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Research article

National survey of hospital child protection teams in Japan

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ABSTRACT

This study aimed to investigate the penetration rate of child protection teams (CPTs) in medical institutions and associations between CPT functions and hospital services. We collected data in October of 2015 from 377 hospitals in Japan offering pediatric organ transplantation. The questionnaire included questions regarding the existence of a CPT, the number of child maltreatment cases discussed and reported per year, CPT functions including 21 items about staffing, manuals, meeting, prevention, education, and collaboration, and the services provided by the hospital. Of the 377 institutions, 122 (32.4%) answered the survey. There were significant associations between CPT functions and the number of pediatric beds ($r = .27$), number of pediatricians ($r = .27$), number of outpatients ($r = .39$), number of emergency outpatients ($r = .28$), and emergency medical care ($p = .009$). In a multiple regression analysis, CPT functions were significantly associated with the number of CPT members, pediatric outpatient numbers, and pediatric emergency outpatient numbers. Japan has no CPT guidelines that outline what CPTs should offer in terms of structure, staffing, functions, and systems. Hospitals with many pediatric and emergency outpatients are expected to play major roles in providing services such as specialty care, intensive care, and education. They are also expected to play a role in detecting and managing child maltreatment, and have, by their own initiative, improved their capacities to achieve these goals.

1. Introduction

Child abuse and neglect cases are increasing every year in Japan; 88,931 were reported in 2014 (Ministry of Health, 2017). Medical institutions have important roles to play in assessing and addressing child maltreatment. Personnel at medical institutions

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encounter many children receiving medical examinations, routine health check-ups, vaccinations, and so on, and this raises possibilities for applying medical knowledge to assess the health and well-being of children. The roles of these medical institutions include the recognition of maltreatment, healing of physical and emotional injuries, fulfilling of mandated reporting procedures, and comprehensive treatment (Joyner, 1973). In 2000, it became a legal requirement for professionals to report suspected child maltreatment. However, it can be challenging for those working in medical institutions to report child maltreatment. There were 2043 reports of child maltreatment in medical institutions, accounting for 2.3% of all child maltreatment reports, which is very low (Ministry of Health, 2017).

Deciding whether or not a child has been maltreated is difficult, especially if training is lacking on how to report such suspicions. Medical personnel might worry that reporting suspected abuse or neglect would be wrongfully damaging to the parents or caregivers. Coordination with Child Guidance Centers (CGCs) corresponding to Child Protective Services in the United States or the police is often inadequate (Jenny, Hymel, Ritzen, Reinert, & Hay, 1999; Lynne, Gifford, Evans, & Rosch, 2015; Markenson et al., 2007).

The child protection team (CPT) shares a common goal of improving the coordination and quality of care provided to children who are suspected victims of maltreatment (Rowe, Leonard, Seashore, Lewiston, & Anderson, 1970; Schmitt, 1978).

As child abuse cases are increasing and professionals are required to report suspected cases of child maltreatment and neglect, some medical institutions have had to expand their child protection work and expertise. Consequently, some have set up CPTs, which have the goal of improving the coordination and quality of care provided to children who are suspected victims of maltreatment and abuse. The organ transplantation law was revised in 2010 and promoted establishing hospital-based CPTs in institutions offering organ transplantation. If a person's intention to donate their organs for transplantation is unknown, family may grant consent. Organ donations from children under the age of 15 are allowed in this way. However, if the child was maltreated or suspected to have been maltreated, the legal judgment of brain death is not possible. Thus, it was mandated that hospital-based CPTs be set up at institutions offering organ transplantation because they had to decide whether or not a child had been maltreated prior to death.

The aims of this study were to investigate the penetration rate of hospital-based CPTs in medical institutions as well as to ascertain the structure and functions of hospital-based CPTs in medical institutions associated with organ transplantation in Japan and to investigate the association between CPT function and hospital services.

2. Methods

This was a cross-sectional study undertaken employing a survey. On October 1, 2015, we mailed questionnaires focusing on CPT to 377 Japanese hospitals offering transplantation to pediatric patients. The data were collected in November 2015. We also collected data on hospital services from the hospitals that responded to the questionnaire.

2.1. Questionnaire

Questionnaire items included the existence of a CPT at the hospital, the number of cases discussed and reported to CGCs per year over the prior year, CPT functions, and hospital services. Hospital services included the number of CPT members, number of occupational categories in the CPT, number of pediatric beds, number of pediatricians, number of outpatients and emergency outpatients per year, hospital classifications (children's hospitals, university hospitals, and other general hospitals with pediatric patients), and categories of emergency medical care (primary, secondary, and tertiary emergency care hospitals). Children's hospitals are defined as those belonging to the Japanese Association of Children's Hospitals and Related Institutions. A primary hospital is defined as one with primary pediatric care, a secondary hospital as one with inpatient care for children, and a tertiary facility as a hospital with pediatric intensive care or other high-level specialties. To evaluate CPT functions, we developed a CPT evaluation tool. The questionnaire (Table 1) included 21 items pertaining to the functions of CPTs encompassing the following issues.

2.1.1. Coordinator

The coordinator aids in gathering information for the team's diagnosis and evaluation process, provides consultation and support to others in the community, and plans the dispositional conference. The coordinator's role in treatment includes implanting team recommendations for families, assisting direct service providers, providing feedback to the diagnostic and evaluation team, collecting data. In many institutions, the staff member assigned to the coordinator role may be a social worker or case manager. We inquired whether or not the coordinator was a permanent team member. We also inquired whether or not they were available during all regular hours and on-call at night as well as on holidays.

2.1.2. Team leader

It is essential that there is a single person who is ultimately responsible for the administration and coordination of the team. A team leader should have broad administrative, educational, and clinical responsibilities and a correspondingly wide range of skills, knowledge, and experience. Whatever the CPT level, the leader should be experienced and trained in child maltreatment issues and have up-to-date patient care, examination, and diagnostic skills. In addition, the team leader should have management skills, be comfortable in a leadership role and with public appearances, and collaborate well with other members of the CPT, hospital colleagues, and community partners. We inquired as to whether or not a team leader was designated. We asked whether or not the team leader was a permanent member of the CPT. Whether or not a team leader was a regional leader, educator, and/or researcher was also among the questionnaire items. We inquired whether or not this individual collaborated with other institutions in the community and supervised and reviewed cases.

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