Studying child abuse and neglect in Canada: We are just at the beginning

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The study of child maltreatment is in its infancy in Canada. Basic questions about maltreatment are just beginning to be answered: How many children in Canada suffer abuse or neglect? What kind of maltreatment do they suffer? To what extent are they harmed? As physicians, how do we identify and protect children at risk?

The Canadian Incidence Study of Reported Child Abuse and Neglect, the first national incidence study of child maltreatment,[1] found that 2.1% of children were the subjects of child welfare investigations in 1998. Maltreatment was substantiated in 45% of these cases. This is likely an underestimate of the true incidence of child maltreatment because it represents only the cases that were reported to and investigated by child welfare authorities.

Trocmé and colleagues[2] now report the results for physical harm associated with these substantiated cases of child maltreatment. In their study, the cases of maltreatment were considered under 4 categories: physical abuse, sexual abuse, neglect and emotional maltreatment. Cases of physical harm were defined by the investigating child welfare worker's judgement of the presence of an injury or health condition (visible for a minimum of 48 hours) because of maltreatment. The severity of harm was based on the investigating worker's judgement about whether medical treatment was necessary: moderate harm was observable but not thought to require medical care, whereas severe harm was defined as requiring medical treatment.

The authors found that some type of physical harm was documented in 18% of cases; medical attention was assessed as being required in 4% of cases; head injuries or bone fractures were the reason for seeking medical attention for less than 2%. Physical harm was more common in cases of physical abuse (43%) than in those of other forms of maltreatment, but neglect resulted in more cases of severe physical harm (47%) than any other form of maltreatment. They noted that severe physical harm was also proportionally more common in cases of shaken baby syndrome (45%) (see Table 2 on page 913). Children under the age of 1 year had the highest rate of severe harm by age category (15%) (see Table 3 on page 914).

The authors concluded that the rate of severe physical harm in reported and substantiated child maltreatment cases (4%) was consistent with that of other studies and that the rates of moderate harm were lower than previously reported. Interpreting this rate of severe physical harm as low, the authors suggested that strict child welfare investigative procedures may need revision and more emphasis may need to be placed on the assessment of longer-term service needs.

At first glance, the relatively low levels of physical harm in substantiated cases of child maltreatment seem reassuring. However, a number of issues arise from these results. The determination of physical harm in this study was made by child welfare workers rather than by health care workers. Even for physicians, physical injury from abuse can be difficult to recognize. In a retrospective study of abusive head trauma in children less than 3 years of age,[3] the diagnosis was missed by physicians in 31% of patients at the time of initial presentation. In a study[4] of a group of asymptomatic but high-risk children less than 2 years of age who were admitted to hospital for investigation of physical abuse, results of imaging studies revealed that 37% had head injuries, despite normal results of neurological examinations. In a recent 10-year chart review of 364 cases of shaken baby syndrome in 11 Canadian centres,[5] 40% had no sign of external injury. In that study, 19% of the children died and 78% of the survivors had health or developmental impairment at the time of their discharge from hospital. In the study of Trocmé and colleagues,[2] only 45% of cases investigated for shaken baby syndrome were thought to require medical attention.

They also found that the rate of severe physical harm to children exposed to domestic violence was low (< 1%). Exposure to domestic violence, however, is not a cause for mandatory reporting to child welfare authorities in all jurisdictions in Canada; this study evaluated only those cases that were investigated by child welfare authorities. Previous reviews have concluded that between 45% and 70% of children exposed to domestic violence are also victims of physical abuse.[6] In addition, there are concerns that these children may suffer adverse effects on their behavioural, cognitive and emotional functioning, even in the absence of physical harm.[6–9]

The study of Trocmé and colleagues[2] therefore reminds us that the physical signs of child maltreatment may be difficult to recognize and should not be our sole indicators for suspected maltreatment. Further, while physical signs can serve as indicators, they are often the most easily remedied

problem associated with the maltreatment. Bruises heal more quickly than the scars from emotional trauma.

We must also recognize that this is the first study to examine the rates of child maltreatment and harm on a national level and that no comparable medical data currently exist. These results should not reassure us; they should draw our attention to the need for further research in this area and for better recognition amongst health care and child welfare workers of the different forms of child maltreatment.

Physicians are sometimes the first to recognize child maltreatment, and they are frequently involved when child maltreatment is suspected by another party. While pediatricians are most commonly involved in such cases, all physicians are required to report to authorities any suspicion that a child has suffered or is at risk of suffering maltreatment. Yet several studies[10–14] have shown that physicians believe they are unprepared and have inadequate knowledge to deal with cases of abuse and neglect. Only 3 of the 16 Canadian pediatric academic centres reported mandatory clinical training in child protection for pediatric residents.[15] The Royal College of Physicians and Surgeons of Canada does not currently recognize child abuse and neglect as a distinct topic for specialty training in pediatrics.

We agree with Trocmé and colleagues[2] that more emphasis needs to be placed on the assessment of the longer-term service needs of these children and families. We must work towards a system that promotes the healthy development of children, youth and families in a biopsychosocial model. We would advocate for the availability of a broader range of supports and interventions after the initial risk assessment. However, the current evidence does not reassure us about the risk of physical harm, particularly for infants. Therefore, we cannot agree with the interpretation of Trocmé and colleagues that "mandatory reporting, abuse investigations and risk assessment may need to be tempered for cases in which physical harm is not the central concern."[2]

It is time to determine the facts about child maltreatment in Canada with further studies, to educate the professionals involved in the care of maltreated children, youth and their families, and to re-evaluate the interventions of the child welfare system. We should establish a national medical database of cases of child maltreatment to complement the child welfare data. We should also develop a national curriculum for physician training in child protection. It is time to guide the field of child and youth maltreatment past its infancy.

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References

1. Trocmé N, Maclaurin B, Fallon B, Daciuk J, Billingsley D, Tourigny M, et al. *Canadian incidence study of reported child abuse and neglect: final report*. Ottawa: Minister of Public Works and Government Services Canada, 2001.
2. Trocmé N, MacMillan H, Fallon B, De Marco R. Nature and severity of physical harm caused by child abuse and neglect: results from the Canadian Incidence Study *CMAJ* 2003;169(9):911-5.
3. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. *JAMA* 1999;281(7):621-2.
4. Rubin DM, Christian CW, Bilaniuk LT, Zazyczny KA, Durbin DR. Occult head injury in high-risk abused children. *Pediatrics* 2003;111(6):1382-6.
5. King WJ, MacKay M, Sirnick A, with the Canadian Shaken Baby Study Group. Shaken baby syndrome in Canada: clinical characteristics and outcomes of hospital cases. *CMAJ* 2003;168(2):155-9.
6. Fantuzzo JW, Mohr WK. Prevalence and effects of child exposure to domestic violence. *Future Child* 1999;9(3):21-32.
7. Knapp JF. The impact of children witnessing violence. *Pediatr Clin North Am* 1998;45(2):355-64.
8. Wolfe DA, Korsch B. Witnessing domestic violence during childhood and adolescence: implications for pediatric practice. *Pediatrics* 1994;94(4):594-9.
9. Johnson RM, Kotch JB, Catellier DJ, Winsor JR, Dufort V, Hunter W, et al. Adverse behavioral and emotional outcomes from child abuse and witnessed violence. *Child Maltreat* 2002;7(3):179-86.
10. Bernard-Thompson K, Leichner P. Psychiatric residents' views on their training and experience regarding issues related to child abuse. *Can J Psychiatry* 1999;44(8):769-74.
11. Biehler JL, Apolo J, Burton L. Views of pediatric emergency fellows and fellowship directors concerning training experiences in child abuse and neglect. *Pediatr Emerg Care* 1996;12(5):365-9.
12. Wright RJ, Wright RO, Farnan L, Isaac NE. Response to child abuse in the pediatric emergency department: need for continued education. *Pediatr Emerg Care* 1999;15(6):376-82.
13. Socolar RRS. Physician knowledge of child sexual abuse. *Child Abuse Negl* 1996;20(8):783-90.
14. Woolf A, Taylor L, Melnicoe L, Andolsek K, Dubowitz H, De Vos E, et al. What residents know about child abuse: implications of a survey of knowledge and attitudes. *Am J Dis Child* 1988;142:668-72.
15. Ward MGK, Bennett S, Plint AC, Jabbour M, King WJ. Are we training Canadian pediatric residents in child protection issues? *Paediatr Child Health* 2002;7(Suppl A):21A-22A.

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