Six-year experience of a hospital-based child protection team in Turkey

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The objective of this article was to review the case series' profile followed up by the Gazi University Multidisciplinary Team for Child Protection and to describe the challenges in our child protection system. The cases referred to this team between February 2001 and January 2007 were analyzed. In addition to the clinical management, challenges encountered during follow-up due to gaps in the child protection system were reviewed. A total of 139 patients were referred to the team during the study period. Mean age for physical abuse, sexual abuse, and neglect were 8.9±6.2, 10.8±4.2, and 5.1±5.5 years, respectively. Sexual abuse was significantly less common while neglect was significantly more common in the 0-5 years of age group. In addition to the gaps within each link of the child protection system (medical, legal and social services) in Turkey, interagency collaboration seems to be inadequate. Hospital-based multidisciplinary teams can start such a collaboration.

Key words: child abuse, multidisciplinary team approach, neglect, hospital-based child protection center.

Increasing interest in clinically managing abused children dates back to the 1970's[1,2]. A hospital-based multidisciplinary team (MDT) model to diagnose, evaluate, and develop a therapeutic plan for the victims of child abuse and neglect (CAN) has been utilized in developed countries since the 1980's and its effectiveness has been clearly demonstrated[3-5]. However, since professional awareness of CAN is relatively recent in Turkey, so is the utilization of a multidisciplinary approach to its management. A retrospective adult study from Turkey reported childhood sexual abuse in 2.5%, physical abuse in 8.9%, emotional abuse in 8.9%, and neglect in 33.9% of the surveyed group[6]. In other studies, childhood sexual abuse was reported with prevalences of 13.4% and 28% in two school-based populations[7,8] and physical abuse was reported with 35% prevalence in a population study[9]. Despite this recognition in the Turkish scientific literature, CAN was not included in the medical curriculum until recently. From a clinical perspective, a designated team of professionals to function as a MDT to clinically manage cases of CAN is a rarity as well.

In Gazi University Medical School Hospital (GUMSH), a hospital-based MDT for child protection was established in 2001, and represents one of the pioneering teams in the country. This team was composed of pediatricians, forensic medicine specialists, child psychiatrists, an adult psychiatrist, a pediatric surgeon, a social worker, a psychologist, and nurses. The evolution of this MDT led to the establishment of the first Child Protection Center (CPC) in a university setting in Turkey in 2006. The aim of this article was to review the profile of the case series followed up by the Gazi University MDT (GUMDT), and to describe the course this MDT took from implementation to structured functioning, the various challenges presented to the MDT

members in the management of CAN, and the methods with which the MDT handled these challenges in order to guide the newer teams that are being established in the country.

Material and Methods

In this study, the cases referred to the CPC of GUMSH between February 2001 and January 2007 were cross-sectionally analyzed.

Subjects and Setting

GUMSH is one of the largest university hospitals in Ankara, Turkey, with an average of 20,000 admissions to the Pediatric Emergency Department each year. Before the establishment of the MDT in February 2001, the number of patients who were diagnosed with CAN was negligible. As there was no structured multidisciplinary approach, there was also no formal system of tracking. The establishment of the MDT was spearheaded by three disciplines, including social pediatrics, forensic medicine, and child psychiatry. Later, the team expanded with the inclusion of pediatric surgery, adolescent and adult psychiatry, social work, psychology, and nursing. The MDT members developed a training curriculum to educate hospital staff on recognition of CAN followed by the development of hospital guidelines on the management of CAN via consultation services provided by the MDT. In-service training was provided to the staff of the Departments of Pediatrics, Pediatric Surgery, Child Psychiatry, Orthopedics, Neurosurgery, Forensic Medicine, and Emergency Medicine in order to raise awareness about CAN.

The flowchart on the MDT's function is depicted in Figure 1. Extramural referrals from regional police departments, regional social services, or the district attorney's office were accepted as well as in-house referrals. The cases were initially assessed by the pediatrician and the social worker on the team to obtain psychosocial and medical information via interviews with the family and the child, and the child was physically examined by the pediatrician or the forensic medicine physician. All children were psychologically evaluated by the team child psychiatrist who then would plan play therapy, group therapy, and family therapy. Therapy was provided by the psychologist on the team.

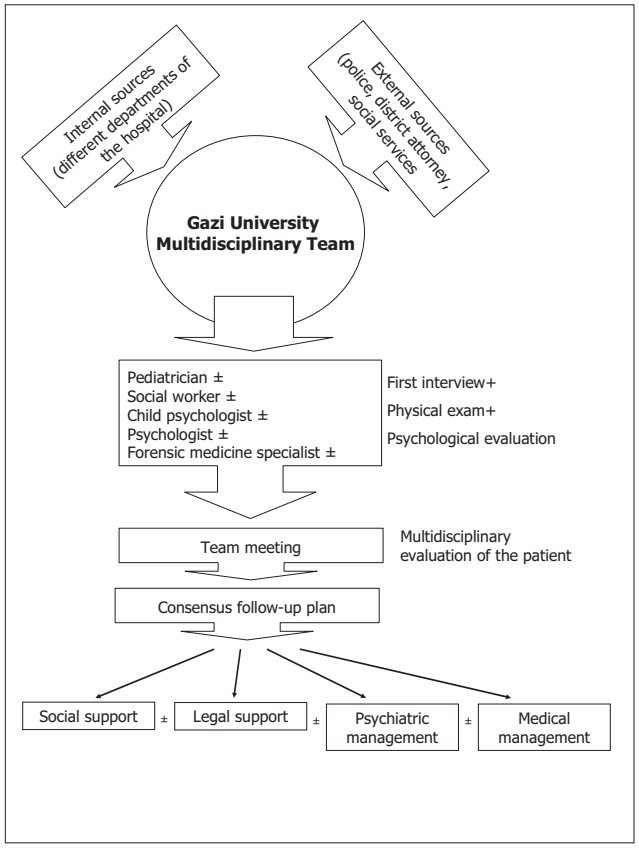

Fig. 1. Flowchart of the function of the multidisciplinary team (MDT).

The team regularly met twice a month with additional meetings as needed. Social workers from the Regional Social Services and attorneys from Ankara Bar Child Rights Section attended these meetings for post-hospital case management purposes. Every case assessed by the team was discussed with the MDT members to develop a consensus follow-up plan to serve the best interest of the child. The follow-up plan included various combinations of medical, psychological, social, and legal interventions. Medical follow-up particularly included treatment of injuries, monitoring growth and development, and treatment of sexually transmitted diseases. Legal interventions included guardian ad litem services via Ankara Bar attorneys who provided legal defense for the child in court when requested. Almost all children and some of their family members obtained mental health services. Occasionally, the adult psychiatrist on the team provided treatment to the offenders.

Home visits to evaluate the family environment and social services were provided by the social worker on the team and the Regional Social Services. Regional Social Services provided economic support to selected families who qualified for such. In cases that required alternative care for child safety, other family members were designated by the Regional Social Services as caregivers or occasionally the children were institutionalized.

The children with a suspicion of CAN who were outpatients or inpatients in the units of the above-listed departments were consulted with the MDT according to the hospital protocol for evaluation of CAN.

Data and Statistical Analysis

Referred cases were assigned to one of two categories as "definite abuse" or "abuse unlikely" at the end of the initial assessment. Data on sociodemographic characteristics of the victims and the perpetrators in addition to the abuse profile on "definite abuse" cases were recorded. These included age and gender of the victim and the perpetrator, the victim's parental educational level, and type and duration of abuse. The definite abuse cases were classified into four age groups as: 0-5, 6-9, 10-14, >14 years for statistical analysis. In addition to the clinical management, case-specific challenges due to gaps in the child protection system and the social perception of CAN were noted during follow-up.

In the statistical evaluation, SPSS for Windows version 11.0 statistical package software (SPSS Inc.; Chicago, IL, USA) was used. The relationship between the age and gender of the victim and relationship of the alleged perpetrator with the child according to the type of abuse was evaluated by chi-square test. The level of significance was set at 0.05.

Results

A total of 139 patients were referred to the GUMSH CPC during the study period. The first year only 12 cases were referred to the team. In subsequent years, the referral rate ranged between 20-33 cases per year, with a mean of 26 patients. CAN was ruled out in 45 cases. The remaining 94 (67.6%) cases were diagnosed as "definite abuse". Table I shows the distribution of cases of "definite abuse" and "abuse unlikely" according to the type of alleged abuse. Among the definite cases, 9 children had more than 1 type of abuse (1 case was abused both physically and sexually and neglected; 6 cases were abused physically and sexually; 2 cases were physically abused and neglected). One of the "abuse unlikely" cases presented with a suspicion of both physical abuse and neglect. "Abuse unlikely" cases were not included in further analyses.

Table I. Distribution of Cases According to Type of Abuse

	Definite abuse	Abuse unlikely	Total
Type of abuse	n (%)	n (%)	n (%)
Sexual abuse	57 (60.6)	22 (48.9)	79 (56.8)
Neglect	12 (12.8)	5 (11.1)	17 (12.2)
More than one type of abuse	9 (9.6)	1 (2.2)	10 (7.2)
Physical abuse	14 (14.9)	13 (28.9)	27 (19.4)
Munchausen syndrome by proxy	2 (2.1)	4 (8.9)	6 (4.4)
Total	94 (100.0)	45 (100.0)	139 (100.0)

In the "definite abuse" cases, 10.9% of the mothers and 1.6% of the fathers had no education. Fifty-three percent of the mothers and 47.5% of the fathers had a maximum of 8 years of education. University graduates constituted 25.0% and 30.5% of the mothers and fathers, respectively. Fifty-nine percent of the mothers and 8.2% of the fathers were unemployed.

Of the abused children, 54 (57.4%) were females and 40 (42.6%) were males (age range: 1 month to 23 years). The age and gender distribution of the victims according to type of abuse is outlined in Table II. There was no statistically significant difference among the groups based on the type of abuse related to gender of the victim ($p>0.05$). Mean ages for physical abuse, sexual abuse, and neglect were 8.9±6.2, 10.8±4.2, and 5.1±5.5 years, respectively. Type of abuse in the various age groups showed a statistically significant difference. Sexual abuse was significantly less common in the 0-5 years of age group ($p<0.001$), while neglect was significantly more common in this group ($p<0.05$).

Age distribution of perpetrators ranged from 11-60 years, with a mean of 30.1±13.1 years. Of the perpetrators, 81.9% were males, and in further detail, accounted for 57.1%, 98.2%, and 41.7% in physical abuse, sexual abuse, and neglect groups, respectively. The perpetrators of two cases of Munchausen Syndrome by Proxy (MSBP) were females. There was no statistically significant difference between the perpetrator's ages based on type of abuse. Gender distribution, on the other hand, showed a predominance of males in perpetrators of sexual abuse ($p<0.001$).

The relationship of the alleged perpetrator to the child in the different abuse types is outlined in Table III. Overall, 56 (59.6%) perpetrators were family members (parents, step-parents or relatives), 28 (29.8%) were extrafamilial acquaintances (teacher, peer, or neighbor), and 20 (21.3%) were strangers. In physical and sexual abuse cases, 73.9% and 34.4% of perpetrators were intrafamilial relations, respectively, and the difference was statistically significant ($p<0.001$).

The patients were followed up for a maximum of 36 months (mean follow-up: 6.3±7.6 months). During the follow-up, 26.6% of the victims received medical treatment while 77.7% received psychiatric treatment. Nine (9.5%) intrafamilial perpetrators also received psychiatric treatment at GUMSH CPC. Although all patients received social support from the team social worker, 23 (24.5%) cases were also officially reported to the Regional Department of Social Services (RDSS). Of the children reported to RDSS, 11 (11.7%) were taken into state custody and placed either in foster care (n: 6) or institutional care (n: 5). Twenty perpetrators (21.3%) were arrested and charged with physical assault, sexual assault, or child endangerment, whichever applied.

Table II. Distribution of Definite Cases According to Age and Gender

	n	Physical n (%)*	Sexual n (%)*	MSBP n (%)*	Neglect n (%)*
Gender					
Male	40	11 (27.5)	26 (65.0)	1 (2.5)	8 (20.0)
Female	54	12 (22.2)	38 (70.4)	1 (1.9)	7 (13.0)
		$\chi^2=0.35$ p=0.631	$\chi^2=0.30$ p=0.657	p=1.000**	$\chi^2=0.85$ p=0.402
Age					
0-5 years	22	6 (27.3)	6 (27.3)	2 (9.1)	9 (40.9)
6-9 years	21	3 (14.3)	20 (95.2)	–	1 (4.8)
10-14 years	35	11 (31.4)	26 (74.3)	–	4 (11.4)
>14 years	16	3 (18.8)	12 (75.0)	–	1 (6.2)
		$\chi^2=2.47$ p=0.655	$\chi^2=24.96$ p<0.001	p=0.153**	$\chi^2=13.84$ p=0.006

*Nine children had more than one type of abuse. Percentages correspond to the number of children in each row (n).
**Fisher's exact test.
MSBP: Munchausen Syndrome by Proxy.

Table III. Relationship of Alleged Perpetrator to Child

		Physical (n=23)		Sexual (n=64)		MSBP (n=2)		Neglect (n=15)	
	Relationship	n	(%)	n	(%)	n	(%)	n	(%)
Intrafamilial	Father	9	(39.2)	10	(15.6)	–	–	4	(26.7)
	Stepfather	1	(4.3)	1	(1.6)	–	–	–	–
	Mother	4	(17.5)	1	(1.6)	2	(100.0)	7	(46.7)
	Father + Mother	1	(4.3)	–	–	–	–	3	(20.0)
	Male relative	1	(4.3)	10	(15.6)	–	–	1	(6.6)
	Female relative	1	(4.3)	–	–	–	–	–	–
Extrafamilial	Teacher or another authority figure	1	(4.3)	7	(10.9)	–	–	–	–
	Friend	3	(13.1)	17	(26.6)	–	–	–	–
	Stranger	2	(8.7)	18	(28.1)	–	–	–	–
	*Total	23	(100.0)	64	(100.0)	2	(100.0)	15	(100.0)

*As some children have more than one type of abuse and perpetrator, total number is higher than the case number. MSBP: Munchausen Syndrome by Proxy.

Discussion

Studies on CAN from Turkey are scarce and mainly follow three different lines. One type is surveys performed in adult populations based on their memories of childhood experiences [6,7,9]. Another type consists of surveys evaluating the awareness and the attitudes of the professionals in this field[10,11]. A third category of studies reports populations clinically assessed and followed up by hospital-based child protection teams[12-14]. Although this strategy has a limitation in its inability to generalize the observations to the regional and national populations, as the patients only represent those who seek help, sharing of clinical practice guidelines and outcome of structured case management may help professionals in the regional and national arena to improve their practice. This latter category of studies would require a well-designed structured CAN team and a detailed recording system. This study is a review of the profile of the largest case series in Turkey, which provides a further review of the challenges involved in implementation of a MDT and the management of cases.

The GUMDT is the first university-based multidisciplinary child protection team in Turkey that has been institutionally recognized. In 1998, a similar team was established in a state teaching hospital in İzmir, and the outcome of this team's work was published[12,13]. However, following a change in leadership, this team became an ad hoc group responding to selected cases of child abuse. GUMDT case management is unique in Turkey in the sense that detailed evaluation and long-term follow-up have been offered to the patients and the families in an increasingly structured manner.

Gazi University Medical School Hospital signed a special contract with the team allowing the team to utilize a sliding scale for hospital expenses for low income families. This, in turn, allowed diversity in the patient population followed up by the team. The authors believe, because of this diversity, the challenges encountered during the first six years might reflect those that can be encountered across the country, even though the patient group is not representative of the Turkish abused children population.

During the study period, we evaluated 139 children, 94 of whom were diagnosed as definite abuse. Abuse was ruled out in 45 of the children after the initial evaluations and team meetings. Although the rate of confirmation is in accordance with other studies[15], the abuse unlikely cases might also suggest the increased awareness of the hospital staff after the in-service training about CAN by the GUMDT.

As in many other countries, Turkish physicians are mandatory reporters of child abuse. This fact coupled with the cultural barriers might have discouraged the families to seek help for sexually abused children. Social stigmatization of the victim is an important problem in the Turkish culture as in most other cultures[1]. In

addition, the urge to protect the perpetrator, who may have a critical role in the survival of the family, may be another factor, especially in incest cases. In physical abuse cases, on the other hand, seeking medical care is rare unless the child is severely injured. Corporal punishment without severe injury is accepted as a disciplinary method as in many other cultures[16,17]. It is thus reasonable to speculate the cases seen by the team might represent only the tip of the iceberg in Turkey.

Even though there were more abused girls in the study group, the gender distribution of abused cases in our series did not show significant difference among the three abuse groups. This finding contradicts the literature findings, since girls are reported to be more frequently sexually abused than boys[18]. This discrepancy may be due to one or more of the following: Firstly, it could be related with admission bias as the families of the sexually abused girls might be reluctant to seek medical help due to risk of social stigmatization of the child. Secondly, while female children are more protected in Turkish culture, boys may be more available for perpetrators since they may be less strictly supervised by their families. Boys are reported to be victims of sexual abuse in other cultures as well[19,20]. We observed that particularly in cases when the perpetrator was an older friend, the victims were mostly young boys who were victimized either in school or the neighborhood.

In our study group, there was no significant difference between type of abuse and the age groups except for 0-5 years, in which sexual abuse was lower and neglect was significantly higher. This is in accordance with the literature[1,19,21] and an expected finding in the sense that children in that age group are more dependent on their caregivers. The lower frequency of sexual abuse in that age group, on the other hand, might be related with the protection of the child by the family against extrafamilial perpetrators. Although they may be susceptible to incest in that age group, they may not be coming to our attention as they can not admit themselves. This may also explain why in our sexual abuse cases, the perpetrator was mostly extrafamilial. Among the intrafamilial abusers, biological fathers were the most common perpetrators, as in other studies[1]. In most of these cases, the mother was the one who brought the child to GUMDT with a plan of divorce because of the disclosure. The perpetrators in our physical abuse cases were mostly the biological parents, in accordance with the literature[1,22]. The predominance of fathers in physical abuse cases can be explained with the mothers' sensitivity to seek help.

Challenges and Suggestions for Solutions

The multidisciplinary management and long-term follow-up of at least a subset of patients enabled us to recognize the gaps within the child protection system and start discussions to overcome these challenges. As the capital and the second largest city in Turkey, Ankara provides consumers with healthcare services in a variety of institutions, including university hospitals, state teaching hospitals, community hospitals, primary health care centers, and private neighborhood clinics. Although it is reasonable to expect that patients with lower resources would seek medical attention at public health institutions, the authors believe that the sample discussed in this article is a good representative sample of an abused children population who seek medical help in Ankara, since the Gazi University CPC accepts all patient referrals regardless of their social security or income status. The small number of the cases reported in this study must be interpreted cautiously, as it does not mean that child abuse is rare in Turkey, but rather implies cultural barriers blocking the way to help-seeking behavior. This hesitancy was particularly more striking when sexual abuse was perpetrated by a family member, for fear of social stigmatization or family disintegration. Even when they sought medical help, these families still tended to cover up the incident. They adamantly asked the team not to report the case to legal authorities even when the child had clear emotional disturbances related to the abuse.

Another observation made by the team was the secondary traumatization of the child by the child protection system due to a variety of gaps within the system. Victims in Turkey usually enter the chain of the child protection system via medical facilities in the process of seeking medical help. Unless the facility has a structured child protection team, physicians and other health care personnel are not trained

on CAN. Due to a lack of coordination of medical services, the child will have to tell his/her story more than once at each unit where the child will be consulted, and physical examinations will have to be repeated. Since there is no team of professionals designated solely to the management of child abuse, even at hospitals with the most abundant resources, most physicians will be reluctant to manage these cases. Physicians' knowledge on the legal and social management of these cases is also limited; therefore, even if they suspect and diagnose abuse, they may fail to report to the police and/or social services.

Although the designated agency for mandatory reporting should be the social services, in Turkey, physicians are obliged to report child abuse to the police or a district attorney's office. The legal system approaches child abuse cases from an evidence collection point of view, not from a child protection perspective. Social services, which is supposed to be the cornerstone of child protection, has extremely inadequate resources in Turkey. This is reflected in the insufficient communication and collaboration between the medical system and the social services. The lack of social workers in most hospitals in turn adds to the problems in dealing with abused cases. Our team might be considered lucky in this respect, because we had a separate social worker whose main responsibility was the management of the abused cases seen in our center. She provided the social work needed for each individual patient as well as communicated with the regional social services when necessary.

Considering the gaps in the medical system, our team has initially focused on improvement of the education and clinical experience of the team members. For that purpose, the team members attended international fellowship programs and international conferences in this field. We consulted some of the cases with the CPC at the University of Iowa. We developed a hospital CAN protocol and trained the residents and other staff in the related departments of the hospital to standardize the recognition and management of cases within the hospital system. We added the subject of CAN into the medical student curriculum. Presenting the MDT model and discussing the team's experiences in various national congresses might have encouraged other professionals in other institutions to establish similar centers.

Considering the importance of collaboration among the three links of the child protection system, namely medicine, law, and social services, we expanded the training efforts to include these fields. With a special protocol signed between Gazi University and the Ministry of National Education, we developed courses for school guidance counselors, one of the major referring agencies. We also emphasized collaboration among the medical, social, and legal services to coordinate management and support to children and families by including the child protection service social workers and lawyers in the regular team meetings.

We also established preventive programs such as family training programs, public education seminars, and interviews for the mass media to increase public awareness of CAN and its associations with parenting practices. We are in the process of developing child protection programs to educate children on how to protect themselves from abuse

To have an impact on the population and traditional values, long-term efforts for prevention of CAN are of critical importance. Being highly aware of this fact, we believe that a structured and widespread population awareness program implemented by both governmental and non-governmental organizations is necessary.

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