' lives (cited in Gelles, 1996). Others like Finkelhor (1990), have refuted these claims with empirical data, finding that in approximately one quarter of all unsubstantiated investigations, parents are not even aware of any complaint against them. Similarly, in B.C., many child protection reports are screened out during the intake process as being unfounded for various reasons.

In reviewing the sparse literature on the detrimental effect of reporting upon families, Kalichman (1993) found:

> little evidence...to support popular perceptions that reporting abuse has detrimental effects on the quality and efficacy of professional services....In fact, studies specifically addressing these issues in naturalistic settings find that reporting has minimal negative, and sometimes beneficial, effects on the treatment process. (p. 54)

Agatstein (1989) described two opposing views to the mandatory reporting of child abuse as the statutory scheme and the therapeutic argument (cited in Crenshaw, Bartell, & Lichtenberg, 1994). The statutory scheme looks at the macro approach of abolishing all child abuse in society and the therapeutic argument looks at the micro approach of helping each family resolve their abusiveness.

The Need to Collaborate.

The Gove Inquiry (1995) in B.C. examined the death of five-year-old Matthew Vaudreuil who was killed by his mother. Although Matthew was seen 80 different times by doctors, only one medical report was made to CPS (Gove Summary, 1995). Judge Thomas Gove specifically confronted physicians' non-compliance of reporting laws for this failure and made recommendations that physicians work more collaboratively with CPS.

Both past and recent child abuse inquiries point to the lack of consistent collaboration between physicians and CPS. Malcolm Hill (1990) examined past inquiries and noted that, although work had been done to encourage collaboration among agencies after serious incidents occurred,

problems persisted. He noted "in spite of machinery to facilitate communication as a result of previous inquiries...paediatricians [sic] and Social Services Departments on the other had become at loggerheads with each other" (Hill, 1990, p. 202).

One of the key areas of intervention in child protection is the overlapping jurisdiction of the physician and the CPS social worker. This is where the act of sharing information is critical and could prevent future harm to children. The community has delegated the responsibility of child protection to CPS social workers, but they cannot meet that responsibility if they do not know the abuse is occurring.

Physicians, like other professionals, have an important role in the protection of children. However, unlike other professionals and community members who also are legislated to report, physicians see children who are sometimes seriously or critically injured. My research examined reporting practices by pediatricians at B.C. Children's Hospital and how experiences with CPS might influence their reporting practices.

Chapter 2

Theoretical Perspectives on Child Abuse Reporting by the Medical Profession

The American Medical Association (1985) stated: "The current understanding of child abuse...requires that no one person or profession be solely responsible for the management of these cases." (cited in Hallett & Birchall, 1992, p. 251). Although CPS social workers are given the mandate to investigate child abuse and protect children, others in the community need to give them the crucial information to do their jobs.

Traditional organizations exchange goods and services, but in the world of child protection, exchange may also include information about abused children. Various theories will be explored in this chapter which support the position that without the free exchange of resources such as child abuse reports, organizations which protect children will not have the ability to function adequately.

As described in the previous chapter, legislation states that members of the medical profession must report all suspected cases of child abuse. A review of the literature has shown that, despite this, physicians are still reluctant to report, largely because of their experiences with CPS. My research explored this phenomenon by examining experiences of BCCH with CPS through the context of organizational, systems, and exchange theories. Since both hospitals and child protection agencies are large bureaucracies, I

began by looking at formal organizational theory.

Organizational Theory

Formal Organizations

In 1930 Max Weber wrote about the Protestant Work Ethic, combining his interests in religion and economics in his writings on the impact of Protestant beliefs on capitalism (cited in Reed and Hughes, 1992). Weber's theories of bureaucracy and formal organizations led him to consider three different forms of authority within organizations: charismatic, traditional, and rational-legal.

Charismatic authority was based on values which are inspired by a leader who elicits loyalty from followers. Traditional authority was based on precedent and hierarchy. Weber's third form of organizational authority was rational-legal, or what he referred to as a "bureaucracy". Weber felt this was the most effective form of organizing: "precision, speed, unambiguity, knowledge of files, continuity, discretion, unity, strict subordination, reduction of friction and of material and personal costs" (cited in Pugh, 1983, p.17). Bureaucracies were based on hierarchy, were depersonalized, and departments were run in orderly ways by professional managers.

Robert Merton (1940) argued that Weber's type of bureaucracy would actually hinder efficiency due to the emphasis on rules and hierarchy. This would make the organization less dynamic and more rigid thus preventing

change from occurring and contributing to its demise (cited in Hill and Egan, 1966). Subsequent theories explored the interactions between individuals and systems within the organizations.

Informal Organizations

"People...not only work for the organization -- they *are* the organization" (Derek Pugh, 1983, p. 158).

Informal organizations exist within every formal organization. These informal systems consist of complex sub-groups with various backgrounds, conformities, status, abilities, levels of cooperativeness, and types of relationships (Blau and Scott, 1962). The sub-groups "like all groups, develop their own practices, values, norms, and social relations as their members live and work together" (Blau and Scott, 1962, p. 6).

In the 1930's, Chester Barnard began to explore the cooperative nature of organizations. His definition of a formal organization as a "system of consciously coordinated activities or forces of two or more persons" (cited in Pugh, 1983, p. 68) was a diversion from Weber's hierarchal bureaucratic structure. Barnard asserted that people must have cooperation in order to achieve success. Barnard had a strong influence on humanistic organizational theory with his "assertions about the importance of norms and moral codes and the responsibility of executives to infuse organizations with value systems" (cited in Ott, 1989, p. 172). He felt it was pointless to study the

formal organization and encouraged other theorists to look instead to the informal organization for their information about how the organization works. Essential to Barnard's theory are three premises: "(i) there are persons able to communicate with each other (ii) who are willing to contribute action (iii) to accomplish a common purpose" (cited in Pugh, 1983, p. 69).

Chester Barnard (1938) was one of the first writers of organizational systems theory and his natural systems theory has endured (cited in Sills, 1968). Others, like Philip Selznick (1948), followed Barnard's logic but, in using his structural-functionalist model, felt that there was no particular conscious reason for organizations to develop in the way they do except, as with other biological organisms, in their own best interests for survival (cited in Jackson, 1991).

Selznick (1948) followed Barnard's logic and contended that Weber ignored the holistic nature of persons employed in organizations and failed to see the interaction within the social structure of the workplace (cited in Blau & Scott, 1962). Like Selznick, Barnard also wrote about relationships among people within the organization which were personal in nature rather than purposeful. These, he said, were the basis of the informal organization and had a strong influence on the formal organization. Barnard determined that both formal and informal systems were needed in order for the organization to survive, i.e., that they were symbiotic, and cultivated growth and dynamism.

Alvin Gouldner (1957) devised three models of bureaucratic behaviour. He described mock bureaucracy as the imposition of bureaucratic rules (such as legislation) foisted upon an organization from an outside source. These rules are not followed by management or workers. Participants' morale is improved as an outcome because management has neither made the rules, nor enforced or followed them. Representative bureaucracy evolves from Weber's authoritarian principles which assume that experts make the rules which workers follow because they believe in the values associated with the rules. Punishment-centred bureaucracy is based on rigid compliance with rules of the organization or incur serious consequences.

However, Gouldner noted that, in spite of this type of authoritarian bureaucracy, workers were often non-compliant, taking action against management which included "working-to-rule" or slowdowns. In terms of their apparent hesitation to report child abuse, physicians need to be in agreement with the act of reporting and the outcomes of making reports before they are likely to comply. Legislation alone will not make them report.

Even as far back as 1911, Michels theorized that the emphasis on strict rules and discipline would eventually undermine the organization through the dissatisfaction of workers (cited in Blau & Scott, 1962). In terms of child protection reporting practices among physicians, it has become evident that the strict regulations around reporting are not effective on their own and may only serve to alienate physicians from CPS workers.

Both child protection agencies and hospitals are large bureaucracies following traditional lines of authority. Thus, both have fairly impermeable boundaries and are possessive of their domains. The formal systems which are currently in place do not lend themselves to open exchange between systems. Most of the writing on interagency communication and development, however, focuses on the informal structures of these organizations as the keys to unlocking closed systems.

Systems Theory

Systems theory is described by Malcolm Payne (1991) as a theoretical approach which emphasizes transformation of the environment rather than the client, and which perceives all organisms, including large organizations, as systems with open or closed boundaries (Payne, 1991). In nature, if an organism does not continually ingest, digest, and egest material into and out of other interfacing systems, it and the surrounding systems will languish and die.

The main purpose of an organization, as with any biological system, is to maintain growth and survive. For this it is necessary to have an open system and to provide a condition which will allow input, throughput, and output of resources which will then disallow a state of entropy. A condition which would allow physicians and CPS social workers to share resources (such as information and expertise) would benefit both systems.

In the 1950's, Ludwig von Bertalanffy published a paper about open and closed systems in nature. He transposed his scientific theories to general systems theories and they were quickly adopted by systems theorists as their most legitimate model to date. His premises around open and closed systems were taken up by Katz and Kahn (1966) who linked von Bertalanffy's biological systems to those of organizations (cited in Jackson, 1991).

Because of their systems and sub-systems, organizations function by way of inputs and outputs. These inputs and outputs can consist of various resources, examples of which may be money, information, personnel, or raw materials (cited in Wexley and Yukl, 1984).

Gouldner (1959) described "functional autonomy" as being the "degree to which any one part is dependent on others for the satisfaction of its needs" (cited in Perlmutter & Slavin, 1978, p. 45). He theorized that if one part of a system does not interact with others, then the system will not function, and that parts of systems are interdependent on other parts. He called this the natural-system model of organizations (cited in Veiga and Yanouzas, 1979).

Gummer (1980) states that in the natural system model, the organization can develop a "character" or "image" almost like a human (cited in Perlmutter & Slavin, 1980). The reasons for this can be as complicated as the ways in which an individual develops a character.

This premise of interdependence also appears to be true with family systems theory (Jackson, 1991) which also discusses the same types of

constraints in closed families as organizational theorists have found in closed bureaucracies. When families have closed and rigid boundaries, they are more likely to display pathological behaviours and when families have appropriately-open boundaries, they will likely be more able to function in a healthy manner (Hill, 1971).

Buckley (1968) studied family systems theory and extrapolated some valid ideas which are easily transferrable to organizational systems. He used the biological term, morphogenesis, to postulate that organizations must be able to adapt to stay alive. This adaptation can come from either within the organization itself, or from the environment. Each time the organization changes, or metamorphasizes, it becomes new and, as Orzack and Oldham comment, "a morphological approach to organizations, seeking to establish the existence of evolutionary phases or points of departure for subsequent variations, seems to be a most useful one" (cited in Varma, 1976, p. 198).

More biological analogies were used when Emery and Trist (1965) wrote about open and closed systems, "any living entity survives by importing into itself certain types of material from its environment, transforming these in accordance with its own system characteristics, and exporting other types back into the environment" (cited in Hill and Egan, 1966, p. 435). This statement could be used to describe a functional organization where important information is shared, transformed, and used to the benefit of both organizations.

Blau and Scott (1962) examined the roles of organizations in relation to other organizations. They cited Goffman who described the "semi-permeable membrane" which surrounds each organization (cited in Blau and Scott, 1962, p. 194). In terms of child protection reporting, the information from one organization is given to another which, after careful assessment, can then use the information to benefit the client.

Although it might be clear that information is necessary for the well-being of the organization, the problem still remaining is how one organization convinces another to share valuable information, especially when it is not of equal or more value than that which is being relinquished.

Power and Hierarchy

In terms of power over the decision to report or not, it is usually assumed that organizations with the most resources are the most powerful and therefore have control over decisions (Gummer, 1980). Tannenbaum refers to control within the organization as:

> any process in which a person or group of persons or organization of persons determines, that is, intentionally affects, the behavior of another person, group, or organization....The exercise of control may be viewed as an exchange of some valued resource dispensed by one person in return for compliance on the part of another. (cited in Perlmutter & Slavin, 1980, p. 41)

A major point of dissension between Weber and others was around the topic of hierarchy and authority. Gouldner (1957) looked at two types of

managers: cosmopolitans and locals. He found the cosmopolitans were experts in their fields but with little loyalty to the organization. The locals were loyal to the company, but held little professional expertise.

Gouldner measured employees' commitment to the organization and commitment to the profession (cited in Blau and Scott, 1962). They found that professionally-trained workers tended to associate more with other professionals and abject loyalty to the company was not a priority.

This may have some relevance for reporting of child abuse to social service agencies. If the expert professionals, those whom Gouldner called "unsalaried", see themselves as having more status in the hierarchy than the other "salaried" professions, then there is a possibility of tension between the two groups. CPS social workers with more professional credentials are more likely to be viewed as equals or as experts in their field than those without a professional education. In a 1996 study on mandated reporting by therapists and CPS social workers, it was found that problems arose between the professions because of educational levels

> ...the educational requirements differ for the two groups, therapists typically need graduate level training while CPS work generally requires a bachelors' degree...CPS workers may receive lower pay....the difference in educational background served as a gap for some therapists. (Deisz, Doueck, George, & Levine, 1996, pp. 276, 283)

Medical doctors could be seen to be an example of unsalaried expert professionals whereas the government-employed child protection social workers, particularly those without professional credentials, could be seen as

the salaried professionals. The "experts" may have a difficult time sharing information with the others who are not viewed as having expertise and they may wonder what benefits they receive from what appears to be an unbalanced exchange. The expertise of the hospital physician in all matters pertaining to the human body clashes with the expertise of the child protection worker in examining the systems relevant to child abuse.

Organizations, according to Wexley and Yukl (1984), expend a great deal of energy accumulating power. They stated that control of information is a source of power within organizations. Because information is seen as a valuable commodity, it is a not a resource easily shared with other organizations. For example, information about child abuse, which is often within the domain of hospitals, is not readily shared with child protection agencies. Similarly, CPS social workers often do not provide feedback to physicians after a report is made, thereby seeming to maintain control over their resources.

When this is combined with the research around "expert power" (Wexley and Yukl, p. 227), where others depend on the expertise of some professionals, the deduction is that there is a definite power difference between the hospital system and child protection system. In terms of public support, approval, image and climate (as cited in Perlmutter & Slavin, 1980), hospitals can be more highly regarded than child protection agencies.

Other inequities may make interagency communication difficult.

Abramson and Rosenthal (1995) stated: "Traditional patterns of male dominance may persist in any organization and are still found on health care teams in which male physicians are in the majority and interact with other professionals who are primarily female" (as cited in Edwards, 1995, p. 1482). Medical dominance was also a problem when the organizational structure did not encourage participatory equality among staff.

Exchange Theory

One of the advantages of effective liaison between organizations can be the maximization of resources which can be shared or exchanged. Salancik and Pfeffer (1977) wrote, "strategic contingency theory argues that departments that mediate critical external dependencies and uncertainties tend to receive more resources over time" (as cited in Baum and Singh, 1994, p. 80). Possibly this could be applied to organizations such as hospitals and child protection agencies where there is a need to exchange resources such as critical information about children.

Gouldner (1960) wrote about what he called "the norm of reciprocity", in which he suggested that scarcity of resources provides motives for organizations to enter into exchanges with other organizations which may be mutually beneficial to both. However, if the exchange is not equitable, one organization may feel that it is being encroached upon, and may suffer a loss of prestige (cited in Negandhi, 1973). A hospital would have little motivation

to share its resources or domain with less-endowed organizations such as CPS unless they could be convinced that the exchange could be made more equitable.

Hallett and Birchall (1992) commented on the competition between organizations for domain, which had caused problems in some collaborative efforts. Rather than enhancing the relationship between groups, the attempt at collaboration actually hampered them. For example, Mayhall and Norgard (1983) commented on the:

> ...lack of professionalism, in the sense of misplaced agency loyalty at the expense of other agencies, and often at the expense of clients, which exhibits itself in turfism, territorialism, and critical asides (about) coworkers....(cited in Hallett & Birchall, 1992, p. 126)

Without child abuse reports, child protection agencies would be non-existent. Roland Warren (1972) researched the role of domain in an organization's "undisputed claim to necessary resources":

> Organizational domain is the organization's locus in the inter-organizational network, including its legitimated 'right' to operate in specific...functional areas and its channels of access to...resources. The two important components here are the organization's right to do something, and its access to the resources it needs in order to do it....In its interaction with other organizations, an organization acts to preserve or expand its domain. (cited in Perlmutter & Slavin, 1980, p. 30)

Organizational Interaction

Lawrence and Lorsch (1969) found that, in many organizations, there are sub-units with diverse roles that must interact with one another effectively in order to carry out the purpose of the organization. In order for

these sub-units to be effective, the organization must provide them with a means of interacting with one another in a positive way, otherwise conflict will occur and the goals will be unsuccessful. Lawrence and Lorsch suggested the use of "integrators" with appropriate personal skills, authority, and attitude who would have the job of coordinating sub-units (cited in Wexley & Yukl, 1977).

Along the same line, Rensis Likert (1969) wrote about organizational interaction: "The entire organization must consist of a multiple overlapping group structure with *every* work group using group decision-making processes skillfully" (cited in Pugh, 1983, p. 157). Likert also speculated that all parts of the organization should overlap and be cooperative with one another. Interaction and group decision-making rather than traditional hierarchal bureaucracy, as well as coordination across functions, should be encouraged by a well-run organization. Likert coined the term "linking pins" which were members who would belong to more than one group and would link the groups, much like Lawrence and Lorsch's integrators. This was the beginning of coordination within organizations and with outside agencies. This model of coordination has been useful for many feminist organizations (such as Vancouver's Battered Women Coordination Committee on Violence Against Women in Relationships) and has been used to facilitate communication between large organizations such as CPS and hospitals (an example is the Child Protection Service Unit Committee at BCCH which holds

regular meetings to serve as a link with CPS and other large organizations).

In terms of managing these types of organizations, Likert believed that the ability to adapt a style and behaviour relative to the workers and workplace was necessary. This was in line with contingency theory which proposed that no one theory could have a universal application. The less traditional managerial trend reflected and encouraged the needs of the workers and the organization. The notion of traditional authoritarian bureaucracy was beginning to make a paradigm shift to more humanistic and flexible types of organizations.

Eric Trist (1951) determined that in order to create an efficient organization, the environment, the workers, and the boundaries of the organization must be taken into account (cited in Pugh, 1983). He found, as did Likert, that the smaller systems or cliques of the organization were crucial and that efficiency depended upon job satisfaction of sub-groups of workers.

He also cautioned that the environment is not static and coined the phrase "the turbulent field" to vividly depict its unpredictability. In order to avoid getting caught up in this turbulence, he encouraged collaboration within and between organizations, sub-groups of employees, and the reduction of hierarchy. He saw group members as valuable resources with broad-based skills, the ability to collaborate, internal controls (by sub-systems), and a flattened organizational structure.

In terms of interagency communication and the protection of children, this model of a system with open boundaries and the possibility of continual interchange of ideas and resources across boundaries has value. If organizations such as hospitals and CPS could operationalize this interchange adequately, physicians and child protection social workers could collaborate by sharing information about a child who may be abused.

Resource Networks

As stated previously, organizations need resources to survive, but large bureaucracies such as CPS and hospitals could find it difficult to attain resource-sharing compatibility. Exchange theory can provide a framework by focusing on reciprocal sharing of resources within and between organizations.

Essentially, organizations are not likely to give up any of their resources without some kind of benefit to themselves. White, Levine, and Vlasak (1961) wrote that although resource-sharing may look like altruism, it is not, as there is always an expected benefit or exchange of resources (cited in Negandhi, 1973, p. 176). According to Gouldner's theory about the norms of reciprocity (1959) this would mean that the exchanges would be either somewhat equal in value, or mutually agreeable (cited in Perlmutter & Slavin, 1980).

Organizational exchange is dependent partially upon "domain consensus", i.e., the amount of agreement upon "matters such as goals,

functions, populations served and ideologies of intervention" (Hallett, 1995, p. 14). This collaboration is operationalized by way of cooperation and problem solving, and the exchange can involve either tangible or intangible resources.

Collaboration

> Helfer and Schmidt (1976) stated:
>
> > We can no longer afford the archaic system...(but must have) a comprehensive team of professionals who work together as a single unit...like a cardiac care team or a football team. (cited in Hallett & Birchall, 1992, p. 248)

Meyer and Mattaini (1996) called informal structures "work-based mutual aid networks" (Meyer & Mattaini, p. 210). Barnard noted that where the formal bureaucracy is deficient, the informal structures of the work environment will fall into place. This can either enhance or inhibit organizational goals (cited in Meyer and Mattaini, 1996).

Blau and Scott (1962) asserted that informal status within a group can also bolster integration. This can possibly help in interagency collaboration where informal group norms and values could be used to motivate employees to work on common solutions to problems across organizations. Thus, if the group norm is to work in partnership with other agencies, if employees have relatively equal status across the organizations, and if the agencies encourage this group norm, then the effort is more likely to be successful.

Transforming Theory into Practice.

A pediatrician in a study of interagency collaboration said: "You get to respect social workers when you work alongside them and see they don't all want to remove children" (Hallett, 1995, p. 317).

Iles and Auluck (1990) found problems in their studies on interagency teams in terms of a lack of commitment, multiple hierarchies, and multiple interests. The interactions usually degenerated around such occurrences as scapegoating, dissatisfaction, conflict, and frustration, rather than the more productive goals of collaboration and cooperation. In their research (1990), a social worker was placed in a medical clinic in order to improve interagency collaboration and services to clients. Although it seemed like a reasonable idea, it broke down "due to issues of motivation, commitment, communication and co-ordination" (p. 158).

Many conflicts have arisen over role and autonomy in these interagency efforts (Hallett & Birchall, 1992). A joint British study between the Royal College of General Practitioners and the British Association of Social Workers, (1978) researched a situation in which social workers were placed in organizations with medical professionals. It was found that both social workers and pediatricians were wary of each others' roles and balked at efforts to collaborate: "A joint document of social workers' and general practitioners' professional organisations [sic] noted low motivations to collaborate, perhaps to avoid social workers' domination by the doctors"

(cited in Hallett & Birchall, 1992, p. 161).

Lawrence and Lorsch (1969) cultivated Barnard's cooperative approach to include the concept of "differentiation and integration" (Lawrence and Lorsch, 1969, p. 12). Differentiation referred to the diversity of sub-units in their goals, time frames, and interpersonal relations. Integration referred to the quality of collaboration and cooperation between interdependent sub-units within the organization. They found that the most effective organizations had both high differentiation and high integration, and that members of the organization saw the strongest leaders possessing both competence and expertise.

Malcolm Payne (1982) emphasized the importance of defining one's own role boundaries, professional practice skills, and expert understanding of one's own role as well as others'. He states: "Most writers argue that domain- and role-blurring is inappropriate in a multi-disciplinary team" (cited in Hallett & Birchall, 1992, p. 240).

Resolution may come about when the bureaucratic systems to begin to ease up their adjoining boundaries and begin the process of interacting positively with one another. It is not enough for the organization to expect the informal sub-groups to interact and take part in creative interchange of ideas and resources. The formal organizations must take responsibility and provide the theatre for these exchanges to occur in a willing and open atmosphere.

Chapter 3

Method

Limited research has been done on Canadian physicians' reporting practices. Therefore, a brief quantitative and qualitative questionnaire was used to conduct an exploratory descriptive study of pediatricians' experiences with the child protection system. Responses were elicited from pediatricians about their experiences reporting to CPS social workers using variables which were thought to influence physicians' adherence to mandatory child abuse reporting laws. The information provided information about interactions between professionals in two large organizational systems.

Research Design

Two methods have been used predominantly to study various types of professionals' reporting patterns. In the "analog method", professionals are typically given a number of case vignettes and are asked which cases they would report (Warner-Rogers, Hansen & Spieth, 1996; Giovannoni & Becarra, 1979; Beck & Ogloff, 1991). Although some researchers such as Morris, Johnson, and Clasen (1985) showed that this method was useful among physicians, it is generally considered to be too subjective with too many

variables, for example respondents' range of child abuse definitions is usually too broad (Warner-Rogers & Hansen, 1994). Another problem is respondents' answers to questions may not reflect actual reporting practice. Physicians may reply to questions because of a social desirability factor and a moral obligation to do so (Anastas & MacDonald, 1994).

The second method of surveying professionals' compliance, the "case method", involves either asking professionals about their past reporting behaviours, (Sundell, 1997) or going through medical records (Warner & Hansen, 1994). Although this method has the benefit of using actual cases, difficulties with questionnaires involving a strong moral demand for compliance may contribute to physicians exaggerating their reporting responses. Additionally, even in an anonymous format, respondents may fear the potential for legal and professional sanction since failure to report is illegal. Due to confidentiality, access to medical records is virtually impossible so this type of research is not feasible except in rare circumstances.

In order to avoid the reliability problems associated with using case and analog methods, an anonymous questionnaire was used. In this method, physicians were not expected to disclose actual reporting behaviour and no moral demand would occur to compromise the reliability of the study.

A consistent problem which arose in other studies of reporting practices related to the definition of child abuse (Kalichman, 1993; Lieber,

1978; Giovannoni & Becarra, 1979). Because of the subjective nature of the definition, reliability in this study did not depend on how doctors define child abuse. Although the term "child abuse" is operationally defined in the covering letter, the respondents could form their own conceptual definition of the term without having it affect the reliability of the questionnaire.

As with any anonymous questionnaire to physicians, the potential of a small response rate was predicted to be problematic. In order to increase the return rate, Dr. Jean Hlady, head of the Child Protection Unit, assisted with piloting and distributing the questionnaires. The questionnaires were placed in doctors' mailboxes at B. C. Children's Hospital (BCCH) with instructions to mail them back anonymously through house mail. An accompanying letter requesting research results could be sent under separate cover in an enclosed envelope. Because some doctors did not have hospital mailboxes, some questionnaires were hand-delivered to their offices. Three weeks later, a reminder letter along with another copy of the questionnaire package was re-distributed to most doctors.

Participants

In order to investigate pediatricians' experiences reporting child abuse to CPS, a questionnaire was developed and distributed to all pediatricians with admitting privileges at BCCH. BCCH is situated in a large urban centre, Vancouver, B.C., and takes over 100,000 referrals per year from the entire

province for assessment and treatment of medical conditions of children.

The pediatricians from the BCCH Child Protection Service Unit act as child abuse consultants for many physicians and CPS social workers throughout the province. In 1997, 48% of the 625 children seen at the Child Protection Service Unit (CPSU) of BCCH were from Vancouver. Referrals to the CPSU pediatricians mainly came from other physicians (64%), but CPS had involvement in 78% of the cases and police were involved in 41%. Many of the children are involved with multiple agencies, in otherwords may have CPS, medical, and police involvement. CPS often routinely refers abuse cases to CPSU, even simple bruising, in order to obtain documentation of the injuries from medical experts. Other physicians, who may have already reported a case to child protection workers, or who may be jointly involved with CPS on a case, will sometimes refer abuse cases which are complex and require a second opinion. (CPSU, March 1998).

The location, a hospital for acute and chronically ill children, would expose these doctors to more potentially-abused children than most physicians. Because of this, these pediatricians would likely be more able to discriminate between abused and non-abused children, and would have had the most likelihood of reporting child abuse in the past and would likely know about mandatory reporting legislation and have experience with the process of making a report to CPS (Warner & Hansen, 1994).

Measures

The questionnaire (Appendix #1) included both open and closed ended questions which were measured on Likert and dichotomous scales. Dichotomous questions were asked of pediatricians about their impressions of the reporting process to CPS. Demographic data was collected including specialty of the pediatrician, age range, years of practice, and gender.

Participants were asked to indicate if they had ever reported child abuse to a CPS social worker. If they answered "yes", they were then asked to go on to the next set of relevant questions which first included an interval scale which asked how often they had reported. If "no", they were directed to the next page which included general reporting practices of physicians.

Participants who had reported were asked to indicate on a 5-point, Likert-type ordinal scale (1 = strongly agree, 5 = strongly disagree) their reactions to statements about the process of reporting child abuse. Some of these statements explored pediatricians' perceptions of CPS social workers' professionalism, ease of reporting, confidence in the effectiveness of CPS, extent of case feedback given, and the level of satisfaction with the process. In order to capture any further comments they were asked for "any other reactions" (See Table 3).

On a nominal scale, reporting participants were asked if they would feel comfortable reporting again and were asked to comment. This question was posed because some studies have shown that other professionals who

have reported in the past are less likely to report again due to poor experiences with CPS (Compaan, Doueck, & Levine, 1997; Crenshaw, Bartell, & Lichtenberg, 1994; Finkelhor & Zellman, 1991; Kalichman, 1993; Warner & Hansen, 1994; Zellman, 1990).

All participants were then asked to choose from a nominal scale to whom they thought child abuse should be reported. This also included an open ended query to include other responses. A qualitative question was added to capture the reasons physicians may be reluctant to report child abuse.

The final section of the two-page questionnaire was a request for demographic data. The last question was a general qualitative question about respondents' opinions of physicians' reluctance to report. Due to ethical considerations and potential legal and professional sanctions, respondents were not asked about their own reporting practices or opinions.

The questionnaire was constructed for the purposes of this research and had not been used previously. Reliability of the questionnaire was not determined. After a pediatrician and a general practitioner reviewed the questionnaire to ascertain face and content validity, it was given to the In-Hospital Research Review Committee of BCCH for review. No problems appeared to be evident, therefore the distribution went ahead as described in the following section.

Procedures

After obtaining approval from the U.B.C. Behavioural Research Ethics Board and the BCCH In-Hospital Research Review Committee, a two-page anonymous questionnaire was delivered to offices and hospital mailboxes of all pediatricians with admitting privileges (N = 50) at BCCH. The reason for the purposive sample was based on the assumption that this group of pediatricians would be more likely to come into contact with abused children than most other types of physicians.

The covering letter described physicians' hesitation to report child abuse because of professional perceptions of the inadequacy of CPS. A brief definition of child abuse was given which was derived from the handout recently given to physicians from the College of Physicians and Surgeons of B.C. A self-addressed envelope was enclosed with instructions to put the completed questionnaire into the house mail. A request for results of the survey with an additional envelope was included to be sent under separate cover to respect anonymity.

Questionnaires were requested to be returned within two weeks and within that time 21 responses were received. A reminder notice was then delivered with another questionnaire to most pediatricians included in the sample and elicited another 5 responses.

Analysis

Data analyzed using the SPSS Program generated frequency distributions and measures of central tendency including median, mode, range, and standard deviations. Comments provided open-ended data for qualitative analysis and scales were analyzed quantitatively.

Qualitative questions were asked of the pediatricians because this survey was partially exploratory, and there is no empirical data about pediatricians' experiences with B.C.'s CPS. As well, the qualitative data could be used as verification of the quantitative data and to use the data to draw both theory and practice for practical use as well as future research. Anastas and MacDonald (1994) describe the grounded theory method as a link between qualitative and quantitative methods:

> *In many instances, both forms of data are necessary*--not quantitative used to test qualitative, but both used as supplements, as mutual verification, and, most important for us, as different forms of data on the same subject.... (p. 65)

Consistent themes and patterns were sought from the qualitative data and the main themes were converted to subsets which were then analyzed quantitatively.

Results were tabulated from the questionnaire to determine how often the sample population of pediatricians had reported and what factors in the course of reporting to CPS affected their future compliance. The questionnaire examined pediatricians' experiences reporting child abuse to

CPS. It elicited recommendations on how pediatricians think reporting should occur and why some physicians are reluctant to report. Results describe pediatricians' experiences with CPS social workers and may provide beneficial feedback to relevant agencies such as CPS, BCCH, and the College of Physicians and Surgeons about how to increase reports of child abuse to child protection social workers.

Chapter 4

Results

Description of the Sample

Of the 50 participants, 26 questionnaires were returned yielding a response rate of 54%. Two of the responses were incomplete with one missing the demographic data.

Demographic data from those 25 responses showed that the sample consisted of more females (56%) than males (44%). Ages ranged between 30 to 60 years with almost half falling in the mid-range between 41 - 50 as shown in Table 1.

Table 1

Ages of the Subjects

AGE	FREQUENCY	PERCENT (%)
31 - 40	8	32
41 - 50	12	48
51 - 60	5	20
Total	25	100

Specialty

Most of the participants noted their specialty as "pediatrics" (N=16, 64%). The remainder showed a fair bit of diversity within the pediatric specialty as can be noted in Table 2.

Table 2

Pediatricians identified by Specialty

SPECIALTY	FREQUENCY	PERCENT(%)
General Pediatrics	16	64
Intensive/Critical care	3	11.5
Child Protection/Emergency	2	7.7
Neonatology	2	7.7
Dermatology/Cystic fibrosis	2	7.7

The pediatricians ranged in experience from 6 to 30 years with almost half (48%) having more than 15 years experience. The average length of career was 17 years (M = 17.1, SD = 6.8). The respondents were equally distributed in terms of low and high experience with 28% (N = 7) having 10 years or less experience and 28% (N = 8) having 22 years or more.

Factors Which Facilitated Reporting

Of the 25 pediatricians who completed the questionnaire, 21 indicated they had reported child abuse to CPS workers. Of those 21 respondents who had ever reported, 19 said they would feel comfortable reporting again. Because the sample size was small, and the data were skewed 21 to 4 and therefore did not assume a normal distribution, there were limits to the calculations which could be made.

Pediatricians were asked to rate statements on interval scales describing their reactions during the process of making a child abuse report. Cross-tabulations were done on the above data to determine if there was a relationship between the comfort the respondent felt making a report and the likelihood of future reports. Examining the Pearson correlation coefficients (r) showed that the higher the degree of comfort the reporter felt when calling CPS was associated with increased confidence in worker professionalism (r = .94, $p < .01$), ease of giving the report (r = .78, $p < .01$), and being treated in a professional way (r = .95, $p < .01$). Additionally, the same test showed the number of reports was higher when reporters felt comfortable making a report (r = .43, $p < .05$).

Pediatricians Experiences Reporting to CPS

Pediatricians' experiences reporting child abuse are presented in Table 3. These results, taken from the quantitative questions, indicated that

although the majority of previous reporters demonstrated that they were positive about their own experiences reporting to CPS, there was a marked exception regarding feedback from CPS. Table 3 shows that pediatricians appeared to be positive about most aspects of reporting except the lack of feedback on cases. The three categories which included outcome, feedback, and followup were ranked lower in satisfaction than the other categories. The categories including outcome and followup were ranked high for undecided. It would appear that the reporters ranked high for ease of reporting to CPS but low for receiving information back from CPS. In the same vein, pediatricians did not appear to know whether or not the child was safer because they had reported.

The 8 categories which involved pediatricians reporting to CPS were satisfactory, but the 4 categories involving CPS reporting back to the pediatricians rated negative or undecided. The other categories which ranked in the middle range involved time factors, being put on hold, and taking too long to make the report.

Table 3

Pediatricians' experiences reporting child abuse

Pediatricians' experiences	positive (%)	Negative (%)	Undecided (%)
Social worker acted professionally	91	10	
Treated in a professional way	91	10	
The social worker did not ask too many questions	91	5	5
Social worker not annoyed to get the report	90	5	5
Report taken without problems	81	19	
I was left feeling something would be done	72	14	14
Not left on hold by reception	67	19	14
It did not take too long to make the report	65	10	25
Child was safer because I reported	57	5	38
Outcome of case was satisfactory	35	20	45
There was followup done	26	26	47
I was given feedback on the case	24	71	5

Factors Which Discouraged Reporting

Of the 25 pediatricians who responded to the quantitative question about whether or not they had reported in the past, four responded that they had never reported. The four non-reporters ranged from 6 to 25 years of experience. Of the remaining 21 pediatricians who said they had reported in the past, two stated that they would not report in the future. Both future non-reporters responded very strongly in a comment section that they felt CPS had not adequately dealt with their situations. One of these respondents stated she had reported only once but had been involved in many other cases with others who have reported; the other had reported between 2 and 5 times but would not report again. Both had over 15 years experience in pediatrics.

Pediatricians were also given a qualitative question asking their opinions why physicians may be reluctant to report. Comments shown in Table 4 were somewhat critical of CPS social workers and also expressed some concerns about other systemic problems such as the courts. Before summarizing these comments in Table 4, I will divide them into three categories : problems with CPS, physicians' definition of patient, and court problems.

Problems with CPS.

Some of the negative comments about CPS workers written on the questionnaires were:

1. "They (physicians) never get feedback."
2. "Previous bad experiences with social workers."
3. "If physicians could be assured of a competent, prompt response to a report I feel there would be less reluctance to report."
4. "MCF needs to focus some of its' disorganised energy...."
5. "Not feeling much will be done...."
6. "There is a tremendous lack of consistency in the social work response across the province."
7. "Some social workers seem inexperienced on the phone."
8. "The response of the social worker has been very variable."
9. "Notably, sometimes I seem to have to convince them they should look into things even with physical evidence reported."
10. "Initially I was frustrated that the worker would not do anything as 'it would not stand up in court'."
11. "The social worker over-reacted, despite my every efforts to prevent this. Finally, the supervisor had to apologize to the parent, but some damage remained. The supervisor's approach was very professional, unlike the social worker who took the case."

Physicians' definition of the patient and loyalty to the parents.

An unexpected outcome of my research was that the second-highest reason stated for physicians to fail to report was because they thought their

patient was the parent, not the child. Many pediatricians expressed physicians' concerns that the relationship with the family would be put in jeopardy. Comments included the following types of statements:

1. Pediatricians felt the trust between doctors and parents would be destroyed.
2. They felt they might make a mistake involving families they know and like.
3. They felt the relationship with the family would be put in jeopardy or changed.
4. They felt that physicians saw the child's caregivers as their patients and found it difficult to believe they would abuse or neglect their child.
5. They feared what could happen to the family.
6. They feared losing the family as patients.

Court problems.

Court also seemed to be a common negative barrier for some who included comments such as the following:

1. They did not want to be involved in a possible legal proceeding.
2. They felt they would have to produce legal reports.
3. They were afraid to go to court.
4. They noted that the legal ramifications and potential abuse of their

time by the justice system was significant.

5. They wanted to avoid court.

These responses are grouped according to frequency in Table 4.

Table 4:

What, in your opinion, are the main reasons physicians may be reluctant to report?

	Number of negative comments citing reasons for reluctance to report
Negative comments about CPS social workers	18
Physician's view that family is the patient, not the child	11
Negative comments about court system	10
Definitional or diagnostic confusion	8
Confidentiality	5
Ignorance of reporting laws or procedures	3
Not willing to get involved	3
Fear the family will not seek help if Dr. reports	1

Chapter 5

Discussion

The findings in this research have been consistent with other research reported in American and European literature concerning reporter satisfaction with reporting to CPS (Compaan, Doueck, & Levine, 1997; Crenshaw, Bartell, & Lichtenberg, 1994; Finkelhor & Zellman, 1991; Kalichman, 1993; Warner & Hansen, 1994; Zellman, 1990). Although most pediatricians at BCCH state that they have reported previously and would likely report again, they are more reluctant to report child abuse to CPS social workers when they have had previous negative experiences in doing so. Data obtained qualitatively through self-reports verified the quantitative data and also complemented it by generating descriptive responses which indicated feelings of frustration with British Columbia's CPS system.

Although most pediatricians at BCCH who responded to the questionnaire said they would feel comfortable continuing to report, the same respondents felt that other physicians may have more reluctance to comply with this duty, citing a lack of confidence in the child protection system in their narrative responses. Other relevant themes coming from the qualitative sections of the questionnaire included the feeling that physicians' loyalty to the family and their definition of who is their patient would influence their decision to report. Some respondents also indicated physicians' reluctance

to become involved in court processes as a result of reporting. Less commonly-cited factors included client confidentiality, and definitional or diagnostic confusion, i.e., whether physicians have the ability to diagnosis child abuse with certainty. In the quantitative questions, pediatricians indicated some dissatisfaction with the general lack of feedback they received on cases they reported, thus they have no way of knowing if there is a positive outcome after a report is made, i.e., if CPS has done anything on a case.

The qualitative information derived from the questionnaire was somewhat different from the quantitative feedback given. This difference might be due, in part, to the fact that the quantitative questions were about the pediatricians' own practice and the qualitative questions asked the pediatricians what they thought other physicians' experiences might be.

Main Obstacles to Reporting

Lack of confidence in CPS.

"The response of the social worker has been very variable. Notably sometimes I seem to have to convince them they should look into things even with physical evidence reported" (anonymous pediatrician responding to questionnaire).

The results of this research are significant in terms of practical application of theory. The legislation that is foisted upon physicians to

ensure that child abuse reports are made is derived from Weber's formal organizational theory which includes strict, unquestioning adherence to rules, with severe sanctions threatened for failure to comply. Physicians, elite professionals, clash with this ideology and feel they get minimal return out of the exchange; in fact they feel that they lose out in terms of time, money, and client trust.

The imposition of this legislation has created a schism between CPS and physicians which clearly has not been adequately managed. CPS is still adhering to its Weberian ideology as a means of extracting information from other networks. There are many theoretical approaches which could be used to improve the collaboration between the two organizations, particularly with systems and exchange theories in mind.

Informal networks with common purposes and skilled, credentialed professionals are fundamental to collaboration and coordination. Although a protocol of interagency communication may contribute to resource-sharing, empirical research and exchange theory have shown that physicians will not begin to adequately report until they have confidence in CPS and feel they are receiving a fair exchange. Expert qualifications of all CPS social workers are essential to thereby reduce the traditional hierarchy between physicians and social workers.

The literature is replete with research attesting to the positive outcomes of interorganizational collaboration in other jurisdictions. The

juncture at which organizational, systems, and exchange theories meet provides a firm basis for collaborative practice. Abramson and Rosenthal (1993) describe interdisciplinary collaboration as an approach which can resolve previously futile situations and create positive and creative solutions. Whether CPS social workers are part of a hospital team or participants at case conferences, they form a positive link to the hospital system where expertise, ideas, and information can be shared. If physicians are responding that they are not satisfied with CPS' reaction to cases, or are uninformed as to the outcome of cases they have reported, then situating a CPS worker on site could help. The problems encountered between CPS and physicians appear in literature to be more attitudinal than knowledge-based and organizational commitment to a collaborative process is needed before information will be shared freely.

The disruption of the family.

"[The] relationship with [the] family [is] put in jeopardy or changed" (anonymous pediatrician responding to questionnaire).

Some of the respondents in this research held the opinion that child abuse reporting and the resultant CPS interventions are detrimental to the treatment process in a family. Helfer (1975) and Levine, Anderson, Terretti, Sharma, Steinberg, & Wallach (1991) studied the concerns of psychologists and other professionals who have ethical dilemmas when abusive families

seek treatment. They found that reporting actually had few negative effects and was often beneficial (cited in Kalichman, 1993).

However, when the qualitative comments are taken into account, physicians' concerns about their patients can be interpreted as lack of confidence in CPS. Many concerns expressed about their families can be contingent upon physicians' confidence in CPS. The literature confirms that if physicians lack confidence in CPS or are unaware of what will occur once a report is made, they may be more likely to feel that they are doing their patients a disservice by reporting and that a negative outcome will occur.

Who is the patient?

"Caregivers are physician's patients - i.e., find it hard to believe they would abuse/neglect child" (anonymous pediatrician responding to questionnaire).

An unexpected result of my research was the high number of pediatricians who felt that physicians would not report because they thought their patient was the family, not the child. A pediatrician who has been in practice for 10 years stated that a child abuse report would "destroy the trust between the doctor and the parents". It appears from many of the comments, that doctors may see their role as providing health care rather than protecting children.

Some pediatricians reflected the feeling that reporting child abuse is a burden to some physicians ("Too much hassle") and is not seen as part of

their regular profession but as an imposition on their preferred role. The dearth of time spent in medical school studying child abuse and neglect encourages the notion that child abuse is of marginal importance.

Recommendations

Recommendation #1

As stated previously, collaborative networking is more likely to achieve a better exchange of information between physicians and CPS workers. Both sets of professionals complained that they do not obtain adequate information form one another. Although it requires considerable effort, collaboration is likely the only way this will improve. Many models of interagency collaboration are being initiated and, some, such as the British model (Hallett & Birchall, 1995) are specific to CPS and medical professionals. Chapter 5 discusses collaborative models which can assist CPS and physicians to work together.

It is recommended that professional reporters be encouraged by CPS to remain involved and work with CPS collaboratively until a child protection case is resolved. It is also recommended that CPS and the College of Physicians and Surgeons develop a collaborative model in which CPS and physicians work together in a shared location with complementary roles.

Recommendation #2

Policy is in place to direct CPS workers to provide feedback to reporters (CFCSA amendments, 1996, S. 3.4-14) but it is not being complied

with consistently. In my research, the most negative reaction by pediatricians to reporting child abuse was to the apparent lack of followup by CPS. Gove (1995) heard submissions in his child fatality inquiry from many physicians complaining that after they had submitted child protection reports, no feedback was provided about whether a case was being investigated (Gove, 1995, volume 2, p. 68). Knut Sundell (1997) in his study on reporting by child care staff, concluded that if CPS is to gain trust from reporters and encourage reporting, they must provide information about followup to the reporters.

It is recommended that CPS social workers become involved in the practice of reciprocal exchange by providing feedback to those who report child abuse suspicions. This could improve communication between the professions and increase reporting by physicians.

Recommendation #3

In my study it was evident that in many instances the parents are viewed as the patient by the physician, not the child. There has been quite a bit of media and other attention about the perceived risks to families once a social worker is called (Jason, Andereck, Marks, & Tyler, 1982; Morris, Johnson, & Clasen, 1985; cited in Van Haeringen, Dadds, & Armstrong, 1998). Van Haeringen et al (1998) caution physicians to be aware of the high rates of mortality which follow serious child abuse injuries and to report if there is a

suspicion of abuse or neglect.

It is recommended that physicians be educated to view to the child as their patient, rather than the parents, when abuse is suspected.

Recommendation #4

Although third year medical students at UBC receive training by a child abuse specialist on the duty to report, there does not appear to be a great deal of interagency exposure to CPS by students. Olafson, Corwin, & Summit (1993) recommend that the cyclical nature about society's awareness of child abuse needs to be replaced with an objective comprehension of the problem and what it means. They recommend ongoing scrutiny of physicians' attitudes in order to predict training needs to deal with reasons for non-reporting (cited in Marshall & Locke, 1997).

Reiniger, Robison, & McHugh (1995) promote the concept of teaching not only recognition of abuse, but procedures to follow around its discovery. They found knowledge gaps in the students around how to report and the role of CPS.

Van Haeringen, Dadds, & Armstrong (1998) also recommended that practitioners not only be well-informed about child abuse diagnoses but be comfortable working with CPS social workers.

It is recommended that medical students receive more thorough training in child abuse identification and reporting.

Recommendation #5

Although the Helpline for Children has been in place for over 20 years, there is no provincial "hotline" for professional reporters to consult on cases with CPS. In my research, pediatricians had negative reactions to the time they spent on "hold" waiting to make reports. When CPS staff are in short supply, there is a backlog which is time-consuming for physicians who have little time to spare. Zellman and Antler (1990) state: "it seems likely that mandated reporters may be more reluctant to pursue marginal reports as reporting becomes more difficult" (p. 32). They cite the example of someone needing to report abuse finding long delays waiting for a worker to take the call. In my survey, 44% of respondents felt less than positive about being put on hold too long. The same number said they felt negatively about the length of time it took to make the report.

Research shows that child physical abuse reports made by professionals are 23% more likely to be substantiated than those made by other types of reporters (Kalichman, 1993, p. 138). Lisa Martz (1995), while researching non-reporting by professionals for the Gove Inquiry (1995), heard recommendations from Beck and Ogloff (1995) that a professional phone line be used "to assist mandated reporters in their decision-making processes, to help minimize feelings of frustration, or that an ombudsperson be available to assist reporters who are dissatisfied with the response of Ministry field staff" (cited in Martz, 1995).

It is recommended that physicians and other professionals develop a 24-hour child abuse reporting phone line specifically for use by professional reporters.

Recommendation #6

Mutual stereotypes of social workers and physicians are enhanced by the lack of interdisciplinary communication and training between the professions. The barriers to communication could be diminished by a mutual understanding of roles and a common goal.

It is recommended that joint training take place in universities, colleges and organizations around the mutual interests of child protection.

Recommendation #7

Child protection legislation does not deal adequately with the trauma of children who witness violence against their mothers. Physicians may not be aware that children who witness violence are being abused. Their patient at the time is likely the mother so they may not ask about the children witnessing. The CFCSA is virtually silent in relation to the ability to act upon this type of emotional abuse although it does define it as abuse. CPS needs to work collaboratively with hospitals and women's groups to establish a safety threshold for children who witness abuse. Support services are provided to some children but these are inadequate and inconvenient.

The relevance to my research is that when a battered woman is brought to hospital and her children are with her or in the home, physicians need to call CPS. Careful collaboration of many agencies is needed to provide support and possibly protection to the child and the mother if she chooses.

It is recommended that physicians and CPS social workers be trained adequately on the risk factors involved when children witness violence against their mothers, and that physicians be aware that children witnessing these assaults is child abuse.

Recommendation #8

As stated in Chapter 1, Sections 65 and 96 of the CFCSA (1996) differ in their requirement to share information with CPS. Public bodies (hospitals) have a different necessity to report than private physicians' offices. Public bodies must share information with CPS but private organizations have the ability to manipulate this, sometimes requiring the CPS worker to apply to court (using Section 65 of the CFCSA) to obtain information about a child.

It is recommended that private physicians be legislated to share information with CPS in the same way as hospital physicians.

Recommendation #9

My research showed that physicians were frustrated with the inability to contact CPS in a timely manner, the length of time it took to make a report,

and the lack of feedback about cases they had reported. CPS social workers have complained for many years that their caseloads do not permit them to adequately protect children in a timely manner.

It is recommended that more CPS social workers be hired to provide child protective services to children.

Recommendation #10

In the Gove Report (1995), statistics for 1994 showed that of all provincial CPS social workers, only 36% had BSW's and 6% had MSW's. Within the province, their immediate supervisors held only two BSW's and one MSW. Gove's recommendation that CPS employ only those social workers with a minimum of a BSW was strictly adhered to until July, 1998. In order to attain respect within the professional community, social workers need to be perceived as a distinct professional body with expertise to share across organizational boundaries with other professionals.

It is recommended that all CPS social workers and immediate supervisors have at least a Bachelor of Social Work degree and ongoing training in their field. Those without BSW's should be upgraded in order to attain professional social work credentials.

Recommendation #11

Professional bodies, CPS, government, and unions have not

traditionally managed the public's perceptions of child protection social workers. Government trouble-shooters have not been skillful in changing the public's perception of the negativity of the work CPS does and need to take some responsibility in this venture. Because of this, the public's awareness of child abuse is impeded; media does not give adequate coverage to child abuse information. Additionally, as my research has shown, reports are not likely to be made to an organization which is negatively perceived. Government is in the process of developing positive collaborative relationships with responsible corporate partners (such as the Canadian Broadcasting Corporation, British Columbia Telephone, and the Red Cross) to provide education and awareness about child abuse to the public.

It is recommended that the media be encouraged by government, unions associated with CPS, and relevant professional associations, possibly by cost-sharing public service spots, to provide more public awareness about child abuse and how to report, rather than promoting negative stereotyping of child protection workers.

Recommendation #12

Hospitals and medical clinics do not have systems in place to alert them to high risk child abuse cases, or those which are being monitored by CPS where information needs to be shared across organizational structures. Difficulties implementing such a system would likely be the reluctance of

hospitals to give up their patient information, which they see as their domain. Confidentiality will certainly be a hindrance to this recommendation, likely from both sides.

It is recommended that hospitals and clinics not only have a system to alert them to specific high risk cases, but that they develop a comprehensive computer system which can interface with the CPS computer system on a level where all systems are alerted to serious cases and crucial information can be shared, while maintaining client confidentiality.

Recommendation #13

Although legislation has introduced fines of up to $10,000 and/or six months in jail for failing to report, there have been no cases in this province where physicians failing to report have been brought before the courts or any professional body for discipline (Matheson, W., June 10, 1998, personal communication). In some instances, physicians may not report for what they feel are very good reasons, but if a failure to report is, as one of my survey respondents wrote "too much hassle", the sanctions of their professional body and the publicity of a prosecution may increase the likelihood of reporting by others.

It is recommended that physicians who deliberately fail to report serious cases be disciplined by their professional associations and prosecuted by the courts.

Recommendation #14

The urgency to report may be diminished by the ambiguous wording of the CFCSA, Section 14, which states that a child abuse report must be made "promptly". Given that there is a 24-hour emergency Helpline which can take reports immediately, the wording should be altered to reflect other provincial legislation, specifically New Brunswick's "without delay", or to use the simple and more obvious term "immediately" to convey its interpretation.

It is recommended that the wording of the CFCSA legislation be changed to reflect the urgency of reporting and that "promptly" be changed to "immediately" or "without delay".

Future Research

This research looked only at BCCH pediatricians, therefore its scope was limited by its sample size. A larger proposal could look at reporting behaviours of all 4,000 physicians in British Columbia, and eventually of all physicians in Canada. I would recommend the brevity of the questionnaire developed for this research be adapted for the larger research since it elicited a large proportion of responses and because an expansion of this data set might be useful in terms of theory and practice.

Information about physicians' actual reporting behaviours is lacking. Future research should include the examination of medical records, including data on child deaths, to find physicians' thresholds of reporting.

More research needs to be done in Canada since, among other reasons, Canadian laws are different around the areas of mandatory reporters. In some other areas, particularly in the United States, only professionals are mandated to report. Research also needs to look at training programs for physicians and social workers to improve working relationships and information-sharing. Protocols have been drawn up by CPS and the College of Physicians and Surgeons but physicians are still hesitant to report all cases of suspected child abuse to CPS. More work needs to be done to explore physicians' and patients' feelings when founded or unfounded reports are

made.

Although B.C. has no registry of abused or neglected children, it would be valuable to research the types and numbers of victims of abuse throughout Canada. The statistical base is mainly American since they have the national Child Abuse and Neglect Data System (NCANDS) which is sponsored by the National Center on Child Abuse and Neglect (NCCAN).

Conclusion

In spite of the criticism of CPS in the questionnaire, it was evident that almost all of the respondents had reported at some time in their careers, and most would feel comfortable reporting again. The respondents provided valuable feedback about both organizations by commenting on their frustrations attempting to interface between systems to protect children.

Organizational, systems, and exchange theories tell us that joint training and informal contacts make it more likely that collaboration will take place. Research literature has shown that professionals who have many common experiences, work on tasks together, and understand one another's roles will be more likely to have an easier time collaborating. It appears that many of the pediatricians at BCCH have had positive experiences reporting and will continue to report. CPS's future task is to attempt to make it easier to receive reports and diminish the frustration of reporters. Changes

need to be made within the CPS system to improve incumbrances such as inadequate staffing levels, lack of public education about child abuse, lack of awareness of social work roles, inconsistency of social work response, and lack of feedback. Changes within the medical profession would include more training for medical students on all aspects of child abuse, and continuing education in this area for all physicians.

More professional education for social workers could create a more even playing field so that hierarchies would be diminished between the two professional groups. Exchange of information would be seen as more equitable if CPS social workers could be perceived as experts in their field. CPS social workers could be sought out by physicians for consultation on difficult child abuse cases, and mutual, reciprocal education might ensue with benefits for all, most notably the children.

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APPENDIX A

Questionnaire

5. Regardless of laws and protocol, to whom do you think child abuse <u>should</u> be reported? (Choose as many as you want):

...a child protection social worker (Ministry for Children and Families) Yes ☐ No ☐
...a medical colleague Yes ☐ No ☐
...a hospital social worker Yes ☐ No ☐
...police Yes ☐ No ☐
...no one Yes ☐ No ☐
Other (please specify) _____ Yes ☐ No ☐

Please answer the following question:

6. What, in your opinion, are the main reasons physicians may be reluctant to report?

_____

_____

_____

B. <u>Demographic information:</u>

1. How many years have you been practising medicine? _____

2. Do you have a specialty? Yes ☐ No ☐

If so, what is it? _____

3. Male ☐ **Female** ☐

4. Age: Under 30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ Other ☐

Thank you for taking the time to complete this questionnaire.

A. The following questions explore the process of reporting by physicians to child protection social workers (from the Ministry for Children and Families) and may be useful in helping to determine some of the barriers to reporting.

1. Have you ever reported suspected child abuse to a child protection social worker?

YES ☐ NO ☐ (If NO, then omit questions 2, 3, and 4)

2. If so, approximately how often?

Once ☐ 2 - 5 times ☐ 6 - 10 times ☐ more than 10 times ☐
Other [please specify] _____ .

3. The following statements describe some professionals' reactions to reporting suspected child abuse. Please rate them in terms of your own experiences on the scales provided (strongly agree, agree, undecided, disagree, or strongly disagree).

	sa	a	u	d	sd
The report was taken without any problems.	☐	☐	☐	☐	☐
The social worker acted professionally.	☐	☐	☐	☐	☐
The social worker seemed annoyed to get the report.	☐	☐	☐	☐	☐
I was left on "hold" for a long time by reception.	☐	☐	☐	☐	☐
I was treated in a professional way.	☐	☐	☐	☐	☐
I was left feeling not much would be done.	☐	☐	☐	☐	☐
I was given feedback on the case afterwards.	☐	☐	☐	☐	☐
The outcome of my report was satisfactory.	☐	☐	☐	☐	☐
I felt the child was safer because I had reported.	☐	☐	☐	☐	☐
The social worker asked too many questions.	☐	☐	☐	☐	☐
It took too long to make the report.	☐	☐	☐	☐	☐
There wasn't much followup done.	☐	☐	☐	☐	☐

Any other reactions: _____

4. Given your experiences reporting, would you be comfortable reporting again?

Yes ☐ No ☐
Please comment if you wish: _____
_____
_____

APPENDIX B

Questionnaire: Cover Letter

APPENDIX C

BCCH In-Hospital Research Review Committee Application for Research Approval

IN-HOSPITAL RESEARCH REVIEW COMMITTEE
APPLICATION (Continued) - Page 2 of 5

EXPECTED STARTING DATE: 97/12/12	EXPECTED COMPLETION DATE: 97/06/30

2. Please state the Purpose of Study: partial completion of Masters degree in Social Work

(a) Publication in a Journal _____	(b) Own study purposes _____
(c) Presentation at a Meeting _____	(d) Other (Please specify): ✓

3. Are the parents of the children you propose to study likely to be approached for participation in another study?

n/a

4. How will you inform the admitting/attending physician of the patient's enrollment in the study?

n/a

5. Outline recruitment and consent procedures to be used in this project.

Anonymous two-page questionnaire to be placed in pediatricians' mailboxes at RCCH. Participation is voluntary.

6. Certificate of ethical review from Clinical or Behaviourial Sciences Screening Committee of UBC submitted with this application:

Yes _____

Pending ✓ submitted to UBC.

No _____

IN-HOSPITAL RESEARCH REVIEW COMMITTEE
APPLICATION (Continued) - Page 3 of 5

7. Are you applying for funding for this project? Name of Sponsor:

YES _____ NO ✓ _____

8. Does this project use Children's Hospital facilities?

YES _____ NO _____

9. Will the project generate costs for Children's Hospital?

YES _____ NO ✓

If so, will there be funding to cover these costs?

YES _____ n/a. NO _____

10. If there is funding, who will administer the funds? n/a.

UBC _____ BCCH _____

☞ If BCCH administers the funds, provide signature of appropriate Vice-President.

VICE-PRESIDENT NAME:

TITLE:

SIGNATURE:

11. If this project is an industry sponsored study, attach copy of the Agreement which must include the following signatures.

- Principal Investigator
- Dr. A.J. Tingle (on behalf of C&W and BC Research Institute for Children's & Women's Health)
- Representative from the drug company
- UBC Institutional Head (Dr. R. Spratley, Director of Research Services, UBC or Mr. W. Palm, Director, UBC Industry Liaison)

12. If hospital staff have significant involvement in the project, the appropriate hospital Department Heads' or PBCU Directors' signature must be obtained (see next page):

IN-HOSPITAL RESEARCH REVIEW COMMITTEE
APPLICATION (Continued) - Page 4 of 5

Laboratory NAME (Please print):	**Radiology** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Pharmacy NAME (Please print):	**Health Records** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Nursing NAME (Please print):	**Neurosciences** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Cardiac Sciences NAME (Please print):	**The Children's Centre at Mount St. Joseph** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Critical Care NAME (Please print):	**Medical Genetics** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Mental Health NAME (Please print):	**Newborn Care** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Oncology/BMT NAME (Please print):	**Paediatrics** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:
Surgery NAME (Please print):	**Surgical Suite** NAME (Please print):
TITLE:	TITLE:
SIGNATURE:	SIGNATURE:

APPENDIX D

University of British Columbia
Behavioural Research Ethics Board
Certificate of Approval

APPENDIX E

B. C. Children's Hospital
In-Hospital Research Review Committee
Letter of Approval

APPENDIX F

Follow-up Letter to Questionnaire