What Is the System of Care for Abused and Neglected Children in Children's Institutions?

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ABSTRACT. *Objectives.* **The objectives of this study were to describe the number of children with suspected abuse or neglect (CAN) cared for in selected children's hospitals, to determine how they are tracked and followed, and to better describe the composition, function, and financial support of child protection teams (CPTs).**

Methods. **A self-administered survey was mailed to child abuse contact leaders at institutions that were members of the National Association of Children's Hospitals and Related Institutions in 2001. Responses from rehabilitation hospitals and those that did not indicate whether a CPT was present were excluded.**

Results. **One hundred thirty-four of 157 leaders responded. One hundred twenty-two (91%) met study criteria. Eighty-eight hospitals (72%) had a CPT—54% were pediatric facilities, 59% had >100 beds, and 89% had a pediatric residency. Compared with institutions without a CPT, institutions with a CPT were less likely to be located in the South (28% vs 70%) and more likely to have >200 beds (26% vs 1%), a medical school affiliation (92% vs 74%), and a pediatric residency (98% vs 68%).**

Sixty-one percent of institutions cared for <300 suspected CAN cases, and 66% had 5 or fewer CAN-associated deaths the previous year. Institutions with a CPT used more comprehensive documentation for CAN, including special CAN forms (55% vs 21%) and photographs (77% vs 53%). They also more commonly referred CAN cases to law enforcement (58% vs 35%) or a CAN clinic for follow-up (52% vs 26%).

Fifty-two percent of CPTs had an annual budget of $500 000 or less. The most common primary source of financial support for CPTs was the hospital (51%), although funding was usually composed of a combination of funds from the hospital, patient fees, and state government.

Functions performed by CPTs included consulting on cases of CAN (89%), functioning as a liaison with child protective services (85%), tracking cases of abuse or neglect (70%), providing quality assurance on CAN cases (63%), and filing reports with child protective services (61%). Twenty-four hour consultative coverage was provided by most CPTs (79%), for which 94% provided phone consultation and 81% provided in-person consultation when necessary.

Conclusions. **The institutions surveyed cared for many children suspected of abuse and neglect. Thirty-eight percent did >300 evaluations per year. In general, institutions with CPTs provided more comprehensive documentation and follow-up of children suspected of having been abused or neglected than institutions without CPTs. Whether this is associated with better outcomes for children suspected of abuse or neglect is unknown.** ***Pediatrics*** **2002;110:1226–1231;** ***child abuse and neglect, child protection teams.***

ABBREVIATIONS. CPT, child protection team; CPS, child protective services; CAN, children with suspected abuse or neglect; NACHRI, National Association of Children's Hospitals and Related Institutions.

Nearly 3 million reports of possible child abuse or neglect were made to authorities across the United States in 1994.[1] Just over 1 million children were found to be victims of maltreatment and an estimated 570 000 were seriously injured. Without a confession of abuse, the diagnosis is difficult to establish, because there are no diagnostic tests that can definitely identify abused children. Children who have injuries from abuse present with a myriad of different complaints and diagnoses.[2] Physically abused children not only have poorer outcomes compared with unintentionally injured children, but they are also likely to be reinjured or killed if allowed to remain in the environment of abuse.[3–6] Moreover, the misdiagnosis of abuse subjects families to enormous distress, sometimes to the point of having children removed from their care.

Hospital-based child protection teams (CPTs) have been organized to assist the clinician in evaluating and managing abused and neglected children. Many of these teams have been formed with only limited institutional fiscal support.[7] A limited number of studies have been published describing how individual CPTs interact with clinicians in their institutions and local child protective services (CPS).[8–17] The goals of this study were to describe the number of children with suspected abuse or neglect (CAN) cared for in selected children's hospitals, to determine how they are tracked and followed, and to better describe the composition, function, and financial support of CPTs.

METHODS

A self-administered survey was mailed to 157 child abuse contact representatives identified by the National Association of Children's Hospitals and Related Institutions (NACHRI). NACHRI is a not-for-profit organization of children's hospitals, large pediatric units of medical centers, and related health systems. Respondents working in rehabilitation hospitals were ex-

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cluded. The survey consisted of 28 questions regarding institutional demographics, institutional experience with and management of CAN, and the presence or absence of a CPT. Information about CPT duration of existence, composition, financial support, and function was also elicited. Before distribution, the survey was piloted using a random sample of 10 child abuse leaders. The study was conducted between June 1, 2001, and August 1, 2001.

Study Outcomes

The study outcomes focused on providing a description of the following: 1) institutional experiences with CAN during the previous year and 2) the status of CPTs in these institutions.

Variables describing each institution's experience with CAN the previous year included the number of cases and related fatalities, parties contacted for CAN evaluation, the CAN tracking system at the institution, composition of CAN data tracked, who performed follow-up, and the presence of a CAN clinic.

If a CPT existed in the institution at the time of survey administration, the respondent was asked questions regarding the number of years the CPT had been in existence, its composition, funding, and function, and whether there was regular participation by CPS (questionnaire available on request).

Proportional comparisons on the outcome variables were made between institutions with and without a CPT using χ^2 and Fisher exact statistics where appropriate. Statistical significance was considered attained at a $P < .05$.

This study was approved by the institutional review board of Boston University School of Medicine.

RESULTS

One hundred thirty-four of 157 institutions provided responses, of which 12 were not eligible for inclusion. Nineteen did not respond, and 4 could not be reached. The response rate was 84% (122/145). Of 122 eligible institutions, 88 (72%) had a CPT.

Institution Demographics

The majority of responding institutions were pediatric hospitals (54%) in a non-Southern state (69%) with >100 beds (59%), a medical school affiliation (87%), a pediatric residency (89%), and no child abuse fellowship (84%; Table 1).

Institutions with CPTs were more likely to be in a non-Southern state (72% vs 30%; $P < .0001$), have >200 inpatient pediatric beds (26% vs 1%; $P = .03$), a medical school affiliation (92% vs 74%; $P = .007$), a pediatric residency (98% vs 68%; $P < .0001$), and a child abuse fellowship (17% vs 3%; $P = .07$). Response rates were similar in each of the 4 regions of the country (Northeast, 89%; Midwest, 81%; West, 92%; and South, 80%).

Institutional CAN Experience

Sixty-one percent of the institutions cared for 300 or less cases of suspected CAN, and 66% had 5 or fewer CAN-related fatalities during the previous year (Table 2). Social workers and child protective services were contacted by a majority of institutions for cases of suspected CAN (85% and 84%, respectively). Thirty-eight percent of the systems used a CPT-based computerized database, 38% used a paper logbook, and 37% used the CPS tracking system to track cases. Fourteen (11%) hospitals, however, stated that they had no CAN tracking system. Data documented on the children included a description of the incident (66%); follow-up care (30%); and medical (40%), legal (20%), and guardianship (31%) outcomes. Routine CAN documentation was most commonly done using the medical record (86%) or photographs (70%). Abused and neglected children were most commonly followed up by CPS (85%). Sixty-five (53%) institutions had a CAN clinic.

TABLE 1. Demographics of Eligible Institutions ($N = 122$)

Variable	CPT Present ($N = 88$)	CPT Absent ($N = 34$)	Total ($N = 122$)
Hospital type			
General	38 (43%)	16 (47%)	54 (44%)
Pediatric	48 (55%)	18 (53%)	66 (54%)
Region*†			
Northeast	21 (24%)	4 (12%)	25 (20.5%)
Midwest	21 (24%)	4 (12%)	25 (20.5%)
West	21 (24%)	2 (6%)	23 (19%)
South	25 (28%)	24 (70%)	49 (40%)
Number of inpatient pediatric beds†			
<50	1 (<1%)	7 (21%)	8 (7%)
50–100	24 (27%)	11 (32%)	35 (29%)
101–200	34 (39%)	12 (35%)	46 (38%)
>200	23 (26%)	3 (1%)	26 (21%)
Medical school affiliation†			
Yes	81 (92%)	25 (74%)	106 (87%)
No	7 (8%)	9 (26%)	16 (13%)
Pediatric residency†			
Yes	86 (98%)	23 (68%)	109 (89%)
No	2 (2%)	11 (32%)	13 (11%)
Child abuse fellowship			
Yes	15 (17%)	1 (3%)	16 (13%)
No	73 (83%)	29 (85%)	102 (84%)

*__Northeast:__ CT, ME, MA, NH, NJ, NY, PA, RI, VT
__Midwest:__ IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI
__South:__ AL, AR, DE, DC, FL, GA, KY, LA, MA, MD, MS, NC, OK, SC, TN, TX, VA, WV
__West:__ AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY.
† $P < .05$.

Compared with institutions without a CPT, those with a CPT were more likely to care for over 300 CAN cases (51% vs 4%; $P < .0001$) and >5 CAN-related fatalities (41% vs 8%; $P = .001$) during the previous year. Institutions with a CPT were also more likely to contact law enforcement for the evaluation of CAN cases (72% vs 47%; $P = .04$). Hospitals without CPTs were more likely to have no formal system of tracking CAN cases (24% vs 7%; $P = .02$). Hospitals with a CPT tracked more complete data surrounding cases, including a description of the incident (82% vs 24%; $P < .0001$); follow-up care (34% vs 18%; $P = .07$); and medical (51% vs 12%; $P < .0001$), legal (26% vs 6%; $P = .01$), and guardianship (41% vs 6%; $P = .0001$) outcomes. Photographs (77% vs 53%; $P = .008$) as well as forms specific for the documentation of CAN (55% vs 21%; $P = .0001$) were more likely to be used in institutions with a CPT. CAN clinics were more likely to exist in hospitals with a CPT (66% vs 21%; $P < .0001$). CAN cases were more likely to be followed up in these clinics (52% vs 26%; $P = .01$) as well as by law enforcement (58% vs 35%; $P = .02$) when they were managed in a hospital with a CPT.

Characteristics and Funding of CPTs

Fifty-six percent of CPTs had been in existence for over 10 years (Table 3). Most commonly, CPTs were composed of a physician (94%), social worker (92%), and registered nurse (73%). The physician was most

TABLE 2. Comparison of Child Abuse Experiences*

	CPT Present ($N = 88$)	CPT Absent ($N = 34$)	Total ($N = 122$)
Number of CAN cases last year†‖			
<100	6 (7%)	16 (59%)	22 (20%)
100–300	34 (42%)	10 (37%)	44 (41%)
301–400	11 (14%)	1 (4%)	12 (10%)
401–500	2 (2%)	0	2 (2%)
>500	28 (35%)	0	28 (26%)
Number of CAN fatalities last year‡‖			
0	2 (2%)	7 (28%)	9 (8%)
1–5	46 (57%)	16 (64%)	62 (58%)
6–10	21 (26%)	2 (8%)	23 (21%)
>10	12 (15%)	0	12 (11%)
Parties contacted for CAN evaluation			
Social work	75 (85%)	29 (85%)	104 (85%)
Child protective services	72 (82%)	31 (91%)	103 (84%)
Child protection team‖	79 (90%)	5 (15%)§	85 (70%)
Law enforcement‖	63 (72%)	16 (47%)	79 (65%)
Other	17 (19%)	10 (29%)	27 (22%)
CAN tracking system			
CPT computerized database‖	46 (52%)	0	46 (38%)
CPS tracking system	6 (7%)	5 (15%)	45 (37%)
CPT paper logbook‖	38 (43%)	1 (3%)§	40 (33%)
Other hospital computerized database	17 (19%)	6 (18%)	23 (19%)
Other hospital paper logbook	15 (17%)	7 (21%)	22 (18%)
No tracking‖	6 (7%)	8 (24%)	14 (11%)
Other	7 (8%)	5 (15%)	12 (10%)
Data tracked			
Description of the incident‖	72 (82%)	8 (24%)	80 (66%)
Follow-up care	30 (34%)	6 (18%)	36 (30%)
Medical outcome‖	45 (51%)	4 (12%)	49 (40%)
Legal outcome‖	23 (26%)	2 (6%)	25 (20%)
Guardianship outcome‖	36 (41%)	2 (6%)	38 (31%)
Documentation of CAN			
Routine medical record	74 (84%)	31 (91%)	105 (86%)
Photos‖	68 (77%)	18 (53%)	86 (70%)
Special CAN forms‖	48 (55%)	7 (21%)	55 (45%)
Other‖	22 (25%)	2 (6%)	24 (20%)
Who follows up CAN cases?			
Child protective services	74 (84%)	30 (88%)	104 (85%)
Routine primary care follow-up	46 (52%)	17 (50%)	65 (53%)
Law enforcement‖	51 (58%)	12 (35%)	63 (52%)
CAN clinic‖	46 (52%)	9 (26%)	55 (45%)
Social work	39 (44%)	15 (44%)	54 (44%)
Child protection team‖	48 (55%)	3 (9%)	51 (42%)
Don't know	8 (9%)	5 (15%)§	13 (11%)
Presence of a CAN clinic‖			
Yes	58 (66%)	7 (21%)	65 (53%)
No	27 (31%)	27 (79%)	54 (44%)

* Some variables may not add up to the total eligible because of incomplete responses.
† Total = 108 because of missing responses.
‡ Total = 106 because of missing responses.
§ These institutions were referring to child protection teams that were not located in their hospital (ie, city or state-based or at a nearby hospital).
‖ $P < .05$.

commonly the chairperson (45%), although this was not uncommonly the position of the social worker (24%) or a shared position with the social worker (18%). Most CPTs had regular meeting participation by CPS (55%).

The majority of CPTs had an annual budget of up to $500 000 (52%). In 51% of cases, the primary funding source was from the hospital but was most commonly supported with a combination of funds from the hospital (75%), patient fees (49%), and state government (40%).

The reported amount of funding and the number of CAN cases the previous year appeared to be related. For example, 62% (23 of 37) of CPTs with $250 000 or less in support were in institutions that cared for <300 CAN cases the same year. However, 73% (11 of 15) of the CPTs with more than $750 000 in funding were in institutions who cared for >400 CAN cases the same year.

CPT Functioning

The function of CPTs was varied but most commonly consisted of consulting on CAN cases (89%), functioning as a liaison with CPS (85%), tracking cases of CAN (70%), providing quality assurance on CAN cases (63%), and filing reports with CPS (61%; Table 4). CPTs were most commonly consulted on unclear cases of CAN (60%) or those requiring mediation between the institution and CPS (41%). The majority of CPTs reported that they were consulted

TABLE 3. Characteristics of CPTs ($N = 88$)*

Number of years in existence	
<2	10 (11%)
2–5	11 (13%)
6–10	13 (15%)
>10	49 (56%)
Members on the team	
Physician	83 (94%)
Social worker	81 (92%)
Registered nurse	64 (73%)
Lawyer	30 (34%)
Law enforcement	20 (23%)
Clergy	14 (16%)
Other (nurse practitioner, psychologist or psychiatrist, child life)	47 (53%)
Chairperson of the team	
Physician	40 (45%)
Social worker	21 (24%)
Registered nurse	1 (1%)
Lawyer	0
Law enforcement	0
Clergy	0
Physician and social worker	16 (18%)
None	4 (5%)
Is there regular participation by child protective services?	
Yes	48 (55%)
No	32 (36%)
Estimated budget last year	
< $250 000	37 (42%)
$250 000–500 000	9 (10%)
$500 001–750 000	5 (6%)
$750 001–1 000 000	7 (8%)
>$1 000 000	5 (6%)
Don't know	19 (22%)
Primary budget source	
Hospital funds	45 (51%)
Patient fees	11 (13%)
State government	9 (10%)
Private donations	4 (5%)
Private foundations	3 (3%)
County government	3 (3%)
Local government	1 (1%)
Federal government	1 (1%)
Other	0
Budget sources	6 (7%)
Hospital funds	66 (75%)
Patient fees	43 (49%)
State government	35 (40%)
Private donations	27 (31%)
Private foundations	28 (32%)
County government	
Federal government	17 (19%)
Local government	11 (13%)
Other	10 (11%)
	11 (13%)

* Some variables may not add up to the total eligible because of incomplete responses or the possibility of multiple responses to some questions.

on over 75% of CAN cases seen in their institutions (51%). On-call consultative coverage was provided by 79% of CPTs 24 hours a day, 7 days a week and was most commonly contacted by pager (91%) or phone (91%). The on-call pager was carried most commonly by a physician (77%) or social worker (67%) from the CPT. Ninety-four percent provided on-call phone consultation and 81% in-person consultation when necessary. Forty-three percent of CPTs used nonlocal consultant services for CAN cases.

TABLE 4. CPT Functioning ($N = 88$)*

Role of the CPT	
Consult on CAN cases	78 (89%)
Liaison with child protective services	75 (85%)
Track cases of CAN	62 (70%)
Quality assurance on CAN cases	55 (63%)
File report with child protective services	54 (61%)
Other	21 (24%)
Types of cases the CPT was consulted on	
Unclear cases of CAN	53 (60%)
Those requiring mediation between the hospital and child protective services	36 (41%)
Cases presenting during business hours	15 (17%)
Other	32 (36%)
Proportion of hospital-based CAN cases in which CPT was consulted	
100%	22 (25%)
7%–99%	23 (26%)
25%–74%	17 (19%)
<25%	11 (13%)
Don't know	25 (28%)
24/7 coverage provided by the CPT	
Yes	70 (79%)
No	12 (14%)
CPT members who carry the on-call pager	
Physician	54 (77%)
Social worker	47 (67%)
Registered nurse	11 (16%)
Lawyer	2 (3%)
Clergy	2 (3%)
Other	9 (13%)
Services provided by the CPT when on call	
Phone consultation	66 (94%)
Provides immediate consultation	57 (81%)
Files child protective services report	39 (56%)
Other	11 (16%)
Use of nonlocal consultants	
Yes	38 (43%)
No	42 (48%)
How often CPTs meet	
Weekly	31 (35%)
Biweekly	8 (9%)
Monthly	15 (17%)
As needed	15 (17%)
Other	14 (16%)

* Some variables may not add up to the total eligible because of incomplete responses or the possibility of multiple responses to some questions.

DISCUSSION

The institutions in this study cared for many children suspected of abuse and neglect. Thirty-nine percent did >300 evaluations a year. CPTs were most commonly composed of physicians, nurses, and social workers. They also received the majority of their financial support from their institutions. The services provided by the CPTs were similar across institutions and included reporting to CPS, tracking cases of CAN, providing consultative and quality assurance services on cases of suspected CAN, and acting as a liaison with CPS. Most respondents reported that their CPTs were consulted on at least 75% of the cases of suspected CAN. The majority of CPTs also provided on-call coverage 24 hours a day, 7 days a week, for consultation either by phone or in person. In general, CPTs provided more complete tracking, documentation, and follow-up of children suspected of having been abused or neglected. Whether this translates into better outcomes for these children is uncertain.

There have been a limited number of published

studies describing individual CPTs.[8–15] These reports describe significant variation in the form and function of their CPTs, which is similar to our results. However, they only detailed their own experiences in the context of providing a model for other institutions to emulate. We are aware of 2 studies that have described a sample of child protection teams.[16,17] Dubowitz[16] surveyed pediatric residency directors in 1985 and asked questions regarding team composition and sources of funding. Many of the findings reported were similar to our results. First, he noted that a majority of the 167 hospitals affiliated with the pediatric residencies that he surveyed had a CPT (81%). In addition, the vast majority of teams included a social worker (99%), pediatrician (98%), and nurse (90%). With regard to budget, the majority of teams studied reported either no budget or an annual budget of less than $100 000. The size of the budget also correlated significantly with the number of pediatric beds and number of case reports for child maltreatment handled at the hospital each year. Dubowitz's results did differ from ours with respect to the types of hospitals and regions of the country more likely to have CPTs. He reported that university-affiliation and region of the country were not significantly associated with the presence of a CPT. Our study, however, noted that CPTs were more likely to exist in university-affiliated hospitals and in a non-Southern region. It is possible that the increased proportion of CPTs being present in a university versus nonuniversity-affiliated hospital may be attributable to an increased number of abused and neglected children cared for in university-affiliated hospitals, which tend to be larger. Why institutions in Southern states are less likely to have CPTs is difficult to determine. The rates of response, proportion of children's hospitals, number of pediatric beds, and number of cases of CAN were very similar between the different regions. However, the South had the smallest proportion of pediatric residency-affiliated hospitals (78%) compared with the Northeast (92%), Midwest (92%), or West (95%). Perhaps residency-affiliated hospitals are more likely to attract physician-experts in the field of child abuse and neglect or there is an increased need for CAN resources for physicians-in-training.

Giardino et al[17] described similar CPT compositions to our study. One hundred percent of their sample of 72 teams had physicians on them, 90% had social workers, and 49% had nurses. They also reported similar sources of funding including patient fees, state government funding, and hospital support. We have tried to provide a larger snapshot of how institutions care for children suspected of abuse and neglect by including not only the composition and characteristics of funding for CPTs, but also how children's institutions care for abused and neglected children and how CPTs fit into their care where they exist.

The field of health services research systematically studies the quality of health care delivery. Quality of patient care is defined by the Institute of Medicine as the degree to which health services for individuals and populations increase the likelihood for desired health outcomes and are consistent with current professional knowledge.[18] Part of health services research is to define the quality of care by accurately assessing the 3 constituents of quality surrounding a health problem or patient group of interest: structure, process, and outcome.[19] With regard to child abuse and neglect, improvements in the quality of care have been difficult to address partly because of a lack of systematically gathered information regarding these 3 components. Basic components of the structure of CAN care include facilities, equipment, financial support, number and types of personnel, as well as the organizational structure including medical staff organization, methods of peer review, and methods of reimbursement. The most important assessment is the impact of these services on health outcomes.[20] This is the most comprehensive study to date to address some of the descriptive issues regarding the structure of child protection teams and their relation to the hospital's CAN experience.

One limitation of this study relates to its generalizability. The experience of the facilities surveyed may not be the same for institutions that are not members of NACHRI. This sample is not nationally representative because a majority of respondents were from children's hospitals. A second limitation relates to the reliability of the responses to the survey. Surveys are always limited by the knowledge and honesty of the respondents. However, we have no reason to believe that the responses don't reflect each institution's experience. The response rate of 84% was very good, suggesting that this survey is representative of NACHRI-associated institutions.

This study is a first step in providing information on the CAN experience of a broad number of children's institutions and their associated CPTs. Future studies should describe what characteristics allow for CPT systems to perform more effectively in the identification and management of CAN cases and what services are associated with improved outcomes for these children.

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BUSINESS AND ETHICISTS

"More than 80% of major corporations have ethics codes. Where there are ethics codes there are business ethicists. But where are these business ethicists when you need them?. . . Around 30 years ago, a new breed of expert loomed up. After a whistle-blowing article was published in the *New England Journal of Medicine*, the medical establishment decided to invite philosophers and theologians to the bedside to monitor the moral practices of physicians and medical researchers. . . the growing fantasy that ethics is just another area of expertise, and that we can subcontract the work of moral reflection, is a parlous one. First, there are simply no grounds for believing that a person can become an authority on matters moral in the same way that he might on market strategies; that is, by mastering the appropriate information and literature."

Marino G. *Wall Street Journal.* July 29, 2002

Note: Mr. Marino is a professor of philosophy at St. Olaf College in Northfield, Minnesota.

Noted by JFL, MD