The Hague Protocol

Detection of child maltreatment based on parental characteristics at the hospital Emergency Department

Hester Diderich - Lolkes de Beer

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Chapter 1

General introduction and outline of the thesis

Introduction

Child maltreatment is a serious social problem leading every year to the estimated deaths of approximately 155,000 children worldwide (Gilbert, 2009). Many more suffer lifelong consequences (Felliti, 2008).

It is notoriously difficult to detect victims of child maltreatment, despite its frequent occurrence. This becomes apparent if one compares the numbers of reported victims of child maltreatment with the known prevalence numbers. In the United States of America (USA), a total of 676,569 children are yearly reported to the Child Protective Services (CPS) (United States Department of Health and Human Services, 2011) while prevalence studies indicate that an estimated 2,905,800 (or 39.5 per 1,000) children were victims of maltreatment in the study year 2005/2006 (Sedlak & Mettenburg, 2010). In the Netherlands, 19.254 children are yearly reported to the Reporting Center for Child Abuse and Neglect (RCCAN), while an estimated 119,000 (34 per 1,000) children are victims of child abuse every year (Alink et al., 2011). This dissertation describes the development and validation of a protocol that seeks to contribute to reducing the gap between the prevalence and detection of child maltreatment. The 'Hague protocol', as this protocol was named, introduces parental characteristics as a critical piece of information that considerably increases the detection of child maltreatment at hospital emergency departments.

History of Child maltreatment and Child protection

Child maltreatment has probably existed since the origins of humankind. Cruelty took place in families and communities and later in schools. It was often justified in the name of discipline. Parental rights were paramount, "Spare the rod and spoil the child", appears to have been the predominant social and religious ethic (Bilston, 2006). Parents were considered to know what was best for their children and they could delegate the responsibility to others if they chose. In recent times, especially in the Western world, the protection of children's rights has become a focal issue, and the protection of children has been institutionalized in communal and governmental policy, policy that may often supersede the interests of the parents. To better understand the evolution of the problem of child maltreatment throughout the centuries, a brief historical overview of child maltreatment in The United States, The United Kingdom and the Netherlands is given below.

The United States of America

In the United States the documented history of child protection may be divided into three periods. The first period extends from colonial times (approximately between 1607 and1763) until 1875. Before 1875, there was no organized child protection. As early as 1642, Massachusetts had a law that gave magistrates the authority to remove children from parents who did not "train up" their children properly (Meyers, 2008). In 1866, this state passed a law authorizing judges to intervene in the family when "by reason of orphanage or of the neglect, crime, drunkenness or other vice of parents, a child was growing up without education or salutary control, and in circumstances exposing the child to an idle and dissolute life." Although criminal prosecution was already used in this period to punish excessive abuse, there was no enforcement of the law, and in the absence of institutional control, many children were left without protection.

The second period extends from 1875 to 1962. During this time, non-governmental child protection associations organized child protection and child protection services. This period was preceded by the rescue of nine-year-old Mary Ellen Wilson in 1874. This girl was being routinely beaten and neglected. A religious missionary to the poor, Etta Wheeler, was determined to rescue her. But she was unable to persuade the police and child welfare charities to intervene. Wheeler then sought advice from Henry Bergh, the influential founder of the American Society for the Prevention of Cruelty to Animals (ASPCA), and his lawyer, Elbridge Gerry. Gerry employed a variant of the writ of 'habeas corpus' (a habeas corpus writ states the right to file a petition with a court by a person who objects to his own or another's detention or imprisonment) to remove Mary Ellen from her guardians. After this event, Bergh and Gerry decided to create a non-governmental charitable society devoted to child protection. The New York Society for the Prevention of Cruelty to Children (NYSPCC), was founded. It claims to be the world's first organization devoted entirely to child protection.

The third period began in 1962 with the first government-sponsored child protective services. The 1960s witnessed a growth of interest in the prevention of child maltreatment, in which physicians played a key role. Prior to the 1960s, medical schools provided little or no training on child abuse and even pediatricians were largely uninformed. Radiologist John Caffey published an article in 1946 describing six young children with subdural hematomata and fractures of the legs or arms (Caffey, 2011).

Although Caffey did not state that any of the children were victims of maltreatment, it was a hint in that direction. This caused some physicians to focus on the possible origins of injuries and relating injuries to abuse. When the pediatrician Henry Kempe published his paper 'The Battered Child Syndrome' in 1962, the medical profession became interested in the subject of child maltreatment (Kempe, 1962).

In 1962, Congress placed new emphasis on child protection with amendments to the Social Security Act. For the first time, this identified Child Protective Services as part of all public child welfare. This amendment also required that child welfare services be available nationwide by 1975. The year 1962 was also important because of the decision made by the Federal Children's Bureau to recommend state legislation requiring doctors to report suspicions of abuse to police or child welfare. This was the beginning of child abuse reporting laws, the first four of which were enacted in 1963. In 1967, all states had reporting laws.

Yet, it took another seven years before Congress authorized federal funds to improve the state response to physical abuse, neglect, and sexual abuse in the Child Abuse Prevention and Treatment Act of 1974 (CAPTA). CAPTA focused attention on improving investigation and reporting, and provided funds for training. In addition, CAPTA marked the final passing of privately funded, non-governmental child protection societies. Congress periodically renewed CAPTA and this important legislation still remains in force today in the United States (Child Welfare Information Gateway, 2011).

The United Kingdom

The overview of the history of child maltreatment in the United Kingdom starts prior to the 1600s, when orphans were the responsibility of the church and many were sent to become apprentices in households. This process was called 'binding out'. In 1601 the Poor Law was introduced. This provided a basic social security system. It also made it possible for pauper non-orphan children to become apprentices. Child labor was cheap and versatile; children could carry out simple repetitive jobs or crawl into spaces too small for adults.

In the 18th century, children were dying at an alarming rate. Mortality rates were extremely high: over 74% of children born in London died before they were five. In workhouses the death rate of children was over 90%. In 1739, Captain Thomas Coram

established the Foundling Hospital for the education and maintenance of homeless and deserted young children (Harris, 2012). This was the first time a charitable organization was created for the welfare of vulnerable children.

In 1802, two hundred years after the Poor Law was introduced, the Factory Acts sought to limit the number of working hours and improve the conditions in which children worked in factories and mines and in cleaning chimneys. Another step was made in 1870, when compulsory school attendance was introduced for children between the ages of 5 and 12 years.

Almost two decades later, in 1889, the first act of parliament for the prevention of cruelty to children, commonly known as the 'Children's Charter' was passed. This enabled British law to intervene, for the first time, in relations between parents and children. Police could arrest anyone found ill-treating a child and obtain a warrant to enter a home if a child was thought to be in danger. The act also included guidelines on the employment of children and outlawed begging. In 1894 the act was amended and extended. It allowed children to give evidence in court, mental cruelty was recognized and it became an offence to deny a sick child medical attention.

The Prevention of Cruelty to Children Act was amended in 1904, to give the National Society for the Prevention of Cruelty to Children (NSPCC) a statutory right to intervene in child protection cases and the power to remove children from abusive or neglectful homes. Four years later, in 1908, Juvenile Courts were introduced and sexual abuse by a family member became a legal rather than a church matter.

The Children Act in 1948 abolished the ad hoc arrangements for looked after children that had existed since the Poor Law was introduced in 1601. Now local authorities had the duty to receive into care any child who was without parents or whose parents could not care for him for any reason. Local authorities were required to establish a Children's Committee and to appoint a Children's Officer.

The next important step came in 1970, when the Local Authority Social Services Act unified local authority social work services and social care provision, including those for children in social services departments. Almost twenty years later, in 1989, the Children Act gave every child the right of protection from abuse and exploitation and the right to have inquiries made to safeguard their welfare.

In January 2003, Lord Laming published his report into the death of child abuse victim Victoria Climbié, which found that health, police and social services missed 12 opportunities to save Victoria (Laming, 2003). It recommended a minister for children; a national agency for children and families; local committees and management boards to oversee children's services; a national child database and a 24-hour helpline for the public to report concerns about children. Margaret Hodge was appointed as the first children's minister in June 2003, but the post was not at cabinet-level as Lord Laming had recommended.

A year later the UK government published 'The Children Bill', which aimed to introduce and implement the electronic children's files, children's directors and the children's commissioner (The National archives, 2004). It allowed local authorities more flexibility in organizing their children's services, with the amalgamation of education and social services no longer being mandatory. Councils were also given another two years to set up children's trusts.

Finally, in 2010 the statutory guidance on Working Together to Safeguard Children was released, which outlined the ways in which organizations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with 'The Children Act 1989' and 'The Children Act 2004'.

The Netherlands

In the Netherlands, as elsewhere in Western Europe, child maltreatment has probably existed since the origins of humankind, but it only came to be seen as a problem at the end of the nineteenth century. At that time, it was realized that the quality of life of a community is to a large extent dependent on the quality of the upbringing of its children. There was concern that the large group of children, who were malnourished, uncared for and exploited by their parents, could become the criminals of the future. Accordingly, many orphanages and houses of correction were established by religious groups to cope with the widespread poverty of children in large cities. During this time, the first secular, private initiatives also started. These initiatives were concerned with victims of child maltreatment and the education of children, but also with pressurizing the government to prevent abusive parents from taking their children out of the care homes where they were placed. As a result, in 1901 and 1905 the first Dutch Child laws were introduced,

making it possible to release parents from their parental rights (de Vries & Tricht, 1907). The organization which imposed these measures was named 'Child Protective Services' (Raad voor de Kinderbescherming), and in the beginning, these services were staffed by civilians (rather than law enforcement officials).

It is important to keep in mind that the emphasis in those days was on the threat that these families formed for the safety and quality of life of the community: the focus was thus on the 'external problems' these families caused. But since the early 1960s, people started to perceive child maltreatment as an 'internal family problem' in which the parent-child relationship needed attention.

This change in perception of child maltreatment was the result of several events. In the Netherlands, Mrs. Clemens-Schröner drew attention to physical and psychological child maltreatment in her thesis (Clemens-Schröner, 1957). The paper in the Journal of the American Medical Association by Henry Kempe in 1962 (Kempe, 1962) concerning 'The battered child syndrome' was particularly influential. Kempe described child maltreatment as a 'syndrome' requiring the broader attention of doctors who at that time routinely interpreted broken bones in young children as being the result of a fragile bone structure. With Kempe's article, child maltreatment was put on the medical and scientific map and began to be taken into consideration as a cause of physical injury, also in the Netherlands.

In 1972, the first Confidential Doctors' Office in the Netherlands (Bureau Vertrouwensartsen), the forerunner of the Reporting Centers for Child Abuse and Neglect (RCCAN), opened its doors to help families cope with their family problems. In 1980 a non-governmental organization was founded named the 'Vereniging tegen kindermishandeling' (Association against Child Maltreatment). Its goal was to raise public awareness of the problem of child maltreatment. New legislation followed, starting with the signing of 'The Declaration of the Rights of the Child' by the Netherlands in 1990 and ratification in 1995. The first Youth Care law, documenting the role of the government in detecting child abuse, and providing families with the necessary support, was also accepted by the Dutch parliament in 1995. Knowledge regarding the extent and severity of domestic violence slowly increased, leading the government to launch its first policy which regards domestic violence and child maltreatment as a public responsibility in 2002 (Minsterie van Justitie, 2002). As the term 'child maltreatment' became more widespread, politicians began to realize their public responsibility to cope with the issue

and to develop effective policies. Elaborating on this, the Dutch government broadened the definition of child maltreatment and included these items in the 'Wet op de Jeugdzorg' (The Law on Youthcare) in 2005. This law contains the official definition of child maltreatment in the Netherlands. Child maltreatment is described as "Every form of actual or threatened violence or neglect, whether physical, mental or sexual, inflicted actively or passively, by parents or other persons on whom the child is dependent, where severe damage is caused, or may be caused, to the child in the form of physical or mental injury" (Article 1 Wet op de Jeugdzorg, 2005).

Since the introduction of the Law on Youth Care, the government issued an amendment stating that caregivers were no longer allowed to spank their children (Article 247, Burgerlijk Wetboek, 2007). In 2008, a second policy was issued by the government in which witnessing domestic violence was explicitly mentioned as a form of child abuse. These political developments correspond with the developments in health care practice. During the 1990s, awareness grew that child maltreatment involves not only physical abuse, but also physical neglect, psychological abuse, psychological neglect, and sexual abuse. Yet, until the first decade of the 21st century, this awareness was not reflected in the annual number of referrals to the RCCAN. An investigation by the Dutch Health Care Inspectorate revealed that child abuse and neglect was detected too rarely at hospital emergency departments (Wal van der, 2008). This led to more interest, awareness, knowledge and education concerning the detection of child maltreatment in hospitals. The development of the Hague protocol should be considered in the light of this background.

The help of Professor Herman Baartman and Professor Francien Lamers regarding the developments in The Netherlands is gratefully acknowledged.

The Hague protocol

The idea for the Hague protocol arose spontaneously on a summer evening in 2007, when an ambulance brought an intoxicated mother with a head wound to the Emergency Department of the Medical Center Haaglanden (MCH). She was accompanied by her eight year old son, because there was nobody to look after him. The boy sat beside his mother for hours, while the personnel treated her for the alcohol intoxication and head injury. Even though we had been very kind to the boy, we were surprised when he begged us to let him stay in the hospital and not to let him go home with his mother. As the boy was not our patient and we had no medical grounds to keep him in the hospital, we had no choice but to send him home with his mother.

This incident made us aware about the lack of guidelines at the Emergency Department (ED) that would cover this type of situation. With the approval of the ED manager and Board of Directors we contacted the Reporting Center for Child Abuse and Neglect (RCCAN). Together we created the Hague protocol, allowing ED doctors and nurses to refer children to the RCCAN when in doubt about their safety on the grounds of specific characteristics of the parents. Based on our experience and the literature (see 'parental categories' in appendix I) we selected the following three parental characteristics as reasons for ED admittens: 1) being a victim of domestic violence, 2) attempting suicide (or having other serious psychiatric disorders) 3) and substance abuse.

Before implementing these new guidelines, all ED nurses and doctors were trained by a RCCAN doctor, a Child Protection Services (CPS) professional and an ED nurse (the author of this thesis). During the training we discussed child maltreatment and domestic violence in general, barriers to detecting child maltreatment, responsibility of ED nurses and doctors for detection, oath of secrecy, the three selected parental categories, communication skills necessary for speaking with these parents, and the roles of the RCCAN and the CPS (investigation and support). This was the first time the ED professionals had received training on these subjects.

The protocol was first implemented under the name 'MCH protocol' at the Medical Center Haaglanden in December 2007. Within six months of the start of implementation (July 2008), the number of referrals from the ED to the RCCAN rose from 4 to 40. This information was presented at a symposium organized to report on these findings. The Minister for Youth and Family at that time was present and encouraged other hospitals to follow our example. As a result, in July 2008, the other four hospitals in the region of

The Hague agreed to implement this protocol, now named the ‘Hague protocol’. Prior to implementation in these hospitals, we trained the ED doctors and nurses.

The next step was to visit the Health Care Inspectorate in 2009, where we asked the Chief Inspector of Public Health, J. van Wijngaarden if the inspectorate could mandate the Hague protocol for all Dutch hospitals. He explained that this would first need to be scientifically evaluated. With this goal in mind, a study group was set up in the same year, consisting of scientists from the Department of Pediatrics of the Leiden University Medical Center and the Department of Child Health of the Dutch Organization for Applied Scientific Research (TNO) in Leiden in collaboration with the MCH and the RCCAN from The Hague. An application for funding was submitted to ZonMw (Dutch organization for healthcare research and innovation) to carry out research on the effectiveness of the Hague protocol. This was granted early 2011. Members of the RCCAN The Hague and the Health Care Inspectorate were invited and accepted membership in the advisory board of this project. During the application period for the ZonMw grant, the ambulance services and general practitioners’ out of hours co-operatives in The Hague region decided to implement the Hague protocol’s guidelines also.

Outline of this thesis

This thesis describes the development, implementation, and results of the ‘Hague protocol’ to detect child abuse. Labelled the ‘Hague protocol’ to indicate its location of origin, this new protocol introduces a key innovation in child maltreatment detection. Specifically, using the hospital emergency department as location, the protocol is based on the idea that child abuse is effectively detected at the ED by considering not only child characteristics but also characteristics of parents. In the case of the Hague protocol, characteristics of parents attending the emergency department in search of treatment for their own medical problems are used to detect child maltreatment. The Hague protocol prescribes that once a parent enters the emergency department with complaints related to domestic violence, serious psychiatric problems, and/or substance abuse, the possibility of child maltreatment will need to be seriously considered. This is the case even though the child is usually not present, or if present, there are no apparent signs of abuse or maltreatment of the child.

This thesis reports the research that aimed to address these questions. Besides the introductory chapter this thesis contains the following chapters:

The second chapter provides an insight into the potential of the Hague protocol: *Can a protocol for screening adults presenting for care in the Emergency Department identify children at high risk for maltreatment?*

In the third chapter, we investigate whether the success of the Hague protocol was limited to the specific location of the implementation region (the multicultural inner city of The Hague), and what the most prominent barriers and facilitators are for successful implementation. For this we conducted research to answer the following question: *Can the Hague protocol guidelines be successfully implemented at EDs in other regions outside the original intervention region and what are the critical facilitators or barriers to implementation?*

In the fourth chapter, we investigate how many cases of child maltreatment based on parental characteristics are missed at the ED after implementation of the Hague protocol, and the underlying reasons for this. The following question was posed: *Are there missed cases in the detection of child abuse based on parental characteristics at the Emergency Department (the Hague protocol)?*

In the fifth chapter we use the data from the research on the missed cases to answer the question: *What parental characteristics can predict child maltreatment at the Emergency Department? Considering expansion of the Hague protocol.*

In the sixth chapter we focus on the investigation and follow up after referral from the ED to the RCCAN to answer the following question: *What sort of support and monitoring were provided for families after child abuse detection based on parental characteristics at the Emergency Department*?

In the seventh chapter we investigate the professionals' fears of losing parents as patients when the Hague protocol guidelines are applied. Therefore we asked the following question: *Does the Hague protocol cause parents to avoid the Emergency Department?*

In the eighth chapter the main findings of this thesis are discussed and the findings of the thesis are summarized in English and in Dutch.

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Chapter 2

A new protocol for screening adults presenting with their own medical problems at the Emergency Department to identify children at high risk for maltreatment

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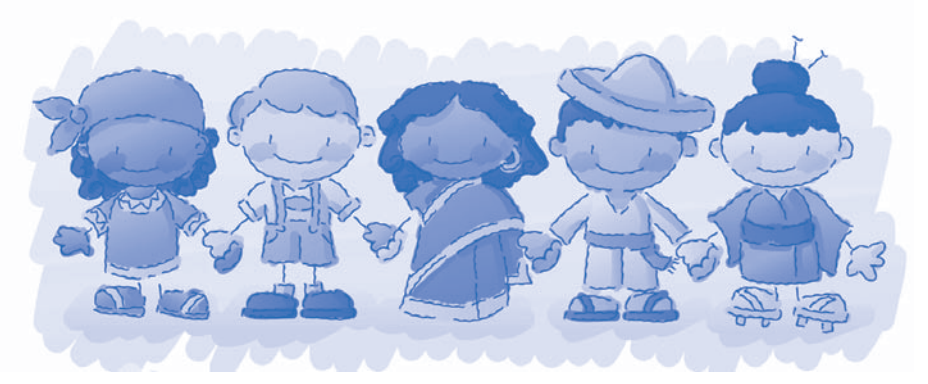

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ABSTRACT

Identifying child abuse and neglect solely on the grounds of child characteristics leaves many children undetected. We developed a new approach (Hague protocol) based on characteristics of parents who attend the Emergency Department (ED) because they have the following problems: (1) intimate partner violence, (2) substance abuse, or (3) suicide attempt or other serious psychiatric problems. The goal of this protocol is to enable the Reporting Center for Child Abuse and Neglect (RCCAN) to rapidly assess family problems and offer voluntary community based support to these parents.

The aim of this study is to assess whether this protocol for screening adults presenting for care in the Emergency Department can identify children at high risk for maltreatment. A before and after study was conducted at 9 EDs in 3 regions in the Netherlands (one intervention region and 2 control regions). During the period January 2006 to November 2007, prior to the introduction of the Hague protocol, from a total of 385,626 patients attending the ED in the intervention region 4 parents (1 per 100,000) were referred to the RCCAN. In the period after introduction of the protocol (December 2007 to December 2011), the number rose to 565 parents from a total of 885,301 patients attending the ED (64 per 100,000). In the control regions, where the protocol was not implemented, these figures were 2 per 163,628 (1 per 100,000) and 10 per 371,616 (3 per 100,000) respectively (OR = 28.0 (95 CI 4.6–170.7)). At assessment, child abuse was confirmed in 91% of referred cases.

The protocol has a high positive predictive value of 91% and can substantially increase the detection rate of child abuse in an ED setting. Parental characteristics are strong predictors of child abuse. Implementing guidelines to detect child abuse based on parental characteristics of parents attending the adult section of the ED can increase the detection rate of child abuse and neglect allowing appropriate aid to be initiated for these families.

Introduction

Child abuse is a serious social problem which is difficult to detect despite the large number of victims. A total of 676,569 children per year are reported to the Child Protective Services (CPS) in the USA (US Department of Health and Human Services, 2011) and in the Netherlands (Jeugdzorg Nederland, 2012) 19,254 children are reported yearly to the Reporting Center for Child Abuse and Neglect (RCCAN). Prevalence studies from the USA indicate that an estimated 2,905,800 (or 39.5 per 1,000) children were victims of maltreatment in the study year 2005/2006 (Sedlak, Mettenburg, Basena, Petta, & McPherson, 2010). In the Netherlands, an estimated 119,000 (34 per 1,000) children are victims of child abuse every year (Alink et al., 2011). The US prevalence study mirrors the Dutch variant because they estimate the same incidences. In both cases the researchers constructed the prevalence numbers by adding the actual number of referrals to the CPS/RCCAN to the number of unsubstantiated and refuted referrals to both organizations. Although definitions of child abuse often vary between countries, which makes it difficult to compare figures, it is clear from these numbers that child abuse is greatly under reported both in the US and the Netherlands.

In the Netherlands the following definition of child abuse is used: “Every form of actual or threatened violence or neglect, whether physical, mental or sexual, inflicted actively or passively, by parents or other persons on whom the child is dependent, where severe damage is caused, or may be caused, to the child in the form of physical or mental injury (Article 1 Wet op de Jeugdzorg, 2005). Witnessing violence in the home is specifically mentioned as a form of child abuse, in a government statement issued in 2010 (Meldcode Kindermishandeling en huiselijk geweld, 2013). In the United States the following definition is used “Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (The CAPTA Reauthorization Act, 2011).

As the Emergency Department (ED) is the frontline of the hospital, it has been identified as a valuable location for detecting children who are victims of child abuse. All injured children visiting the ED should be screened for physical abuse or neglect using child based screening markers (age, repeat attendance and injury type). However, as research shows, this is not sufficiently accurate to be considered a reliable screening tool (Woodman et al., 2010). An investigation by the Health Care Inspectorate of the

Netherlands found that child abuse and neglect was detected too rarely at hospital Emergency Departments (IGZ, 2008). Although systematic screening and training of ED staff concerning child abuse has been shown to be effective (Louwers, Korfage, Affourtit, de Koning, & Moll, 2012), narrowing the gap between the known prevalence of child abuse and the detection rate in hospitals seem insurmountable. Therefore it is important to look for additional methods to detect child abuse at the ED, preferably using methods with a high predictive value. At the adult section of the ED of the Medical Center Haaglanden (MCH) we suspected, in the case of some parents who visit the ED, that there is a high risk that their children at home may be victims of child abuse or neglect. The specific characteristics of these parents include being a victim of intimate partner violence (IPV), attempting suicide (or having other serious psychiatric disorders) and substance abuse. This hypothesis is supported by studies which indicate that parental characteristics such as alcohol and substance abuse and psychiatric problems are associated with child abuse and neglect (Dube et al., 2001; Hurme, Alanko, Anttila, Juven, & Svedstrom, 2008; Kelleher, Chaffin, Hollenberg, & Fischer, 1994).

Intimate partner violence (IPV)

IPV can be labeled as an independent stressor/adverse event for children, as a marker for other forms of maltreatment and IPV exposure can be acknowledged as a form of maltreatment itself. While these three concepts are clearly related, they are medically and legally distinct. Witnessing IPV has been defined as "a child being present while a parent or sibling is subjected to physical abuse, sexual abuse or psychological maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behavior" (Higgins, 1998). Some countries classify witnessing IPV as a special form of emotional maltreatment. However, a growing number of professionals regard witnessing family violence as a unique and independent subtype of abuse (Higgins, 2004). Regardless of the classification used, research has shown that IPV is directly associated with child maltreatment (Edleson, 1999; Thackeray, Hibbard, & Dowd, 2010; Wright, Wright, & Isaac, 1997). Children who witness IPV have a high risk of developing psychological problems such as developmental delay and posttraumatic stress disorder (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Lamers-Winkelman, De Schipper, & Oosterman, 2012; Wright et al., 1997). In addition, these children are more likely to be abused and neglected. Where boys exposed to IPV are more likely to engage in IPV as adults, girls are more likely to be victims (Brown & Bzostek, 2003). Felitti found a strong graded relationship between exposure to IPV as a child and multiple risk factors for

several of the leading causes of death in adults (Felitti et al., 1998). This suggests that the impact of this adverse childhood experience can have lifetime consequences for children. Felitti's study shows the effect of adverse childhood experience, including all forms of child maltreatment on the health and wellbeing in later life. Families with concurrent IPV and child maltreatment issues have high cumulative risk levels and their children are 10 times more likely to be placed in foster care than children of families with low risk levels (Kohl, Edleson, English, & Barth, 2005). Early identification of IPV may be one of the most effective means of preventing child abuse and identifying caregivers and children who need extra support, care or therapy (Thackeray et al., 2010).

Severe psychiatric problems

Parental psychiatric problems are a well-known risk factor for child abuse (Hurme et al., 2008). Two thirds of women with mental illness are mothers (Nicholson, Beibel, Hind, Henry, & Stier, 2001) and mental illness increases the risk of coercive or hostile parenting (Chung, McCollum, Elo, Lee, & Culhane, 2004). Parents with depression or undifferentiated mental illness are twice more likely to abuse their children than parents without mental illness (Brown, Cohen, Johnson, & Salzinger, 1998; Walsh, MacMillan, & Jamieson, 2003). Studies show that maternal depression is clearly linked to child neglect (Hien, Cohen, Caldeira, Flom, & Wasserman, 2010). Many low income mothers are diagnosed with a mental disorder only after the first maltreatment report of their child. This means that concerns about a child's welfare have opened the gateway to mental health services for the mother (Kohl, Jonson-Reid, & Drake, 2011).

Substance abuse

For decades it has been well known that substance abuse has negative consequences for the unborn child (Bailey, Hill, Oesterle, & Hawkins, 2009; Bennett, 1999; Kuczkowski, 2007; McFarlane, Parker, & Soeken, 1996). Recent research has shown that mothers who are substance abusers react less adequately to their babies' needs than parents who are not substance abusers (Landi et al., 2011). A clear association has been found between substance abuse and child abuse or neglect (Dube et al., 2001; Hurme et al., 2008; Kelleher et al., 1994). Children of substance abusers are 50% more likely to be abused and, or, neglected than children whose parents are not substance abusers (Kelleher et al., 1994). People with problems related to IPV, psychiatric problems and substance abuse often need medical care at the ED. Awareness of these parental characteristics at the ED may make it possible to detect child abuse at an early stage, even when the child is not present at the ED.

Background of child abuse detection, reporting and protocol in the Netherlands

In the Netherlands, professionals involved in medical care, education or other types of care for children are not obliged by law to report suspicions of child abuse or neglect to the legal child protection services. In the Netherlands the aim is to give parents all necessary help and support to look after and protect their children. Therefore when a professional or any other person is concerned about the safety of a child they may contact the RCCAN. These centers are located in all provinces and metropolitan cities in the Netherlands. They are staffed by specially trained doctors, child psychologists, other behavioral specialists and social workers. After a center is contacted concerning the safety of a child, they contact the family to evaluate the situation. The assessment is carried out using CARE-nl, a Dutch adaptation of the Child Abuse Risk Evaluation (CARE) (Ruiter & de Jong, 2005). When indicated, they arrange that parents are provided with the necessary support to protect and look after their children. This is always based on voluntary community based services. Only in serious cases of child abuse and neglect, when parents do not comply with the advice and do not avail of the support provided, will the family be reported to the National Child Protection Services which have legal powers to place a child in care or to make parents avail of the necessary support.

New approach

Based on our experience and the available medical literature we developed a new approach to detecting child abuse and neglect, the so called “Hague protocol”. This was developed in collaboration with the RCCAN to identify parents whose children may be at risk of a form of child maltreatment. This protocol aims to identify these high risk parents when they visit the adult section of the Emergency Department. The aim is that, in this way, child abuse may be stopped and voluntary community based support can be provided for the family. This protocol has been implemented since December 2007 in the Hague region and has been introduced in a large number of other hospitals in the Netherlands since then. Variations on the concept of detecting child abuse based on parental characteristics at the adult section of the ED have also recently been implemented in some Dutch hospitals (Hoytema van Konijnenburg, Sieswerda-Hoogendoorn, Brilleslijper-Kater, van der Lee, & Teeuw, 2013).

The current study aims to evaluate the guidelines of the Hague protocol by answering the following question: *“Can a protocol for screening adults presenting for care in the Emergency Department identify children at high risk for maltreatment?”*

Methods

Procedure the Hague protocol

Inclusion criteria. Adult patients who, on questioning confirmed that they were responsible for the care of under aged children (irrespective of whether they were a parent, informal caretaker or legal guardian) and who attended the ED for one of the following reasons, were included:

A. Intimate partner violence (IPV). This includes not only clear cut cases, but also cases where the adult patient denies being a victim of IPV but the ED professional has a strong suspicion that this is the case. According to the Revised conflict tactics scale (Straus, 1996) the sustained injuries fall under the heading of severe partner violence. All patients are included irrespective of the extent of the sustained injuries, severity of illnesses or depth of the wounds.

B. Suicide attempt or other serious psychiatric disorder. Patients who are seen after a suicide attempt or auto mutilation are included in the protocol, regardless of the amount of pills taken or the way the suicide was attempted and irrespective of the depth or size of the wounds in the case of auto mutilation.

C. Serious substance abuse. Patients seen after intoxication with hard drugs. In the Netherlands the term “hard drugs” is used to describe psychoactive drugs that are addictive and perceived as especially damaging. Examples of these are Ecstasy or XTC, Heroin, Cocaine and Amphetamine). This term is used to distinguish them from “soft drugs” (Cannabis products, Sedatives and Tranquilizers) that are believed to be non-addictive (or minimally addictive) and less damaging. Patients who abused alcohol or “soft drugs” were only included if, when asked, they confirmed that they were responsible for the care of under age children and when the following situations were present:

(i) There appeared to be no adequate care for the children.

(ii) The other parent or family members indicated that the substance abuse has adverse effects on the domestic situation.

(iii) When it appeared from hospital records that the patient has previously been admitted several times following abuse of these substances.

Exclusion criteria. Patients who attended the ED for problems other than those mentioned above or who stated they were not responsible for the care of under aged children were excluded.

The intervention

The ED professional asked patients if they were responsible for minors. If patients were unable to answer this question (as a result of their sustained injuries, severity of illnesses or depth of the wounds) other methods were used to obtain this information. For example the ambulance professionals or the local police department were asked for information about the domestic situation. Patients were not specifically asked if they were legal guardians or informal caretakers of under aged children. Patients in the intervention region who fulfilled the inclusion criteria were informed by the ED nurse or doctor about this protocol and that a referral was being made to the RCCAN. The referral was documented in the patient's medical record. In those cases where the referral was not substantiated, the referral was removed from the medical record afterwards.

Because ED professionals have neither the time nor the capacity to extensively investigate families for possible child abuse this task is carried out by RCCAN workers.

To make ED professionals aware of the Hague protocol and its consequences for their daily routine, all personnel of each ED in the region were trained by a RCCAN medical doctor and an ED nurse, specialized in child abuse and neglect.

In the intervention region the local RCCAN started a special program, employing extra personnel, to assess these patients and their children. In this way it was possible to prevent flooding their standard system. The approach to these ED referrals needs to be different to the approach to regular referrals made by pediatricians from the hospital where there is usually more information available about the domestic situation and the specific sustained injuries.

Within a week after the referral the RCCAN invited the family to the RCCAN office or visited them at home to assess the situation. A social worker and medical doctor spoke to the parents, while at the same time a behavioral specialist evaluated children from the age of six upwards. The situation was evaluated using the CARE-nl (Ruiter & de Jong, 2005). After this first assessment the social worker contacted informants around the family. These include the general practitioner, the school, the Well Baby Clinics and the School Health Care system.

Based on the information from all these parties, the RCCAN doctor and social worker determined whether the child was, or was not, a victim of child abuse or neglect. There are three possible outcomes from this evaluation:

The referral is substantiated, which means that the child is a victim of child abuse or neglect. In these cases, parents were offered the necessary help and support in a voluntary setting, but if parents did not accept, it could be made mandatory when considered necessary.

The referral is not substantiated, which means that it is not possible to determine whether the child is, or is not, a victim of child abuse or neglect. If child abuse could not be substantiated, the child's data remained in the RCCAN system, but no help was initiated.

The referral is refuted, which means the child is not a victim of child abuse or neglect. Parents were sent a letter of apology by the board of directors of the hospital and the child's data were removed from the RCCAN system. A note concerning the refuted referral was added to the patient's hospital record.

Setting and analyses

We used a quasi-experimental pretest–posttest design with a non-randomized control group. The positive predictive value (PPV) was determined by calculating the proportion of true positives. This was done by calculating the number of referred cases where child abuse was confirmed, as a proportion of the total number of referred cases.

The study was carried out in three regions in the Netherlands, one intervention region where the new protocol was introduced and two control regions. The Hague protocol was introduced in the inner city of The Hague and adjoining four suburban areas with a total population of 754,733 inhabitants. 50.5% have a non-Dutch background and 50.7% of all The Hague residents are female (Starmans & Vermeulen, 2012). This region has two large inner city hospitals and three smaller local hospitals, all with EDs. The total number of patients attending these five EDs in 2011 was 222,657. The two control regions are Flevoland and Zuid-Limburg. Flevoland is a rural area with 387,881 inhabitants and has two small hospitals with EDs. Zuid-Limburg has 620,000 inhabitants, who have access to one University hospital and three smaller hospitals of which two hospitals have no ED. The total number of patients attending these five EDs in 2011 was 95,898.

During the study period no significant secular changes have taken place in the intervention and control regions. The implementation of the protocol was funded by each hospital organization separately. The RCCAN was allowed extra funding by the government to cover the increase in the number of referrals.

Data collection. Data were collected from existing archived RCCAN and ED records of patients who had attended the ED and had been referred to the RCCAN, over the period January 1st 2006 to December 31st 2011 in both the intervention region and the control regions. The Hague protocol was introduced on December 7th 2007 in the intervention region of the Hague. We collected all referred cases of child abuse, based on parental characteristics, made by the EDs during the study period, from the computerized administration of the RCCAN. All referred parentally based cases came from hospital EDs, not from other medical providers.

Statistical note. Data were analyzed using SPSS, version 17.0. To analyze whether the number of reported cases was higher in the intervention region compared to the control region, we used logistic regression to calculate the odds ratio (OR) and 95% confidence interval (CI).

Results

Cases detected by the protocol

A total of 581 RCCAN charts of children referred by the EDs, based on the studied parental characteristics were reviewed. These were comprised of 569 cases (4 cases before implementation and 565 after implementation) from the Hague region and 12 cases from the control regions, from the years 2006 up to and/including 2011. Table 1 shows the number of cases referred by the EDs to the RCCAN per year in the intervention and control regions. The number of referrals for child abuse made by EDs increased substantially in the intervention region after introduction of the Hague protocol, from approximately one per 100,000 ED attendances to almost 64 per 100,000 attendances. The number of referrals per 100,000 ED visits remained almost unchanged in the control regions, showing only a very modest increase from 1.5 to approximately three per 100,000 ED attendances.

Table 1 Yearly number of referrals of child abuse from ED to the RCCAN, based on parental characteristics.

Number of referrals of child abuse	Before protocol (January 1st 2006 to December 6th 2007)		After protocol implemented (December 7th 2007 to December 31th 2011)			
	2006	2007	2008*	2009	2010	2011
Intervention region						
- n/N	3 / 199,118	1 / 186,508	111 / 228,653	149 / 217,569	127 / 216,422	178 / 222,657
- Referrals per 100,000	1.5	0.5	48.5	68.5	58. 7	79.9
Control regions						
- n/N	1 / 79,720	1 / 83,908	2 / 92,939	3 / 89,648	2 / 93,131	3 /95,898
- Referrals per 100,000	1.3	1.2	2.2	3.3	2.1	3.1

Note: n, number of referrals of child abuse; N, number of total visits to the ED.

* Before and after protocol implemented, intervention versus control region: OR = 28.0,(95 CI: 4.6–170.7); $p < 0.001$.

Most caregivers referred to the RCCAN were female (84%) and both parents were referred in only 2% of cases, as shown in Table 2. Fortytwo percent of the referred parents had a Dutch ethnic background and in 8% of cases the background was unknown. Most reported parents had one or two children and 12% had three or more children in their care.

Table 2 General characteristics of the referred cases in the intervention region December 7th 2007 - December 1st 2011 (N=565).

	% (n)
Gender of referred parent	
Male	14 (80)
Female	84 (476)
Both parents	2 (9)
Ethnicity	
Dutch	42 (238)
Turkish	11 (59)
Moroccan	6 (35)
Suriname/Caribbean	14 (79)
Other ethnicity	19 (108)
Unknown	8 (46)
Number of children in family	
1	45 (256)
2	43 (244)
3 or more	12 (65)

Almost half of the cases based on parental characteristics referred by the ED to the RCCAN were caregivers who attended because of IPV injuries (48%). The second largest group comprised those admitted after a suicide attempt or auto mutilation (29%) and in 3% of the cases it was a combination of all three risk factors. Referrals of 7% of the caregivers were based on other risk factors (mainly other psychiatric problems) which were not included in the protocol (Table 3).

Table 3 Type of referrals of child abuse from the ED to the RCCAN, based on parental characteristics (N=565).

Number of referrals of child abuse from the ED to the RCCAN, based on parental characteristics (*N* =565)	% (n)
Reason for report to Reporting Center	
- Substance abuse	14 (78)
- Suicide attempt	28 (161)
- Intimate partner violence	48 (269)
- Combination	3 (17)
- Other*	7 (40)

* These cases include mainly other psychiatric problems: confusion, delusion.

Positive predictive value

Our results indicate that child abuse was confirmed in the great majority (91%) of the referred cases. This indicates that the positive predictive value of detecting child abuse with the Hague protocol is 0.91. In 7% of cases the presence of child abuse could not be confirmed at the time of investigation. In these cases some form of child abuse had been detected but the problem had already been solved or the caregivers had undertaken steps to prevent recurrence of the problem, for example: parents had split up or a parent had enrolled in a rehabilitation program. In 2% of the cases the RCCAN concluded that no child abuse was present (Table 4).

Previously known to the RCCAN

We investigated whether the confirmed cases of child abuse had been previously known to the RCCAN. These results are shown in Table 5. Of the total number of children reported, 73% were previously unknown to the RCCAN. Although 27% were already registered in the RCCAN system, professionals working with these families were often unaware of the reason why the parent attended the ED.

Table 4 Positive predictive value of the Hague protocol (all cases after December 2007) (N=557).*

	All cases *% (n/N)*	Substance abuse *% (n/N)*	Suicide attempt *% (n/N)*	Intimate partner violence *% (n/N)*	Combination *% (n/N)*	Other** *% (n/N)*
-Child abuse confirmed	91 (509/557)	87 (68/78)	89 (143/159)	93 (247/264)	100 (17/17)	87 (34/39)
-Child abuse not confirmed	7 (36/557)	9 (7/78)	8 (12/159)	5 (13/264)	0 (0/17)	10 (4/39)
-No child abuse	2 (12/557)	4 (3/78)	3 (4/159)	2 (4/264)	0 (0/17)	3 (1/39)

* Missing data for eight cases.

** These cases include mainly other psychiatric problems: confusion, delusion.

Table 5 Percentage of confirmed child abuse cases previously unknown to the RCCAN.

	All cases (*n* = 509) % (n)	Substance abuse (*n* = 68) % (n)	Suicide attempt (*n* = 143) % (n)	Intimate partner violence (*n* = 247) % (n)	Combination (*n* = 17) % (n)	Other* (*n* = 34) % (n)
New case?						
- Yes	73 (371)	62 (42)	80 (115)	74 (182)	76 (13)	56 (19)
- No	27 (138)	38 (26)	20 (28)	26 (65)	24 (4)	44 (15)

* These cases include mainly other psychiatric problems: confusion, delusion.

RCCAN investigation

After investigation by the RCCAN the most common finding (present in 40% of cases) was that children were witnesses of IPV. This was followed by a combination of being a witness of IPV and suffering educational neglect and emotional neglect (27%) (Table 6).

Table 6 Type of abuse found after investigation by the RCCAN (*N*=565).

Type of abuse	% (n/N)
Educational neglect	17.3 (98/565)
Witness of intimate partner violence	39.8 (225/565)
Emotional neglect	8.0 (45/565)
Psychological violence	4.4 (25/565)
Physical abuse	0.4 (2/565)
Physical neglect	0.5 (3/565)
Combination*	26.9 (152/565)
No abuse	2.7 (15/565)

* These combinations mainly consist of educational neglect, emotional neglect and witness of intimate partner violence.

Discussion

This study focused on the detection of child abuse and neglect at the adult section of the ED using the Hague protocol. The Hague protocol was introduced in the inner city of the Hague and adjoining four suburban areas where a substantial number of the inhabitants (50.5%) have a non-Dutch background. This was represented in the population of ED patients who were detected through the protocol, as 57% of the referred cases had a non-Dutch background. The main finding was that the Hague protocol has a very high

positive predictive value. The overall rate of substantiated referrals to RCCAN was 27% in 2011 (19.254 out of 65.993). The reason that a large number of cases of child maltreatment, were found with this new specific protocol based on parental referrals, is due to the fact that these guidelines were mandated for a restricted group of professionals (ED) combined with a specific group of patients (IPV, suicide, intoxication).

Use of the protocol, focusing on parental characteristics of adult ED patients, can help detect substantially more abused or neglected children than the methods generally used. Identifying victims of child abuse and neglect within the care setting is nothing new. However, the Hague protocol is unique and appeared to be successful for a number of reasons. To start with, to our knowledge, the Hague protocol is the first to focus on screening markers based on characteristics of parents attending an ED. This may provide a more valid focus for screening for child abuse and neglect than the traditional focus on child based markers.

Screening instruments or markers require a high validity (sensitivity, specificity and positive predictive value). Woodman and colleagues conducted a systematic review to evaluate three markers for physical abuse or neglect in injured children attending the ED (Woodman et al., 2010). These markers were young age, specific types of injury and previous attendance at the ED. They concluded that these child based markers have low validity, implying that using these child based markers is likely to divert clinician attention away from abused children without these markers and to generate an unacceptable number of incorrectly suspected parents (false positives).

The Hague protocol is focused on three parental characteristics at the ED (IPV, substance abuse and suicide). These categories of patients are easily identified at the ED. In this study, as in the legal definition used in the Netherlands, witnessing intimate partner violence is classified as a form of child abuse. Moreover, the selection of these parental characteristics is in accordance with the current literature as many other studies have reported that parents with these problems have a high risk of abusing or neglecting their children (Dube et al., 2001; Fantuzzo et al., 1997; Finkelhor, Turner, Ormrod, & Hamby, 2009; Hien et al., 2010; Kelleher et al., 1994; Windham et al., 2004; Wright et al., 1997).

Another explanation for the success of the Hague protocol may be found in its simplicity and the clear guidelines, which leave little room for error. In a survey of nurses and physicians, 71% of respondents rated their current methods of identification of

maltreatment as being “rather difficult”. Work pressure, unfamiliarity and awkwardness were cited as barriers (Paavilainen et al., 2002). In our study, the ED professional can detect high risk parents relatively simply by checking the reason for seeking medical aid at the ED and the medical diagnosis and then asking these patients if they are responsible for under aged children. The only extra task the nurse or doctor has to perform is to explain the procedure to the patient and fill out a form that is then sent to the RCCAN.

A third strength of the protocol can be found in the standard feedback that ED professionals get from the RCCAN in response to their referral. Professionals remain highly motivated to refer new cases when they receive confirmation of abuse or neglect of a referred case and when they know that appropriate interventions have been initiated in response to the referral. In their study concerning health care providers’ experience reporting child abuse in the primary care setting Flaherty and colleagues found that negative experiences with CPS contact or concerns about the impact on the child or family can negatively influence their decision to refer a child (Flaherty, Sege, Binns, Mattson, & Christoffel, 2000).

Of the children referred using the Hague protocol, three quarters were previously unknown to the RCCAN. Most families had never received help and support prior to referral following the ED attendance. The high positive prospective value of this protocol makes it, in our opinion, ethical to target these specific groups. This is in contrast to other socio-demographic risk factors, like poverty or single parenting which do not have a high positive predictive value in combination with a visit to the ED.

One reason for hesitation in adopting this policy in other settings might be concerns about flooding the support system, as experienced in Minnesota in the USA in 1999. In 1999 Minnesota legislature amended the definition of child neglect to include child exposure to IPV, as a consequence referrals to child protection agencies expanded rapidly. Unfortunately no new state funding was provided and the support system flooded (Edleson, Gassman-Pines, & Hill, 2006). Prior to implementing the Hague protocol, we roughly estimated the number of extra referrals to the RCCAN that could be expected, by calculating how many patients attended the EDs with complaints based on the three selected characteristics. In these calculations we took into account that these patients would not all be parents responsible for minors. In this way the RCCAN was prepared to handle the extra referrals from the EDs without creating delays for other families. Another safety net to prevent flooding is the restriction, in accordance with our

protocol, allowing only ED professionals to refer to the RCCAN on the grounds of parental characteristics. In our opinion it is not desirable that everyone in general society should report parents with known serious mental health problems, substance abuse and IPV to child welfare services. The ED is a responsible base to start from and expanding the scope of reporters could possibly be investigated at a later stage. The reason that a large number of cases of child maltreatment, based on parental referrals, were found, is due to that these guidelines were mandated for a restricted group of professionals (ED) combined with a specific group of patients (IPV, suicide, intoxication).

This does not mean that the high proportion of maltreatment in this group will be substantiated in all other referrals, based on child markers, made to the RCCAN nor does it mean that, for example, all parents with suicidal thoughts maltreat their children.

It can be argued that the Hague protocol mainly detects children who witnessed IPV and who were educationally neglected. Physical abuse was found in only 0.4% of the cases and physical neglect in 0.5%. This is an expected result of the protocol's design, because the RCCAN doctor does not perform a physical examination of the child during the investigation and the children were not present and therefore not examined at the ED. On the grounds of the number of children detected, based on IPV of parents, this should be considered as a form of child maltreatment or at least as a serious risk factor for child abuse and should lead to adaptation of this policy in other countries.

We recognize that the control regions differ fundamentally from the intervention region with regard to degree of urbanization and perhaps some small cultural differences. However the pre- posttest design of this study provides strong support for the effect of the Hague protocol. A possible disadvantage of using the Hague protocol could be that it may discourage some parents to visit the ED. When patients hear about this procedure it is possible that some may decide not to seek medical aid at the ED. This disadvantage is not specific to our protocol and it is common to all protocols for detecting child abuse, but will be further explored in our follow-up study. We do know that these patients are in urgent need of medical care and that all ED's, ambulances and General Practitioners clinics use the same protocol in the Hague region, so a referral will be difficult to avoid. In a later study we will also analyze possible missed cases; cases that were not reported to the RCCAN according to the Hague protocol's guidelines. We acknowledge the differences in definitions of child abuse as well as cultural and judicial backgrounds between the Netherlands and many other countries, including the USA.

In the Netherlands community based support is available for everyone, regardless of their status or income which is different to other countries. The type of help offered to the families, how often voluntary support was accepted and if this was sufficient will be topics in our next study.

Despite initial hesitations, the Hague protocol has been endorsed and mandated as an official policy by the Dutch Ministry of Health, Welfare and Sports in 2013, for all EDs, ambulance services and General Practitioners Clinics (during non-office hours) in the Netherlands. Expanding the use of this protocol to other medical settings may detect more cases of child abuse and neglect, but we have not studied this as yet. Our protocol has also resulted in guidelines for hospital Boards of Directors concerning the detection of child abuse. It states, among other items, that all hospital professionals should be educated about parental risk factors.

The parental characteristics we focused on in this study have a very high positive predictive value and using these may substantially increase the detection rate of child abuse or neglect. By identifying these parental risk factors at the ED, professionals can help parents to address their specific problems and potentially help stop and prevent child maltreatment.

This current protocol was developed to fit specifically within the Dutch legal and health care system. If this protocol would be applied in other countries it would probably need to be adapted to fit within the country's legal and medical systems. However we think the Hague protocol is such a valuable original tool for detecting new cases of child abuse, that we strongly urge others to consider the possibility of adding a suitable adaption to their current local guidelines. In the end we all share the common goal of attempting to stop and prevent child abuse and neglect.

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Chapter 3

Facilitators and barriers to the successful implementation of a protocol to detect child abuse based on parental characteristics

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ABSTRACT

To determine the critical facilitating and impeding factors underlying successful implementation of a method to detect child abuse based on parental rather than child characteristics known as the Hague protocol. The original implementation region of the protocol (The Hague) was compared to a new implementation region (Friesland), using analysis of referrals, focus group interviews (n=6) at the Emergency departments (ED) and at the Reporting Centers for Child abuse and Neglect (RCCAN) as well as questionnaires (n= 76) at the EDs.

Implementation of the Hague protocol substantially increased the number of referrals to the RCCAN in both regions. In Friesland, the new implementation region, the number of referrals increased from two out of 92,464 patients (three per 100,000) to 108 out of 167,037 patients (62 per 100,000). However in Friesland, child abuse was confirmed in a substantially lower percentage of cases relative to the initial implementation region (62% vs. 91%, respectively).

Follow-up analyses suggest that this lower positive predictive value may be due to the lack of training for RCCAN professionals concerning the Hague protocol. The focus group interviews and questionnaires point to time limitations as the main impediment for implementation, whereas an implementation coach has been mentioned as the most important facilitating factor for success. The Hague protocol can be used to detect child abuse beyond the initial implementation region. However, training is essential in order to assure a consistent evaluation by the RCCAN.

Introduction

The 'Hague protocol' offers a solution to the pervasive problem of the underreporting (see Benger & Pearce, 2002; Bleeker, Vet, Haumann, van Wijk, & Gemke, 2005) of child maltreatment by adding a new approach to the existing protocols that focus on child characteristics. It uses parental characteristics rather than characteristics of the maltreated child as a detection tool in adult emergency departments (EDs). As shown in a recent US child maltreatment report (US Department of Health and Human Services, 2011), parents are the perpetrators in 81.2% of cases of child maltreatment. The Hague protocol recommends that children of parents who present at an adult ED with complaints related to (1) domestic violence, (2) substance abuse, or (3) a suicide attempt be referred to the Reporting Center for Child Abuse and Neglect (RCCAN), the federal assessor and support provider for child maltreatment in the Netherlands (Diderich et al., 2013). This organization will investigate whether the children are victims of child abuse and, when this is the case, offer the family voluntary community-based services to stop the maltreatment.

The Hague protocol is based on a Dutch definition of child abuse: 'Every form of actual or threatened violence or neglect, whether physical, mental or sexual, inflicted actively or passively, by parents or other persons on whom the child is dependent, where severe damage is caused, or may be caused, to the child in the form of physical or mental injury' (Article 1 Wet op de Jeugdzorg, 2005).

Evaluation has shown that implementation of the Hague protocol yielded a significant increase in the number of cases of child abuse referrals to the RCCAN (from 1 per 100,000 to 64 per 100,000 ED visitors) and a high rate of child abuse detection (high positive predictive value of 0.91) (Diderich et al., 2013). Moreover, Diderich, Verkerk et al. (2014) showed that only 6.6% of child abuse cases detected on the basis of parental characteristics were missed by ED professionals using these guidelines. Of the children referred to the RCCAN based on the Hague protocol, two-thirds were unknown to the RCCAN prior to referral by the ED (Diderich et al., 2013).

There are multiple reasons for the increase in detection rates and the high positive predictive value as a result of implementing the Hague protocol. First, not all forms of child maltreatment result in clearly observable physical signs. Second, parents who are responsible for child maltreatment may avoid seeking medical care for their children for

fear of being detected. Third, even if physical signs are found, it is difficult to be certain that the child's injury is the result of child maltreatment by the caretaker. Conversely, using parental characteristics to screen for child maltreatment has a number of advantages. First, because the caretaker arrives at the ED with serious problems that also affect the ability to take care of children, it is easier to broach the subject of the negative domestic situation and discuss child maltreatment. In other words, it is easier to relate the caretaker's physical problems (as specified by the protocol) to a child's well-being than it is to relate the child's physical problems to the caretaker's acts. In addition, the caretaker may be more motivated to visit an ED based on the serious nature of his or her injuries (or others may be more motivated to bring the caretaker to the ED) than when the child is injured, in which case the caretaker may wish to conceal the injuries of the maltreated child. Finally, the criteria of the Hague protocol leave little room for interpretation: domestic violence, substance abuse and suicide attempts are indications of serious domestic problems that can be easily identified as such. Accordingly, there is much less ambiguity in assessing child maltreatment using parental characteristics compared with using child markers.

All of these factors might have contributed to the increased positive predictive value of child maltreatment assessment after the implementation of the Hague protocol (Diderich et al., 2013). In July 2013, the Dutch government issued a mandate to make the use of parental characteristics obligatory for all health care professionals who work with adult patients and clients (e.g., ambulance services, general practitioners) to enable screening for child abuse (Ministrie van Volksgezondheid Welzijn en Sport, 2013).

The current study is part of a large research project in which the following topics were investigated: (i) the effectiveness of the Hague protocol, (ii) whether implementation leads to parents' avoiding medical care, (iii) the number of missed cases, (iv) whether the parental categories should be extended and (v) what help was offered to the families after referral to the RCCAN. The study was submitted for evaluation to the Medical Ethical Committee (number 11-040), which decided that their approval was not required. The majority of these studies have already been published or accepted for publication (Diderich, Dechesne, Pannebakker, Buitendijk, & Oudesluys-Murphy, 2014).

In this study, the aim was to explore whether the Hague protocol guidelines can be successfully implemented in EDs in other regions outside the original intervention region and to identify critical facilitators or barriers to implementation.

The implementation was evaluated and compared in two regions: (a) the urban, multicultural region of The Hague, where the protocol was developed in 2010 as a cooperative initiative between hospital EDs and the RCCAN, and (b) the more rural province of Friesland as a new implementation region. In The Hague, the protocol was developed using a bottom-up process by which the practices at the ED and the RCCAN were gradually formalized. Implementing the protocol in a different region in a top-down fashion would reveal the blind spots in the implementation process.

In this study, we were less interested in the distinction between bottom-up versus top-down implementation of the process and more interested in whether the Hague protocol could also be implemented in a region other than the region from which it originated. In the original implementation region, the protocol developed through accumulated experience that only gradually led to a formal instrument for detecting child maltreatment. As a result, in the original implementation region, the formal protocol coincided with many practices that remain implicit but can nonetheless play a decisive role in its execution. By considering the implementation of the protocol in a new region, it becomes possible to separate the effectiveness of the formal protocol from the more implicit professional practices that may also have contributed to the acceptance of the protocol's use by ED personnel and its high positive predictive value in the original implementation region.

Thus, our study aims to answer the following question: Are there differences in acceptance and implementation of the Hague protocol in the new implementation region? Differences could reveal possible facilitators and barriers to the countrywide implementation of the Hague protocol.

The Hague protocol

Situation prior to implementation

Unlike in many other countries, (medical) professionals in the Netherlands are not mandated to report if they suspect child maltreatment. However, they are mandated to check the child's safety and well-being. If this cannot be assessed by the (medical) professional, he/she has to either: (1) refer the child to the RCCAN and the RCCAN will then take responsibility or (2) arrange for appropriate support services without involving the RCCAN.

Prior to the Hague protocol, professionals referred children to the RCCAN solely on the basis of child characteristics (e.g., age, injury type, number of ED visits or reason for ED visits) but not on parental characteristics. As shown in a study on the effectiveness of this protocol (Diderich et al., 2013), only one per 100,000 ED patients was referred to the RCCAN on the basis of parental characteristics before the implementation of the Hague protocol; this number rose to 64 per 100,000 ED patients after implementation. In 91% of these referred cases, a form of child maltreatment was determined after investigation by the RCCAN. The EDs in The Hague were the first in the Netherlands to use the procedure of screening for child abuse based on parental characteristics (often without having seen the children themselves) and referring the families to the RCCAN.

The inclusion of the three parental categories - (1) domestic violence (DV), (2) intoxication with alcohol or drugs and (3) suicide attempt or self-harm - was based on the seriousness of these conditions that often require medical care at an ED and are conditions that may severely and adversely impact any children of these patients. If parents present with other severe mental illnesses and the ED professional is in doubt about the safety of the children, they are also included in the protocol (on the professional's own initiative), and these families are interviewed by the RCCAN. To prevent overburdening of the system and a high percentage of false positives, we deliberately limited the protocol to the current three categories.

The outcomes of many studies show that the children of this specific group of parents have a high risk of being victims of a form of child maltreatment. The following literature served as the scientific basis for the protocol's use of the three categories (see also: Diderich et al., 2013).

Domestic violence

Research has shown that domestic violence is directly associated with child maltreatment (Edleson, 1999; Thackeray, Hibbard, & Dowd, 2010; Wright, Wright, & Isaac, 1997) and that witnessing domestic violence entails a high risk of developing psychological disorders, e.g., developmental delay, posttraumatic stress disorder (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Lamers-Winkelman, De Schipper, & Oosterman, 2012; Wright et al., 1997). Felitti et al. (1998) reported a strong, graded relationship between exposure to domestic violence as a child and multiple risk factors for many of the leading causes of death in adults. High cumulative risk levels were found in families with concurrent domestic violence and child maltreatment issues, and such families' children

are 10 times more likely to be placed in foster care than are children of families with low risk levels (Kohl, Edleson, English, & Barth, 2005). Early identification of domestic violence may be one of the most effective means of identifying caregivers and children who need extra support, care or therapy (Thackeray et al., 2010).

Severe psychiatric problems

A well-known risk factor for child abuse is parental psychiatric problems (Hurme, Alanko, Anttila, Juven, & Svedstrom, 2008). Studies show that children whose parents have depression or an undifferentiated mental illness are twice as likely to be abused than are children of parents without mental illness (Brown, Cohen, Johnson, & Salzinger, 1998; Walsh, MacMillan, & Jamieson, 2003). Other studies show that mental illness increases the risk of coercive or hostile parenting (Chung, McCollum, Elo, Lee, & Culhane, 2004). Kohl, Jonson-Reid, & Drake (2011) found that many low-income mothers are first diagnosed with a mental disorder after the first report of maltreatment of their children.

Substance abuse

Many studies have demonstrated the association between substance abuse and child maltreatment (Dube et al., 2001; Hurme et al., 2008; Kelleher, Chaffin, Hollenberg, & Fischer, 1994). It is also known that substance abuse has negative consequences for the unborn child (Bailey, Hill, Oesterle, & Hawkins, 2009; Bennett, 1999; Kuczkowski, 2007; McFarlane, Parker, & Soeken, 1996). Landi et al. (2011) reported that mothers who are substance abusers react less adequately to their babies' needs than do parents who are not substance abusers.

The RCCAN

Parents and their children are referred to the RCCAN in accordance with the protocol's guidelines when parents fall into one or more of the three parental categories at the ED and, on being asked, confirm that they are pregnant or are responsible for minors. The RCCAN specializes in conducting investigations concerning possible child abuse and neglect and making voluntary community-based services available to families. Their professionals (a medical doctor, a social worker and a behavioral specialist for children) invite the parents and the children to the RCCAN office within one week. Using the CARE-nl criteria (de Ruiter & de Jong, 2005), these RCCAN professionals determine whether child abuse or neglect is substantiated. If this is the case, a voluntary, community-based support plan (anger management therapy, psychiatric help, financial support, or enrollment in a drug or alcohol rehabilitation program) is developed in collaboration with

the parents. The RCCAN is a federal rather than judicial organization and has the ability to refer children to Child Protective Services (CPS) when necessary. This referral is made when serious measures are required, for example, when children are in danger or when parents consistently shun cooperation with the RCCAN.

Methods

This study includes the following components: data collection from EDs and RCCANs in the original and the new implementation regions, focus group interviews at the EDs and at the RCCANs and questionnaires for ED professionals

Sample

The province of Friesland is a mainly rural area with 591,901 inhabitants, of whom 8.6% have a non-Dutch background (Centraal Bureau voor de Statistiek (CBS), 2013). Friesland has one large inner-city hospital in Leeuwarden and four smaller local hospitals, all with EDs. The inner city of The Hague and the adjoining four suburban areas have a total population of 754,733 inhabitants, of whom 50.5% have a non-Dutch background (Centraal Bureau voor de Statistiek (CBS), 2011). This region has two large inner-city hospitals and three smaller local hospitals, all with EDs.

Preparation

Prior to implementation of the Hague protocol in both regions, all ED nurses and doctors were given face-to-face training by an ED nurse, an RCCAN medical doctor and a CPS professional. During a morning session, the nurses and doctors were informed about the nature and occurrence of child abuse and neglect, the difficulties in detecting it and the organizations that address and work with child maltreatment, as well as practical guidelines on how to communicate with parents.

Data collection

We identified the number of cases of child abuse that were referred by the EDs to the RCCAN in both regions by collecting the data originating from all the EDs (n = 2 x 5) in their regions.

Files of each specific case submitted by the ED in The Hague in the years 2006-2011 and in Friesland in the years 2009-2012 were extracted from the RCCAN database. Among

other characteristics (such as the parents' ethnicity and the number of children in the family), these cases were screened for type of studied parental characteristic (domestic violence, substance abuse or suicide attempt/self-injury) and the conclusion reached after investigation. The quantitative data for the study were obtained by a retrospective review of records. This was conducted by one person (author PJGS), thus establishing consistency in the data collection. This person was a registered ED nurse trained by the RCCAN in documenting data from the files. The RCCAN creates a file for every case that explicitly includes these variables and categories. Therefore, there is no room for interpretation when these data are extracted from the files. One person collected the data from the files to ensure no differences in interpretation, which could have been the case if the task had been undertaken by more people. We also checked all RCCAN documents concerning the investigation and outcome of these ED referrals to seek an explanation for possible differences.

An exploratory study was performed among professional workers at the EDs and the RCCANs that focused on identifying factors that could possibly facilitate or impede successful implementation of the Hague protocol using focus group interviews at the EDs and at the RCCANs. Two EDs per region were included: one from a large hospital and one from a small one. In The Hague, two focus group interviews per ED were held (n = 4), and in Friesland, one interview per ED was held (n = 2). Each individual focus group consisted of four to seven individuals, and we actively invited professionals to participate. The selection of ED nurses and doctors was based on the number of referrals they had made to the RCCAN. We purposely selected those ED nurses and doctors who were involved in using the new guidelines as well as those who appeared less motivated to follow the protocol's guidelines. The interview topics were sent to the participants two weeks prior to the interview. Their home addresses were made available to us by the ED managers after they had informed their staff about our research.

The interviews were led by two researchers and held in the hospital, and each lasted between 60 and 90 minutes depending on the number of participants. The interviews were audio-taped with participants' consent and later transcribed. The RCCAN focus group interviews (n = 2) were organized to include the RCCAN manager, doctors and social workers in both regions using the same method as the ED interviews.

A questionnaire was developed for ED workers containing 26 questions (16 closed, 7 semi-closed and 3 open) regarding work experience with the Hague protocol

(for example: *In your opinion, is the protocol useful in daily practice in effectively screening for child abuse in the ED?*), areas for improvement and factors in successful implementation (for example: *What, in your opinion, are the main barriers to successful use and implementation of the protocol in other EDs?*). We distributed 120 questionnaires to ED workers in four EDs (the same two EDs in each region as were used for the focus group interviews). These were sent to ED doctors, nurses, and nurses in training at their home addresses, which were made available to us by the ED managers, after they had informed their staff about our research. Respondents were asked to return the questionnaires within one month. The participants were informed that all data would be treated confidentially. Two-thirds of the questionnaires were returned completed (n = 80). Four participants indicated a lack of knowledge about the Hague protocol and were discarded from further analysis. A total of 76 (120 - 40 - 4 = 76) questionnaires were available for further analysis using SPSS version 20.0.

Results

The outcomes of the implementation in Friesland are shown in Tables 1-5. One of the most notable outcomes is the increase in the number of referrals from the ED to the RCCAN in Friesland, from 3 to an average of 62 per 100,000 ED patients (Table 1). This agrees closely with our earlier research, which showed a similar increase from one to an average of 64 per 100,000 ED patients in The Hague region (Diderich et al., 2013).

Table 1: Yearly number of referrals of suspected cases of child abuse from Emergency Departments to the RCCAN in Friesland based on parental characteristics.

Number of referrals of child abuse	Before protocol (January 1st 2009 to May 31st 2010)		After protocol implemented (June 1st 2010 to December 31th 2012)		
	2009	2010	2010	2011	2012
Friesland region					
n/N	2 / 65,477*	0 / 26,978**	18 / 37,866**	52 / 66,262	38 / 62,909
Referrals per 100,000	3	0	48	78	60

n = number of referrals of child abuse; N = number of total visits to the ED.
* One hospital could not present the number of ED patients; therefore, we used their number from 2010.
** These hospitals could not present their monthly numbers of ED patients, but these numbers were approximately 5/12 respectively 7/12 of the total number per year; seasonal influences were not visible.

In Table 2, we show the general characteristics of the referred parents in both regions. The percentage of non-Dutch parents who were referred to the RCCAN was much lower in Friesland (14%) than in The Hague region (58%). In both regions, there was a (slight) overrepresentation of the number of referred non-Dutch parents in comparison with the population in the region (Friesland 9%, The Hague 50.5%).

Table 2 General characteristics of the referred cases after implementation of the Hague protocol in Friesland (N = 108) and The Hague (N = 565).

		Friesland	The Hague	χ2-test for percentages
		% (n)	% (n)	
Gender of referred parent	Male	20 (22)	14 (80)	$\chi2 = 2.49$ $p = 0.12$
	Female	80 (86)	84 (476)	
	Both parents	0 (0)	2 (9)	
Ethnicity	Dutch	86 (93)	42 (238)	$\chi2 = 58.12$ $p < 0.00$
	Non-Dutch	14 (15)	58 (281)	
	Unknown	0 (0)	8 (46)	
Number of children	1	42 (45)	45 (256)	$\chi2 = 16.46$ $p < 0.00$
	2	32 (35)	43 (244)	
	3 or more	26 (28)	12 (65)	

The type of parents who were most often referred to the RCCAN in Friesland were those who had attempted suicide (44%), as shown in Table 3. This differs from The Hague region, where domestic violence represented nearly half of all ED referrals (48%) to the RCCAN. The positive predictive value (PPV) of the Hague protocol differed between the two regions: In The Hague, it was 0.91, but Friesland had a lower PPV of 0.62 (Table 4).

Table 3 Types of child abuse referrals from the ED to the RCCAN in Friesland (N = 108) and The Hague (N = 565), based on parental characteristics.

Number of referrals of child abuse from ED to RCCAN based on parental characteristics	Friesland	The Hague
	% (n)	% (n)
Reason for referral to Reporting Center		
Suicide attempt	44 (48)	28 (161)
Substance abuse	21 (23)	14 (78)
Domestic violence	17 (18)	48 (269)
Other*	13 (14)	7 (40)
Combination	5 (5)	3 (17)

* These cases mainly include other psychiatric problems such as confusion or delusion.

Table 4 Positive predictive value of the Hague protocol in Friesland and The Hague.

	Region	Child abuse confirmed % (n/N)	Child abuse not confirmed % (n/N)	No child abuse % (n/N)
All cases	Friesland*	62 (63/101)	17 (17/101)	21 (21/101)
	The Hague*	91 (509/557)	7 (36/557)	2 (12/557)
Combination	Friesland	80 (4/5)	0 (0/5)	20 (1/5)
	The Hague	100 (17/17)	0 (0/17)	0 (0/17)
Domestic violence	Friesland	76 (13/17)	6 (1/17)	18 (3/17)
	The Hague	93 (247/264)	5 (13/264)	2 (4/264)
Suicide attempt	Friesland	68 (30/44)	16 (7/44)	16 (7/44)
	The Hague	89 (143/159)	8 (12/159)	3 (4/159)
Other**	Friesland	50 (6/12)	17 (2/12)	33 (4/12)
	The Hague	87 (34/39)	10 (4/39)	3 (1/39)
Substance abuse	Friesland	44 (10/23)	30 (7/23)	26 (6/23)
	The Hague	87 (68/78)	9 (7/78)	4 (3/78)

* Friesland is missing data for seven cases, and The Hague is missing data for eight cases.
** These cases mainly include other psychiatric problems such as confusion or delusion.

In Table 5, we show that nearly 60% of all children referred from the ED based on parental characteristics in Friesland had been previously unknown to the RCCAN prior to this referral. In The Hague region, nearly three-quarters (73%) of referred children had been previously unknown to the RCCAN.

Main findings from the focus group interviews (n = 6 at EDs and n = 2 at RCCANs) and questionnaires (n = 76)

We analyzed the transcriptions and counted the frequency of the facilitating and Impeding factors that were cited during the six focus group interviews (Table 6).

Table 6 Facilitating and impeding factors from the focus group interviews (n = 6).

	Total	Friesland	The Hague
	n = 6	n = 2	n = 4
Facilitating factors			
1. Facilitator on work floor	6	2	4
2. Education	6	2	4
3. Motivation on work floor	5	2	3
4. RCCAN reporting back to SEH	4	1	3
5. Management support	3	2	1
Impeding factors			
1. Time	6	2	4
2. Education new employees	3	2	1
3. Forgetting	3	1	2

Table 5 Percentage of confirmed child abuse cases previously unknown to the RCCAN in Friesland and The Hague.

	All cases		Substance abuse		Suicide attempt		Domestic violence		Combination		Other**	
	F*	H*	F	H	F	H	F	H	F	H	F	H
Total *n*	63	509	10	68	30	143	13	247	4	17	6	34
New case?	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)
Yes	59 (37)	73 (371)	40 (4)	62 (42)	67 (20)	80 (115)	62 (8)	74 (182)	75 (3)	76 (13)	33 (2)	56 (19)
No	41 (26)	27 (138)	60 (6)	38 (26)	33 (10)	20 (28)	38 (5)	26 (65)	25 (1)	24 (4)	67 (4)	44 (15)

F* F = Friesland, H = The Hague.

** These cases mainly include other psychiatric problems such as confusion or delusion.

Outcomes from focus group interviews at the ED (n = 6)

The ED professionals reported that the Hague protocol was easier to use than the sole previously available detection method based on child markers, particularly because the new method had categories that were clearer and easier to detect; injuries to a child are often difficult to unambiguously attribute to abuse.

Table 6 shows that forgetting to ask patients if they have minors in their care was cited by ED professionals as an impediment in one focus group (n = 1) in Friesland and in two focus groups (n = 2) in The Hague region. Another challenge was time: in particular during peak hours, ED personnel reported not having time to complete all of the Hague protocol's steps (n = 6). Respondents also cited lack of new employee training on the Hague protocol as an impediment. Because of the high turnover of ED personnel, it was not always feasible to raise awareness of the Hague protocol through training (n = 1 in Friesland, n = 2 in The Hague). Adequate training, both written and face-to-face, was identified as being essential (n = 6). All participants (n = 6) further indicated that having an implementation coach on the work floor was essential for success.

The ideal coach was described as a nurse or doctor with experience in this topic and with excellent communication skills. Another facilitating factor cited by the ED professionals (n = 4) concerned the feedback letter describing the assessment and support offered by the RCCAN following a referral, which was considered an incentive for continued use of the protocol. According to some participants (n = 2 in Friesland, n = 3 in The Hague), successful implementation depends on the coach on the work floor. This coach can convince ED nurses and doctors of the added value of these guidelines and offer support when there is reluctance to inform parents about their referrals to the RCCAN. When a new protocol is imposed without information or consultation, it can lead to resistance. Overall, as shown in Table 6, regardless of the nature of implementation (bottom-up or top-down), participants from both regions valued the same facilitating factors and cited the same possible barriers to future implementation.

Outcomes from focus group interviews at the RCCAN (n = 2)

Participants from both RCCANs perceived the Hague protocol as useful and efficient for detecting child abuse. They received more referrals from the EDs than they had prior to implementation. They noted that some referral forms contained only a minimum of information and were difficult to read because of illegible handwriting or medical terminology, and these were regarded as impediments. As a barrier to future

implementation at other RCCANs, it was discussed that current capacity could be inadequate for managing the increase in referrals. In addition, in The Hague region, it was feared that limitations in monetary and human resources could undermine future application.

Outcomes from the questionnaires (n = 76)

The ED work experience of the doctors (n = 23), nurses (n = 50), and student nurses (n = 3) ranged from one month to thirty years. Nine participants had never referred a child to the RCCAN. Reasons given for not referring varied: 'I always ask the doctor to talk to the patient about these guidelines' or 'I have just started working here, and I have never treated patients included in the guidelines'. Although 24.3% (n = 18) had previously had a negative experience (mostly with aggressive parents), the majority indicated that this would not stop them from making referrals. Among the participants, 76.3% (n = 58) remembered having been instructed about the new guidelines, but 43.9% (n = 29) found they needed more information.

Before the implementation, an implementation coach was appointed on the work floor, and information about the new guidelines was provided. Sixty-six participants (86.8%) acknowledged being aware of the presence of this coordinator and of the guidelines. More than 90% of the ED professionals felt supported by their peer workers and superiors in screening for child abuse according to the Hague protocol's guidelines.

Discussion

The goal of this study was to assess the feasibility of implementing the Hague protocol as a whole in a region other than where the protocol was, to a large extent, informally developed. Prior research into the effects of implementing the Hague protocol in its region of origin showed a large increase in the number of children referred to the RCCAN (from one to 64 per 100,000 ED appearances), with a positive predictive value (PPV) of 0.91 (Diderich et al., 2013). This study demonstrated that the Hague protocol can be successfully implemented in a new region, with an increase in the number of referred children from three to an average of 62 per 100,000 ED presentations.

The most striking finding was the difference between the Friesland and The Hague regions in RCCAN confirmation of child abuse, as reflected in the high positive predictive value of 0.91 in The Hague and the relatively lower positive predictive value of 0.62 in Friesland.

The RCCAN in The Hague region was already aware of the importance of parental characteristics in detecting child abuse before the protocol was introduced is part of the explanation. In contrast, the RCCAN in Friesland was still investigating the referrals based on parental characteristics as if they had been based on child characteristics. A follow-up inquiry at the RCCAN in Friesland confirmed that the focus on child markers rather than parental characteristics had influenced the staff's conclusions regarding the presence or absence of child abuse in these referrals. Subsequently, professionals from the Friesland RCCAN were invited to The Hague to discuss how RCCAN Friesland could learn from the experience for future parent referrals. This led to the adaptation of its policy of addressing referrals based on parental characteristics, in line with the approach in The Hague.

Facilitating and impeding factors to implementation

The focus group interviews with ED and RCCAN professionals and questionnaires among ED workers provided insight into the facilitating and impeding factors that are critical for successful implementation.

Facilitating factors

Francke, Smit, de Veer, and Mistiaen (2008) found that when guidelines can be easily understood and implemented, the chance that they will be used greatly increases; all of our participants found the Hague protocol guidelines to be clear. Education was provided by colleagues who work with the protocol on a daily basis, which makes it possible to share experiences. Previous research has confirmed this to be a positive determinant in other contexts (Wensing, Bal, and Friele, 2012). Additionally, that the Hague protocol was user-friendly, developed on the work floor and implemented 'bottom-up' could be considered a facilitating factor.

Similar to Cabana et al. (1999),we found that peer and management support were important for the successful implementation of guidelines. In addition, when professionals are directly and actively involved in implementation, there is greater awareness (Francke et al., 2008). All of the ED and RCCAN workers had played an active role in the daily implementation of the Hague protocol. Finally, the presence of a implementation coach on the work floor who gives feedback to colleagues about the protocol's effects was perceived as motivating, which is in line with findings of Belizan et al. (2007).

Impediments

Lack of time is commonly cited as an impediment to following guidelines, especially in EDs, hectic workplaces where patients require immediate medical care (e.g., trauma patients, patients needing resuscitation). Some guidelines are considered to be too time-consuming and are not assigned a high priority. Nevertheless, lack of time did not prevent the ED professionals from following the Hague protocol guidelines, and inventive solutions (for example, completing the forms after working hours) were identified that made it possible to implement the protocol.

Because of the high turnover in ED personnel, continuous education is crucial for successful implementation, as described by Grol and Grimshaw (2003). However, education requires an investment of considerable resources, which could be considered a barrier. A possible solution could be embedding the subject of screening for child maltreatment based on parental characteristics in the standard education that nurses and doctors receive during their introduction periods at their hospitals.

Strengths and limitations of the study

Strengths

The protocol has already been in place for a number of years in The Hague region, which serves as a reference group for studying implementation in a new region, and, additionally, nationwide. We used a number of research methods to assess the critical factors for the successful implementation of the Hague protocol. Professionals from the EDs and RCCANs completed extensive questionnaires, and we visited multiple EDs and RCCANs for focus group interviews, yielding a significant number of perspectives from our participants. Finally, the hospitals and the RCCAN in the Friesland region deserve our gratitude for their willingness to implement the Hague protocol, their openness to our suggestions for improvement and that they actually executed these suggestions afterwards. The proportion of returned questionnaires (66%) was a good return yield for mailed questionnaires among medical professionals (Cummings, Savitz, & Konrad, 2001), and the focus groups were constructive.

Limitations

A limitation of our study is that 34% of the questionnaires were not returned, and we thus have no information concerning these ED professionals. However, we have no indications that the composition of this group substantially differed from that of the group who

completed the questionnaires because in the responder group, no overrepresentation of one specific group in profession, age or years on the job was found.

Another limitation could be that the answers were scored at an individual rather than a group level; during the group interviews, participants might have influenced each other. However, we have no reason to suspect that the answers obtained from the focus groups were in any way influenced by the social setting or by any social desirability considerations. Had that been the case, we would have found substantial discrepancies between the outcomes of the focus groups interviews and the results of the individually completed questionnaires, but this was not the case.

This study did not delineate abuse types, and it therefore is unclear whether the Hague protocol works equally well for physical, sexual, and emotional abuse and neglect. In our previous study on the protocol's effectiveness, all outcomes on types of maltreatment found by the RCCAN after investigation were listed (Diderich et al., 2013). The main type of abuse was having witnessed domestic violence (39.8%). It is important to realize that whatever the outcome of the investigation, the main goal of this approach is the early detection of child abuse. The Hague protocol leads to the early detection of child maltreatment on the basis of parental characteristics before there has been time for the child to develop clear-cut evidence of maltreatment, which would be detected much later on the basis of child characteristics. Because the actual number of missed cases cannot be determined, it is difficult to predict whether the Hague protocol is the only tool that should be added to raise the number of detected child maltreatment cases in EDs.

Finally, since the Hawthorne effect was coined by Henry Lansberger in 1950 (Gillespie, 1991), it is known that there may be improvement or modification simply as a result of the implementation of a new protocol, regardless of what the protocol specifically entails. Indeed, we cannot rule out that the implementation of the new protocol and the associated training produced a generally increased vigilance regarding child maltreatment. This vigilance may have caused an increase in reporting irrespective of the three parental categories specified by the Hague protocol.

Although we recognize this as a limitation of the current study, we consider it unlikely that this alone explains the increase in referrals. Other initiatives aimed at increasing the number of referrals have not yielded similar increases. For example, the increased supervision in the Netherlands imposed by the Health Inspectorate in 2008 did not lead to

similar increases in the absence of the Hague protocol, as would have been implied by a Hawthorne explanation of the current findings (Diderich et al., 2013).

Conclusion

The Hague protocol is not only effective in detecting child abuse, but it can also be implemented successfully in other regions that are quite distinct from the initial implementation region.

Implementation should be prepared for and organized in both EDs and the RCCANs. An important finding in our study is that the RCCANs need to recognize that victims of child abuse do not always display clear signs of abuse. Knowing that these children live in conditions under which they are at high risk of becoming victims of abuse (reflected in these reasons for their parents' presentation at EDs: domestic violence, substance abuse or a suicide attempt) is sufficient cause for concern.

In view of the high predictive value of the Hague protocol and of studies that report that these parents have a high risk of abusing or neglecting their children (Dube et al., 2001; Fantuzzo et al., 1997; Finkelhor, Turner, Ormrod, & Hamby, 2009; Hien, Cohen, Caldeira, Flom, & Wasserman, 2010; Kelleher et al., 1994; Windham et al., 2004; Wright et al., 1997), we consider it ethically responsible to target the specific parental characteristics outlined in the protocol.

Because the aim of the Hague protocol is the early detection of child abuse based on parental characteristics, it can, in some cases, help prevent more serious forms of child abuse. Providing additional information about the Hague protocol and the importance of parental characteristics in identifying the risk of child abuse to institutions such as the RCCAN may thus contribute to a more preemptive approach to child abuse, sparing children any potentially traumatic experiences.

In this study, we identified vital facilitators and impediments that can be taken into account in the national rollout of the Hague protocol. This approach has proven to be an innovative new tool - using parental characteristics identified in the ED helps detect children who are victims of child abuse who would not otherwise have been detected at the time.

We acknowledge the differences in cultural and judicial backgrounds as well as the organization of facilities concerning child abuse and neglect between the Netherlands and other countries. However, we have shown that the use of the Hague protocol to screen for child abuse based on parental characteristics in other settings is possible, provided that attention is paid to facilitators and barriers to implementation. In this way, many more maltreated children can be detected, and help and support can be offered to them and their families.

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Chapter 4

Missed cases in the detection of child abuse based on parental characteristics in the emergency department (the Hague protocol)

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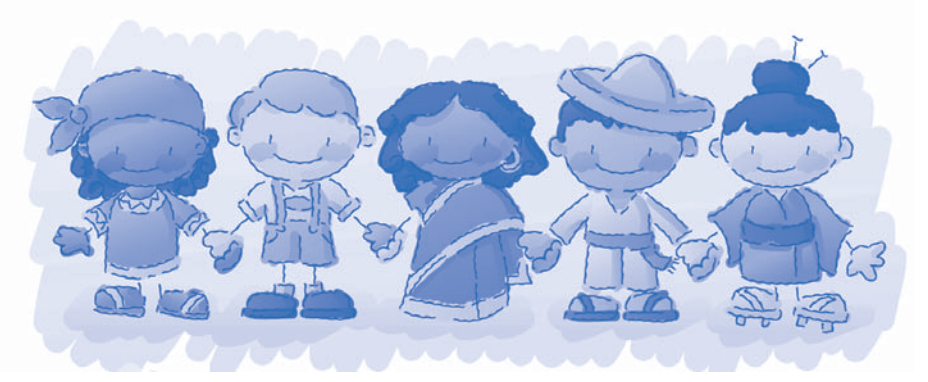

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ABSTRACT

Introduction: We aimed to assess the number of “missed cases” in the detection of child abuse based on the Hague protocol. This protocol considers 3 parental characteristics of ED adult patients to identify child abuse: (1) domestic violence, (2) intoxication, and (3) suicide attempt or auto-mutilation.

Methods: This study focuses on parents whose children should have been referred to the Reporting Center for Child Abuse and Neglect (RCCAN) in The Hague, the Netherlands, according to the guidelines of the Hague protocol. Data were collected from all referrals by the Medical Center Haaglanden (Medical Center Haaglanden) to the RCCAN in The Hague between July 1 and December 31, 2011. The hospital’s database was searched to determine whether the parents had visited the emergency department in the 12 months before their child’s referral to the RCCAN.

Results: Eight missed cases out of 120 cases were found. The reasons for not referring were as follows: forgetting to ask about children and assuming that it was not necessary to refer children if parents indicated that they were already receiving some form of family support.

Discussion: Barriers to identifying missing cases could be relatively easy to overcome. Regular training of emergency nurses and an automated alert in the electronic health record to prompt clinicians and emergency nurses may help prevent cases being missed in the future.

Introduction

Child abuse is a serious social problem, and despite efforts to develop effective screening tools, the number of child abuse cases is still underreported. Research shows that a total of 676,569 children were referred in 2011 to Child Protective Services in the United States,[1] and on average, 19,254 children are referred yearly to the Reporting Center for Child Abuse and Neglect (RCCAN) in the Netherlands.[2] Prevalence studies conducted in both countries underline the gravity of the problem; in the US an estimated 2,905,800 (or 39.5 per 1,000) children were victims of maltreatment in the study year 2005/2006.[3] In the Netherlands an estimated 119,000 (or 34 per 1,000) children are victims of child abuse every year.[4]

The emergency department is the frontline of the hospital and, therefore, the filter of the organization to identify child maltreatment. Over the past few years, many studies have been conducted to discover reasons for the low numbers of child abuse reports from emergency departments.[5] Systematic screening for child abuse in the emergency department and training ED staff in the Netherlands have proven effective in increasing the number of referred child abuse cases [6], but the number of children detected in the emergency department is still too low.[7] Woodman et al. [8] conducted a systematic review to evaluate three markers (young age, specific types of injury, and previous attendance in the emergency department for physical abuse or neglect) in injured children attending the emergency department. They concluded that these child-based markers have a low validity and can lead to an unacceptable number of incorrectly suspected parents (false positives) when used for detecting cases of child abuse.

It is questionable whether focusing on children visiting the pediatric emergency department is the only method to detect child abuse. This was the reason a new protocol for the detection of child abuse (the Hague protocol) was created in 2007 in the emergency department at the Medical Center Haaglanden (MCH) in the Hague, the Netherlands.[9] The principle of this new approach is to focus on patients who are responsible for the care of minors and who attend the adult section of the emergency department after (1) domestic violence, (2) substance abuse, or (3) a suicide attempt. Their children are referred to the RCCAN, which investigates the domestic situation and offer the family voluntary community-based services when indicated. The Hague protocol is successful in detecting new cases of child abuse.[9]

Between January 2006 and November 2007, before the introduction of the Hague protocol, a total of four parents out of 385,626 patients attending the emergency department in the intervention region (approximately one per 100,000) were referred to the RCCAN. In the period after the introduction of the Hague protocol (December 2007 to December 2011), the number rose to 565 parents out of 885,301 ED patients (approximately 64 per 100,000). Child abuse was confirmed in 91% of referred cases after assessment. The Dutch Ministry of Health, Welfare and Sports has made this approach of detecting child abuse based on parental characteristics mandatory for all Dutch emergency departments, ambulance services, and general practitioner clinics (during non-office hours).

Although the Hague protocol has proved to be very efficient,[9] we sought to investigate whether cases of child abuse based on parental characteristics were missed. This study was conducted to answer the following research question: In emergency departments that use the Hague protocol, are there cases of child abuse based on parental characteristics being missed despite working with the Hague protocol? If so, why were these missed cases not referred?

Methods

Procedure of the Hague protocol

The Hague protocol includes three parental categories: (1) domestic violence, (2) intoxication with alcohol or drugs, and (3) suicide attempt or auto-mutilation.[10–12] The protocol prescribes that when a parent attends the emergency department with one of these problems, his or her children should be referred to the RCCAN. Because emergency nurses have intensive contact with patients, they are usually the best professionals to explain the procedure to parents. Therefore most referrals from the MCH emergency department to the RCCAN are made by emergency nurses.

The RCCAN is a non-judicial organization, specializing in conducting investigations concerning child abuse and neglect and providing voluntary community-based services for the family. Its professionals (medical doctors, social workers, and behavioral specialists for children) invite the parents and their children, within 12 days of referral, to the professionals' offices to evaluate the problems and offer them community-based support. Although the RCCAN is not a judicial organization, it has the authority to refer children

to Child Protective Services, which can intervene with serious measures if children are in danger or parents are not willing to comply.

Study design, setting, and data source

This study was a secondary analysis of RCCAN referrals in the Hague region. All RCCAN referrals in the Hague region that were not derived from parental reports from an emergency department and were confirmed as child abuse were gathered over a period of six months (July 1 to December 31, 2011). The MCH database was searched to investigate whether the parents of these children had visited the emergency department of the MCH in the 12 months before referral of their child to the RCCAN. Consequently, the search covered a period of 18 months including the six-month data collection (July 1, 2010, to December 31, 2011). Using this method, we found a group of parents whose children should have been referred according to the Hague protocol's guidelines when they attended the emergency department. These are referred to as "missed cases". A researcher reviewed the parents' ED records to investigate why a referral was not made to the RCCAN according to the protocol's guidelines.

Results

A total of 112 referrals based on parental characteristics were made from the emergency department to the RCCAN in the 18-month period (July 1, 2010 to December 31, 2011). During the six-month study period, 108 parents were found who had visited the emergency department of the MCH in the year before their children were referred to the RCCAN. On the basis of the Hague protocol's guidelines, eight of these cases should have been referred. These parents had visited the emergency department for one of the reasons that are part of the protocol's criteria, that is, after a suicide attempt, substance abuse, or domestic violence. We investigated the file of the parent's ED visit for each of these eight missed cases to find the reason that the child or children were not referred to the RCCAN. In four cases there was no registration in the patient's file that he or she had children. We could not deduce from the file whether the ED professional had asked the patient if he or she was responsible for minors or whether the question was asked but the answer was not reported in the patient's file.

The medical record of one patient mentioned that the children were not present during the suicide attempt but were staying with the patient's ex-partner. The children of another patient were not referred because a family guardian had been appointed and, according

to the patient, the police were already involved. In the remaining two cases, the medical records stated that the patients were asked about children but no explanation of why the RCCAN had not been notified could be found. As shown in the Table, the parents attended the emergency department after domestic violence in three of the eight missed cases, after a suicide attempt in two cases, and after substance abuse in another two cases, and in one case there was a combination of substance abuse and domestic violence. Among these eight cases, the type of child maltreatment found by the RCCAN was classified as "witnessing domestic violence" in six cases, and in the other two cases, the conclusion was "educational neglect."

Table. Reasons parents were admitted to emergency department (N = 8).

Reason for ED referral	Number of parents (*n*)
Domestic violence	3
Suicide attempt	2
Substance abuse	2
Combination	1

Discussion

Emergency departments are very busy workplaces,[13,14] and when professionals are burdened with extra tasks, some tasks may be forgotten. In the implementation process, one should take into account that some children will be missed for the reasons previously mentioned. Assuming that a referral is not necessary because a patient states that he or she already receives some kind of support is an understandable mistake. It is not possible for ED professionals to check this during the parent's ED attendance. Therefore it is vital that these children are also reported to the RCCAN. The RCCAN can check whether the children receive sufficient support and notify the authority involved about the current ED visit of the parent. In our opinion, the reasons for emergency nurses and physicians not referring according to the protocol's guidelines should be relatively easy to overcome. Finding ways to remind them to ask about the presence of minors could be a solution. An automated alert in the electronic health record to prompt clinicians and emergency nurses when key words such as "drug abuse" or "suicide attempt" are entered could be helpful. Grol and Grimshaw[15] found that interactive and continuous training for professionals can help in changing practice. This could help nurses and physicians to

become and stay alert about parental reasons for attending the emergency department. The training should also focus on situations in which parents indicate that they are already receiving support.

Limitations

Although no other studies were found in the literature describing the use of these guidelines, it is possible that this method is being used in other emergency departments. In this study our aim was to assess the number of missed cases in the detection of child abuse based on the Hague protocol. We found eight missed cases out of 120 cases (112 were referred according to the guidelines), which is not an insurmountable number. However, this finding is important because the guidelines of the Hague protocol will be used nationally in the Netherlands and the numbers will add up.

Implications for Emergency Nurses

The involvement of emergency nurses is critical in preventing missed cases because they refer many of these children to the RCCAN and they are the most stable factor in the emergency department. Regular training of emergency nurses and physicians and adding a reminder in the ED nursing and medical files will improve the chance that these families receive the support they need. Detecting child abuse based on parental characteristics has proven to be very successful and should be combined with the regular child screening methods in all emergency departments. This will help in detecting more victims of child maltreatment and offering them the necessary support.

Conclusion

Detecting child abuse based on parental characteristics has proven to be very successful and should be combined with the regular child abuse screening methods in all emergency departments. This will help in detecting more victims of child maltreatment and offering them the necessary support.

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Chapter 5

What parental characteristics can predict child maltreatment at the Emergency Department? Considering expansion of the Hague protocol

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ABSTRACT

The Hague protocol considers three parental characteristics of Emergency Department adult patients to identify child abuse: (a) domestic violence, (b) intoxication, and (c) suicide attempt or auto mutilation. This study investigated whether additional parental characteristics could be included to improve the chance of detection. Using a nested case-control design, we compared parents identified as child abusers who were missed by the protocol with a matched group of non-abusing parents, The parental characteristics used were, among others, all physical injuries possibly resulting from domestic violence, psychological, or mental complaints that might indicate elevated domestic stress levels and the number of Emergency Department visits during the previous year.

None of the characteristics were statistically significantly associated with child abuse. The Hague protocol will not be improved by adding one or more of the characteristics that were investigated.

Introduction

The Emergency Department (ED) is the hospital frontline and a suitable location to detect child abuse. Currently, however, this potential is insufficiently realized, The Dutch Inspectorate has highlighted this issue [1] . To improve the efficiency of child abuse detection at the ED, a new protocol, called the 'Hague protocol', was created at the ED in the Medical Center Haaglanden (MCH) in The Hague in 2007 [2]. The focus of this protocol is based on parents (not on children) attending the adult ED seeking medical assistance after (a) domestic violence; (b) intoxication with alcohol or drugs; and (c) suicide attempt or auto mutilation. ED professionals ask these patients whether they are responsible for minors or whether the patient is pregnant. If this is the case, their children will be referred to the Reporting Center for Child Abuse and Neglect (RCCAN). The referral is based on the knowledge that the children of these parents have a high risk of being, or becoming, victims of maltreatment [3-7]. The RCCAN is a non-judicial institute. It investigates the situation and offers voluntary community-based services, or in severe cases, hands them over to the Child Protective Service (CPS).

The RCCAN professionals (medical doctor, social worker, and child behavioral specialist) invite the family for an interview and evaluate the problems. The Hague protocol has proven to be very successful. Before its introduction (2006-2007), a total of four parents out of 385 626 patients attending the ED (one per 100 000) were referred to the RCCAN. In the period after its introduction (2008-2011), the number increased to 565 parents out of 885 301 patients (64 per 100 000). At assessment, child abuse was confirmed in 91% of referred cases [2]. The Dutch Government has made the detection of child abuse on the basis of parental characteristics mandatory for all medical professionals. Knowing that the Hague protocol has a high positive predictive value (PPV), we set out to investigate whether it could be broadened by the addition of extra categories of parental characteristics and thereby enhance the already high PPV. We aimed to find characteristics that would distinguish parents who are perpetrators of child abuse from parents who do not abuse their children.

Materials and methods

We investigated parents who attended the ED and who were identified as potential child abusers by the RCCAN, but did not fit into the three categories of the protocol.

We compared these child abuse cases with similar cases of parents whose children were not referred to the RCCAN.

From July 1st, 2011 to December 31st, 2011 (six months), we collected all RCCAN child referrals from The Hague region that were not derived from an ED. We then searched the MCH hospital's database to investigate whether one or both parents of these children had visited the ED at the MCH during a 12-month period before referral of their child to the RCCAN, and if so, for what reason. Parents who were admitted to the ED for reasons not included in the protocol guidelines were collected and labeled as 'rightfully missed" (RM).

We investigated this 'RM group' for distinctive characteristics relative to a control group using a nested case-control design, in which we matched this RM group with a 'control group'. The control group included parents who attended the MCH adult ED during the same period as the RM parents. Each RM-control group pair was also matched on the basis of three characteristics: age, sex, and postal code.

The RM group was compared with the control group on a number of variables: that is, (a) all physical injuries possibly resulting from domestic violence; (b) psychological or mental complaints that might indicate elevated domestic stress levels (e.g. cardiac pain or hyperventilation); (c) number of ED visits during the previous year; (d) patients transported to the ED by ambulance; and (e) having a positive Audit-C score. The Audit-C is an alcohol screening that can help identify patients who are hazardous drinkers or have active alcohol use disorders, including alcohol abuse or dependence [8].

Injuries that possibly could have resulted from domestic violence were grouped into various categories (e.g. wounds, concussion, fracture). According to the protocol's guidelines, children of parents who are admitted to the ED as a result of domestic violence are automatically referred to the RCCAN. The cases in this study are not. This 'theoretically possible domestic violence' group, used as a variable, includes all parents whose injuries, in theory, could have been a result of domestic violence. They were not referred to the RCCAN because their injury, behavior, or history did not strike the ED professional as a clear domestic violence case. Nevertheless, this group was used as a variable to explore whether a specific injury might be significant enough to be added to the current categories.

Statistical analyses

Data from cases and controls were analyzed as matched pairs. Differences between the two groups were examined using McNemar's test (for categorical variables) and dependent *t*-tests for continuous variables. Analyses were carried out using SPSS, version 20.0 (IBM Corp., Armonk, NY, USA). For all tests, a two-tailed significance level of 0.05 was used.

Table 1: Various factors present in the group 'Rightfully missed' cases (N = 100) and the control cases (N = 100).

	'Rightfully missed' cases (*n*)	Control cases (*n*)	Significance
Medical Diagnosis			
Possible Domestic Violence			
No	76	66	0.164
Yes	24	34	
Stress-related symptoms			
No	90	96	0.180
Yes	10	4	
Excessive alcohol usage			
No	97	97	1.00
Yes	3	3	
Referred by the general practitioner			
No	81	80	1.00
Yes	19	20	
Diagnosis hyperventilation			
No	97	97	1.00
Yes	3	3	
A specific cardiac pain			
No	97	99	0.625
Yes	3	1	
Gynecological problems			
No	91	95	0.388
Yes	9	5	
Mode of transport to ED			
Ambulance	12	8	0.388
Other	88	92	
Mean (SD)			
Number of MCH ED visits previous year	3.2 (5.0)	2.7 (3.8)	0.388

note: ED: Emergency Department, MCH: Medical Center Haaglanden

Results

The RM group was compared with the matched control group on a number of variables. None of these showed a significant difference between the RM group and the control group (Table 1). As shown in Table 1, one quarter of the RM group and 34% of the parents in the control group had injuries that theoretically could have been sustained by domestic violence. Specifying the variables of injuries possibly caused by domestic violence (Table 2) did not indicate any significant difference between the groups.

Table 2: Types of injuries possibly caused by domestic violence (N = 100).

	'Rightfully missed' cases (*n*)	Control cases (*n*)	Significance
Medical diagnosis			
Fracture			
No	95	93	0.774
Yes	5	7	
Wounds			
No	94	92	0.607
Yes	6	2	
Contusion			
No	86	86	1.000
Yes	14	14	
Head or neck trauma			
No	100	97	-
Yes	0	3	
Brain injury			
No	100	98	-
Yes	0	2	

Discussion

The numbers of patients in this study are not very large; however, it is large enough to provide insight into strong predictors. None of the variables studied were prevalent among the child abusers or in the control group. Therefore, our results indicate that the variables studied are not strong predictors of child abuse. Future research could test our findings in a prospective study.

Another limitation involves the parents in our control group. Although their children were unknown to the RCCAN, there is a small chance that they could be perpetrators of child abuse.

The Hague protocol has a high predictive value [2]. If it were possible to improve the detection of child maltreatment by adding extra groups of parental characteristics, it could be a breakthrough. However, no scientific grounds were found to expand the protocols' guidelines with one or more parental categories.

The results also show that haphazardly referring children of parents who are admitted to the ED with any type of injury could lead to many false-positive referrals. Of course, this outcome does not excuse ED professionals from remaining alert in these situations. Studies by Boursnell and Prosser [9] and McMurray [10] showed that specialized training of ED professionals can improve their confidence, practice, and skills in the identification of domestic violence.

This can be substantiated by the outcomes of the study by Diderich et.al. [2], where all ED professionals were trained before implementation and child maltreatment was not confirmed by the RCCAN in only 2% of all referrals on the basis of parental characteristics (n=565).

Conclusion

The PPV for detection of child abuse on the basis of the parental characteristic of the Hague protocol is high, namely, 0.91. This study shows that the additional characteristics studied will not improve the validity of the protocol. Doing so could lead to many 'false-positive' referrals that could undermine the credibility of the protocol. We therefore conclude that the Hague protocol is very valuable as it is. At present, there are no good reasons to extend it.

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Chapter 6

Support and monitoring of families after child abuse detection based on parental characteristics at the Emergency Department

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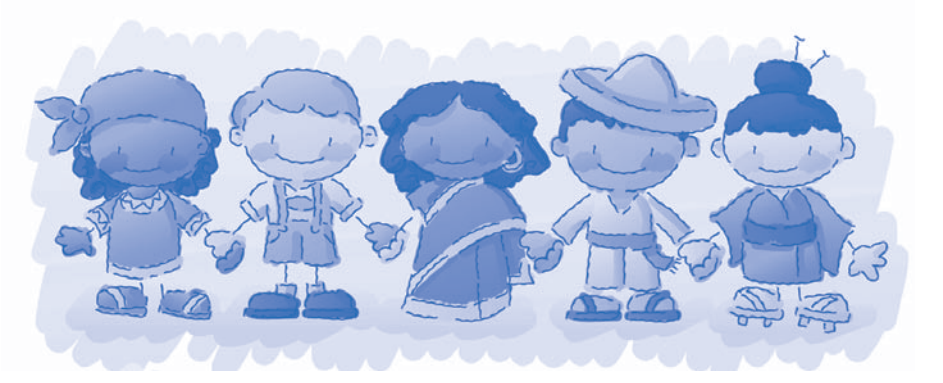

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ABSTRACT

Background The 'Hague protocol' enables professionals at the adult Emergency Department (ED) to detect child abuse based on three parental characteristics: (i) suicide attempt or self-harm, (ii) domestic violence or (iii) substance abuse, and to refer them to the Reporting Center for Child Abuse and Neglect (RCCAN).This study investigates what had happened to the families three months after this referral.

Method ED referrals based on parental characteristics (N = 100) in which child abuse was confirmed after investigation by the RCCAN were analyzed. Information was collected regarding type of child abuse, reason for reporting, duration of problems prior to the ED referral, previous involvement of support services or other agencies, re-occurrence of the problems and outcome of the RCCAN monitoring according to professionals and the families.

Results Of the 100 referred cases, 68 families were already known to the RCCAN, the police or family support services, prior to the ED referral. Of the 99 cases where information was available, existing support was continued or intensified in 31, a Child Protection Services (CPS) report had to be made in 24, new support was organized for 27 cases and in 17 cases support was not necessary, because the domestic problems were already resolved. Even though the RCCAN is mandated to monitor all referred families after three months, 31 cases which were referred internally were not followed up.

Conclusion Before referral by the ED two thirds of these families were already known to organizations. Monitoring may help provide a better, more sustained service and prevent and resolve domestic problems. A national database could help to link data and to streamline care for victims and families. We recommend a Randomized Controlled Trial to test the effectiveness of this protocol in combination with the outcomes of the provided family support.

Introduction

The hospital Emergency Department (ED) is a location where child abuse may be expected to be detected. Yet, in the Netherlands, only 4% of all reports made to the Reporting Center for Child Abuse and Neglect (RCCAN) are made by ED professionals (IGZ, 2008). In the United States, where all professionals are mandated to report child abuse, only 8.4% of all Child Protective Services (CPS) reports come from medical professionals (US Department of Health and Human Services, 2011).

Clinicians' lack of awareness and training (Paavilainen et al. 2002) and the absence of reliable screening tools (Woodman et al. 2010) have been proposed as possible explanations. Louwers and colleagues (2012) reported that screening tools based on characteristics of children attending the ED can, to some extent, be successful in screening for child abuse. In 2007, a new protocol was introduced at five EDs in The Hague, the Netherlands. This protocol detects child abuse using a screening tool based on parental rather than child characteristics. This so called 'Hague protocol' recommends referral of children to the RCCAN when an adult patient attends an adult ED as a direct result of (i) suicide attempt or self-harm, (ii) substance abuse or (iii) domestic violence (also even if the patient denies being a victim).These patients are asked by the ED nurse or doctor whether they are pregnant or responsible for minors, if this is the case these children will be referred to the RCCAN, who will start an investigation.

The Hague protocol is a feasible and accurate screening tool as demonstrated by the observation that in 91% of the referrals, child abuse is substantiated by the RCCAN investigation (Diderich et al. 2013).

In July 2013, the Dutch Government made detection of child abuse based on parental characteristics according to the Hague protocol mandatory for all Dutch medical professionals (Meldcode Kindermishandeling en Huiselijk Geweld 2013). If the child's safety and well-being cannot be assessed by a medical professional, the professional has to either; (i) refer the children to the RCCAN in accordance with the guidelines of the Hague protocol (the RCCAN then takes over the responsibility) or (ii) arrange appropriate support services without involvement of the RCCAN (Fig. 1). In the latter case, the professional remains responsible for the child's well-being until confirmation is received that the child and/or the parents have been accepted by the designated support services.

In this study, we reviewed the cases of 100 referrals from the ED to the RCCAN in accordance with the protocol's guidelines and investigated whether the parents and children received the necessary support.

This study attempts to answer the following four questions:

What proportion of children and parents were already known to the RCCAN, other support services or the police prior to referral by the ED?

How long did it take for the RCCAN to contact these families?

What support was offered after investigation by RCCAN?

How were families getting on three months after support or help was initiated?

Background

The RCCAN is a sub-department of Bureau Jeugdzorg (BJZ), a non-judicial government funded organization. BJZ can be compared with Youth Care in the United States of America or the Children's Social Care Services in The United Kingdom (Wolfe & McKee 2014). At the RCCAN, medical doctors, social workers and child behavioral specialists investigate suspected child abuse cases following referrals by professionals and non-professionals (family, neighbors, etc.). If a health care professional refers a child to the RCCAN on the basis of parental characteristics, the RCCAN will conduct an investigation or refer the case to BJZ in those cases where a legal guardian has already been appointed for the family (Fig. 1).

For this investigation, the RCCAN invites families to their office or carries out a home visit if parents have serious mental health or addiction problems. A behavioral specialist assesses all children from the age of six upwards, while a social worker and medical doctor discuss the identified problems with the parents. Then the RCCAN professionals will determine, using CARE-nl criteria (de Ruiter & de Jong 2005), whether child abuse or neglect is 'substantiated'. If substantiated, a voluntary, community-based support plan is developed with the parents' consent. Parents are offered a variety of types of support, including psychiatric help, financial support, anger management therapy or enrolment in a drugs or alcohol rehabilitation program tailored to their requirements.

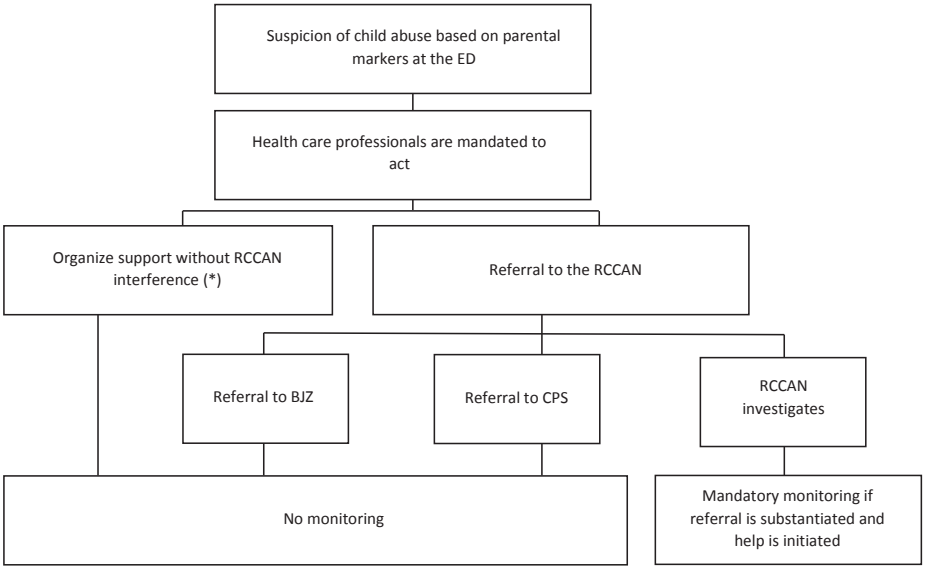

Figure 1. Steps to be followed by health care professionals.

*e.g. parenting classes, anger management classes, alcohol and drugs programs.
ED = Emergency Department; RCCAN = Reporting Center for Child Abuse and Neglect, BJZ = Bureau Jeugdzorg, CPS = Child Protective Services

When parents are unwilling to cooperate with the voluntary support services, or in cases of severe child maltreatment, the children are referred to the Child Protective Services (CPS), a judicial agency which has the authority to impose mandatory measures. The RCCAN and the CPS are the only institutes in the Netherlands allowed to conduct an investigation concerning the child's welfare, if necessary, without the parents' approval. If the presence of child maltreatment is substantiated, all data concerning children in the family will remain in the RCCAN / CPS database until the youngest child in the family is eighteen years old.

Methods

A total of 178 children were reported to the RCCAN from the ED of the Medical Center Haaglanden between 1 January and 31 December 2011. One hundred RCCAN files of children referred in this period from the EDs on the basis of parental characteristics were investigated. The 100 cases used in this research were selected, by taking all uneven case

numbers (n = 89) and adding the first referral from the first 11 months (n = 11) to get a total of 100 cases.

One of the authors (P.J.G.S.) extracted data from these files using a previously developed checklist, which contained questions pertaining to: type of child abuse, reason for parental report by the ED, duration of the problems prior to the ED referral and whether support was initiated for the children and their parents and the type of support. The notes made by the RCCAN at evaluation, three months after the initial investigation to determine whether the received support had been adequate were also checked. In these notes, we checked whether the children had been referred yet again in the three months interval between referral and evaluation and if the professionals now assisting these families were satisfied with the progress made. This information was taken as an indication of the current state of affairs within the family. As the RCCAN files often failed to clearly state the time at which the problems had started, a dichotomy was made to analyze the problem duration, whereby single, isolated incidents were differentiated from long-term, persistent problems.

Results

Families known to the RCCAN prior to referral by ED

As shown in Fig. 2, the family was already known to the RCCAN, the police or family support services in 68 of 100 cases (in Fig. 2 combined under the heading ‘organizations’). In 20 of these 68 cases, only the parent was known, in three cases only the children and in the remaining 45 cases both the parent and children were known. This means that 32 cases were newly detected families, who were unknown to services prior to the ED referral. In 16 of the 48 cases (45 both child and parent known plus 3 only child known) the children had previously been referred to a single organization, the others were known at up to six different organizations (e.g. social services, CPS, Youth Care, police). In 23 of these 48 cases the children were already known to the RCCAN prior to the ED referral. The parents were known to a single organization in almost half (n = 31) of the cases and the others received help from two to six organizations (e.g. rehabilitation center, anger management, police, social services).

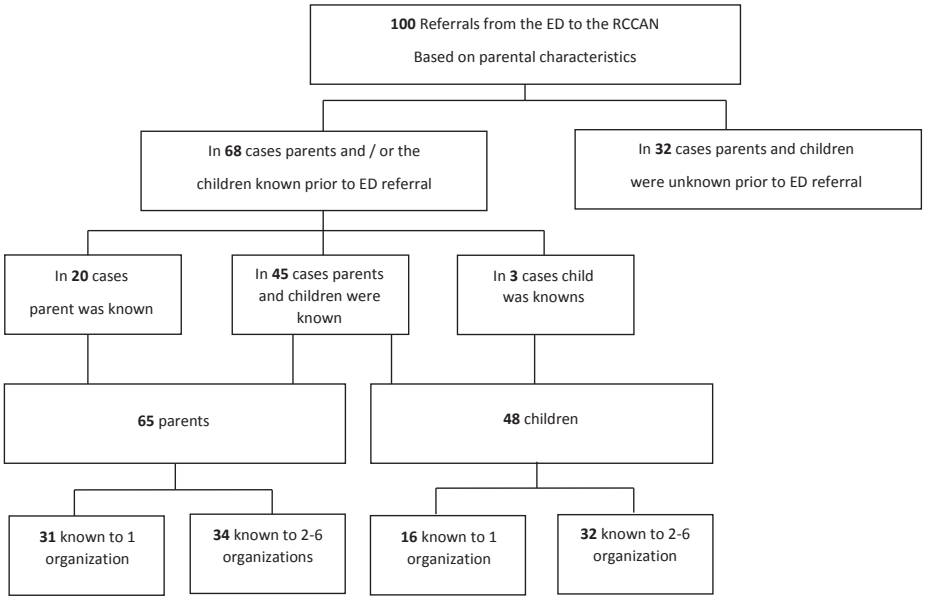

Figure 2. Families known or unknown prior to ED referral.

*e.g. Police, RCCAN, CPS, rehabilitation center, social service

Duration of the problems prior to ED referral

As shown in Table 1, the RCCAN file stated in 27 cases that the event leading to the ED referral was an isolated incident. In 57 cases the problems already existed for a longer period of time and in 16 cases information on the duration of the problems could not be found in the RCCAN files. The majority of the files stating that the problems existed for a longer period concerned domestic violence cases (n = 23), followed by suicide attempts (n = 12).

Table 1: Duration of the problems prior to the ED referral.

	Duration of the problems			
Reason for ED referral	Isolated incident % (*n*)	Non-isolated incident % (*n*)	Not found in file % (*n*)	Total % (*n*)
Substance abuse	35 (6)	53 (9)	12 (2)	100 (17)
Suicide attempt	41 (9)	55 (12)	4 (1)	100 (22)
Domestic violence	16 (7)	54 (23)	30 (13)	100 (43)
Combination	40 (2)	60 (3)	0 (0)	100 (5)
Others*	23 (3)	77 (10)	0 (0)	100 (13)

* Others includes other psychiatric problems such as delusion and confusion.

Findings after ED referral

Table 2 shows the reasons why the ED decided to refer the children to the RCCAN and the types of child maltreatment found by the RCCAN after investigation. These conclusions could be extracted from the files of 96 of the 100 cases in this study. Most children were referred because one or both parents attended the ED as a result of domestic violence (40 of 100), many of these children were found to be witnesses of domestic violence (n = 18) or had a combination of different forms of maltreatment (educational and emotional neglect and witness of domestic violence, n = 18). The second largest group of parents were those attending the ED after a suicide attempt (n = 22). Their children were found to be victims of various types of maltreatment, but mainly educational neglect (n = 9). The pattern was less clear in the 17 cases of referrals based on substance abuse.

In 12 cases, the RCCAN referral was not substantiated, which means that when the RCCAN investigation was carried out it was not possible to determine whether the child was, or was not, a victim of child abuse or neglect. For example, the perpetrator of the domestic violence had left the household or a parent had already enrolled in a rehabilitation program. In these cases the child's data remain in the RCCAN system and may be used in the case of future referrals.

Table 2: Types of maltreatment found after investigation by RCCAN (N = 96*)**

	Type of referral from ED				
Types of maltreatment	Substance abuse (n = 17) % (n)	Suicide attempt (n = 22) % (n)	Domestic violence (n = 40) % (n)	Combination (n = 5) % (n)	Other (n = 12) ** % (n)
Witness of domestic violence	6 (1)	5 (1)	45 (18)	0 (0)	8 (1)
Educational neglect	29 (5)	41 (9)	0 (0)	40 (2)	25 (3)
Emotional neglect	18 (3)	9 (2)	0 (0)	20 (1)	0 (0)
Psychological violence	0 (0)	18 (4)	0 (0)	0 (0)	0 (0)
Combination*	35 (6)	18 (4)	45 (18)	40 (2)	42 (5)
Referral refuted	0 (0)	0 (0)	2 (1)	0 (0)	0 (0)
Referral not substantiated	12 (2)	9 (2)	8 (3)	0 (0)	25 (3)

* These combinations mainly consist of educational neglect, emotional neglect and witness of domestic violence.

** Other includes other psychiatric problems such as delusion and confusion.

*** In four cases no conclusion could be found in the RCCAN file.

Help and support organized by RCCAN

The RCCAN started its investigation, on average, 12 days after referral by the ED (n=76; SD=13, range 0–60). In 35% of the cases, families were contacted by the RCCAN after five days, 72% were contacted after 14 days. Data on the support the RCCAN had arranged for families were found for 99 of the 100 cases, one case was missing. Existing care was continued or intensified in 31 of the 99 cases and 24 cases were referred to Child Protective Services (CPS).

In 17 cases support was not necessary because the problems had already been solved e.g. parents had split up or parents had already enrolled in a support program on their own initiative. In 27 cases 'new' support was organized for the families after referral by the ED. The initiated help for these 27 families was as follows; 19 mothers received psychiatric help or were assigned a social worker, 12 fathers were referred for psychiatric help, were treated for their substance addiction or were enrolled in an anger management training program. Children (n=13) were supported by school social workers or referred to an organization specialized in the diagnosis and treatment of children, adolescents and young adults, with mental health problems (Fig. 3).

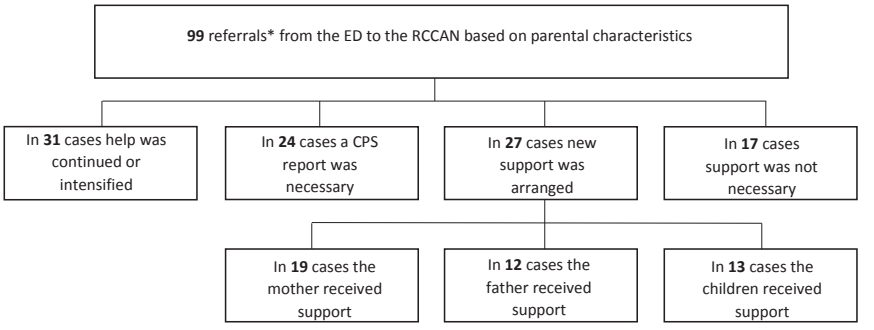

Figure 3. Overview of support arranged after ED referral.

* In one case data concerning monitoring was missing.

Situation after 3 months

The RCCAN is mandated to re-assess all families, three months after their initial investigation to gain insight into the current domestic situation, unless the family is referred to BJZ (because, in that case, they already have a legal guardian) or the CPS. They gather their information from the families themselves and the professionals who are currently helping these families. The RCCAN also contacts other professionals surrounding the family; e.g. the General Practitioner, the Well Baby Clinic, schoolteachers etc. to gather information about the children's wellbeing. These professionals are asked to keep an eye on the child and to contact the RCCAN if their situation should deteriorate. In 69 of the 100 cases information on monitoring could be retrieved from the RCCAN files (Fig. 4).

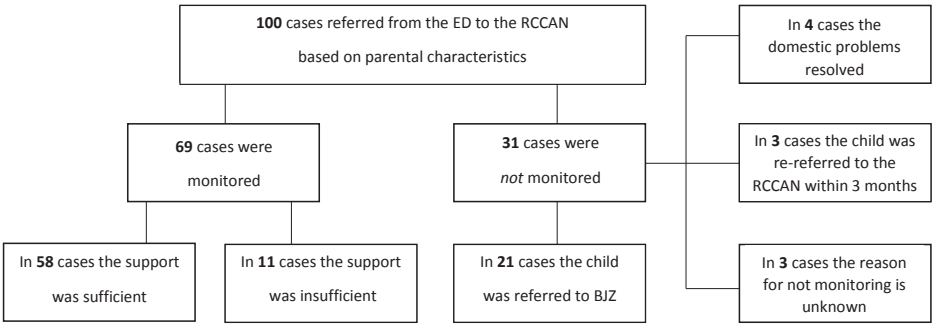

Figure 4. Overview of follow-up by the RCCAN after three months.

Among these 69 cases, the initiated help was insufficient in 11 cases. These were subsequently reopened and new or additional support was arranged or the CPS was notified. In the remaining 58 cases the families and professionals judged that the support was sufficient and it was continued. In the 31 cases which were not monitored by the RCCAN, 21 had been referred internally to BJZ, releasing the RCCAN from the obligation for follow-up. In four cases, the RCCAN did not follow up on the domestic situation, because professionals judged that the abuse had already ended at the time of the investigation, for example, the perpetrator of the domestic violence had permanently left the home. In three cases, the family had been referred once more within the three month follow-up period. In the remaining three cases it was unknown why the RCCAN had decided not to follow up the family.

Discussion

The results indicate that all cases referred to the RCCAN were investigated and families were offered support or existing support was continued or intensified. The support was generally sufficient and well monitored according to the families and professionals involved. Some results were remarkable.

Firstly, only 13 children from the 27 'new' families, i.e. those who were previously unknown to the RCCAN (see Fig. 3), had to be referred for personal support. This relatively low number of children needing support could be a result of screening for child abuse based on parental characteristics. As a result of this specific focus, child abuse may not have fully manifested itself as would be reflected in serious mental or physical injury to the child. This highlights the signaling function of the Hague protocol, encompassing the potential to prevent child abuse by recognizing the signals of early onset (i.e. parental visits to the ED) rather than responding to the fully manifested conditions (i.e. a seriously harmed child). In our previous research (Diderich et al. 2013), we found that 73% of all children referred by the ED, based on parental characteristics, were unknown to the RCCAN, prior to the ED referral. Again this underlines the preventive aspect of these parental referrals.

Secondly, prior to the ED referral 68 out of 100 families were already known either to the RCCAN, to the police, or other support services (see Fig. 2). However, this had not prevented a continuation or reoccurrence of the domestic problems leading to a RCCAN

referral from the ED. The reason for this large percentage of families already known to organizations could be the result of legislation in the Netherlands regarding professionals' responsibility in detecting child maltreatment. All professionals who are concerned about possible child abuse may organize support and help for families. However, only the RCCAN and the CPS have the legal authority to check whether children and parents actually comply with the suggested support. This makes it relatively easy for parents to avoid surveillance by 'outsiders', by failing to show up or to co-operate. This 'escape route' could explain why many families were already previously known, but did not receive sufficient or even any support to prevent a referral by the ED. Mandatory involvement of the RCCAN in monitoring families could possibly prevent this. By providing a backup for organizations supporting these families when children or parents do not show up or the offered support is insufficient for the needs of these families.

Thirdly, in 23 out of 48 cases where the children were already known prior to the referral by the ED, the children were already known to the RCCAN (the other 25 were known to other organizations e.g. the police), meaning that child maltreatment had been previously confirmed and help was initiated. However this had not prevented the need for a re-referral by the ED. This raises the question of whether a single follow-up after three months is sufficient to determine whether the domestic situation of those families who have been provided with support is improving adequately.

The lack of sufficient monitoring is a worldwide problem. We found in a study of the literature, personal communication with researchers, and professionals in the field (e.g. ED, social work, pediatrics) that England, Western-Australia and the USA have no mandatory guidelines requiring organizations to monitor families for whom support was arranged after child abuse or neglect was substantiated. Even when support is mentioned in guidelines, it is often not put into practice.

Mandatory monitoring of these 'child maltreatment' families for a certain period of time and registration in a national data-base could possibly help prevent reoccurrence of the problems. This would require a cautious approach in considering the length of the monitoring period, data access, and the applicable privacy legislation. The database could also be used, as recommended by Gilbert and colleagues (2012), to link information on whether the same children are presented to multiple services and whether they overlap.

Leading professional in the monitoring process

One could discuss whether the family General Practitioner (GP) is the designated person to become the 'leading professional' monitoring the families' progress and wellbeing after help is initiated in those countries where GPs play a prominent role in family medicine. In the Netherlands, only 2.5% of all referrals to the RCCAN came from GPs (Jeugdzorg Nederland 2012). The GPs note that the barriers to detecting and reporting include fear of losing the family as patients and lack of confidence in the CPS (National Society for the Prevention of Cruelty to Children (NSPCC) 2011). Therefore we do not consider the GP to be the right professional to fulfil this task at this moment. This view is endorsed by research done by Woodman and colleagues (2013), who found that although the GP could become the 'leading professional', more research is necessary to determine whether this is feasible. GPs have a therapeutic relationship with their patients and it is not clear if they should be the designated persons to monitor and coach these families. A report from Kingston University (2010), initially set up to investigate potential 'conflicts of interest' of GPs in detecting and safeguarding child abuse victims, revealed that GPs saw their role in most cases as referring patients/families, while others expected fuller engagement in all stages of child protection processes. GPs stated in this report (Tompsett et al. 2010) that in difficult cases, separating the child's needs from the needs of the parents is highly complex and requires specialist knowledge. In some cases allocating separate GPs to parent and child/children is needed. Many GPs indicated that they were not up to this task and would favor the attachment of social workers or a heath visitor, making this monitoring task a team responsibility.

It could be wise to consider having another person or organization to assist the GP in taking the leading role in monitoring families who are offered support and help after a substantiated child abuse referral. Another option could be that monitoring these families becomes a CPS / Social Services responsibility. Unlike the GPs, the professionals working in these organizations are well aware of what services are available for the children and their parents. They are also able to conduct a follow-up review if parents or children do not cooperate with the services they were assigned. However, it should be emphasized that the legal ramifications of CPS involvement in support for parents may dissuade these parents from becoming involved and participate in the programs to come to grips with child abuse (see Dale 2004; Buckley et al. 2011, for parents' perception of the CPS). A study conducted by the Local Authorities Research Consortium (Easton et al. 2014) in the United Kingdom reported positive outcomes for families who have worked

with local services. Families reported that the emotional support and helpful and practical advice they had received, were the reasons for these improvements. A precondition for this choice would be for governments to grant these organizations enough financial resources. A recent survey from Community Care (Pemberton 2013) of 600 children's social workers and managers in the UK found that as local authority budgets are squeezed, most professionals are struggling to protect vulnerable children.

It is important to realize that detecting these children is not a guarantee that the family is provided with the necessary support. For example in England, many studies state that children with known maltreatment-related problems do not have access to services before they reach a crisis point (Easton et al. 2014). In the United States up to 40% of the child maltreatment victims do not receive post-response services (US Department of Health and Human Services 2011).

To the authors' knowledge, no specific legislation exists in England, Western-Australia or the US mandating (health care) professionals to act or report possible maltreatment of children on the basis of parental characteristics. This was also the case in the Netherlands prior to the specific adjustment to the law regarding these parental characteristics. Also, other countries do not have a direct RCCAN equivalent or the same legislation. However, some countries already have policies in place to promote the detection of these vulnerable children based on parental characteristics, for example 'Think family' (UK Department for children 2009), a policy by the previous UK government. This means that the Hague protocol might be feasible in other countries and in keeping with policy agendas.

Conclusion

The results of this current study, combined with the results of our previous studies on the Hague protocol, show that the protocol and the RCCAN together can provide a package of care that aims to improve outcomes for children and families. However, it is important to realize that a follow-up study should be conducted to provide information on the long-term outcomes of these children. A randomized controlled trial is needed to test the effectiveness of the Hague protocol in combination with the long term outcomes of the provided family support.

On the basis of our findings (68 families already known to various organizations concerning worries about the effect of child welfare, prior to ED referral), we recommend standard monitoring of referred families during a certain, yet to be specified period of time, before concluding that the initiated support is adequate. In the light of the possible internationalization of the Hague protocol, these findings could be used to emphasize the importance of a good monitoring system. Even if countries have a well-functioning system for detection of child maltreatment and have good services for families and children, this is insufficient without a good monitoring system. Not monitoring these families could lead to unwarranted deprivation of essential support and future re-referrals.

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Chapter 7

Detecting child abuse based on parental characteristics: Does The Hague protocol cause parents to avoid the Emergency Department?

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ABSTRACT

Objectives: The Hague protocol is used by professionals at the adult Emergency Departments (ED) in the Netherlands to detect child abuse based on three parental characteristics: (1) domestic violence, (2) substance abuse or (3) suicide attempt or self-harm. After detection, a referral is made to the Reporting Center for Child Abuse and Neglect (RCCAN). This study investigates whether implementing this protocol will lead parents to avoid medical care.

Method: We compared the number of patients (for whom the protocol applied) who attended the ED prior to implementation with those attending after implementation. We conducted telephone interviews (n = 14) with parents whose children were referred to the RCCAN to investigate their experience with the procedure.

Results: We found no decline in the number of patients, included in the protocol, visiting the ED during the four year implementation period (2008–2011). Most parents (n = 10 of the 14 interviewed) were positive and stated that they would, if necessary, re-attend the ED with the same complaints in the future.

Conclusion: ED nurses and doctors referring children based on parental characteristics do not have to fear losing these families as patients.

Introduction

Each year, more than 150,000 children worldwide die as a result of maltreatment (Gilbert et al., 2009). Many more suffer lifelong consequences (Felitti et al., 1998) and lasting changes have been reported in their core physiological systems (Schury and Kolassa, 2012). Child maltreatment remains a major public health and social welfare problem, even in high income countries (Keane and Chapman, 2008).

In the Netherlands, approximately 19,000 children are reported annually to the Reporting Center for Child Abuse and Neglect (RCCAN) (Jeugdzorg Nederland, 2013). In the USA approximately 6,800,000 children per year are reported to the Child Protective Services (CPS) (US Department of Health and Human services, 2011). Since the Dutch Healthcare Inspectorate published a report in 2008 on the inadequate detection of child abuse at the Emergency Department (IGZ, 2008), finding a solution for this became a Government priority. This led to the development of educational material to train ED staff, and to the development of screening instruments for the detection of child maltreatment (Louwers et al., 2012). However, research shows that screening tools based on child markers are not reliable (Woodman et al., 2010).

The Medical Center Haaglanden (MCH) and the RCCAN in The Hague developed a new protocol, the "Hague protocol", which detects cases of child abuse based on specific characteristics of parents who attend the adult Emergency Department (ED) with their own medical problems (Diderich et al., 2013). The children of these parents will be referred to the RCCAN. The RCCAN specializes in conducting investigations concerning child abuse and neglect and provides voluntary community based services for families. The RCCAN professionals (medical-doctor, social worker and behavioral specialist for children) meet with the parents and the child(ren) within 12 days of the ED referral and evaluate the problems in order to offer appropriate help to the family members. If necessary, the RCCAN can refer the family to the CPS, which has the authority to place children in foster care.

The present research focuses on the implementation of this new protocol to detect child maltreatment at hospital Emergency Departments in the Netherlands. In this study we investigate the effects of implementation of the Hague protocol at Emergency Departments (ED) regarding avoidance behavior of parents who have an increased chance of being detected for child maltreatment. Implementation of the protocol

provides a context to understand more general, universal processes associated with the implementation of new measures for child maltreatment detection.

The Hague protocol focuses on detecting child abuse at an adult ED on the basis of parental characteristics rather than on the basis of the current guidelines that focus on child characteristics. The Hague protocol has proven to be very effective, with the number of referrals to the RCCAN rising from 1 to 64 per 100,000 ED patients. Child abuse was confirmed in 91% of referrals (positive predictive value of 0.91; Diderich et al., 2013). In July 2013, the Dutch Ministry of Health, Welfare and Sports made the method of the Hague protocol mandatory by law for all medical professionals in the Netherlands. The Hague protocol has already been successfully implemented in all Dutch hospitals, many ambulance services, and General Practitioners offices have also started the implementation process. This year these guidelines will probably be implemented in 11 hospitals in Germany, the first international pilot study. Recently in some hospitals in the United States, the focus on parental characteristics has been added to the existing guidelines concentrating on child characteristics (Horner, 2014).

During the implementation of the protocol, some medical professionals expressed fear that patients in need of medical care may stay away from the ED to avoid their children being referred, thereby undermining the effectiveness of the Hague protocol. This fear has also been discussed in several previous studies focusing on experiences of health care professionals when deciding to refer a child to the CPS (Flaherty and Sege, 2005; Flaherty et al., 2000, 2008; Vulliamy and Sullivan, 2000). Avoidance of medical care has been identified as an issue in many different domains. For example, Henderson et al. (2013) reported on avoidance of medical care by people with mental illness. They found that lack of awareness of medical symptoms, ignorance concerning treatment excess, prejudice regarding mental illnesses and the expectation of discrimination by those with mental illness were the main reasons for treatment avoidance. While the first two reasons may be less relevant in the current context, it is clear that prejudice against child abusers and expectations of negative treatment by child abusers may play an important role in a decision to avoid medical treatment at the ED (Henderson et al., 2013). This is in line with a study by Moore et al. (2004) who showed that perceptions of patients on how they are treated are a critical factor in the avoidance of healthcare treatment. The present study specifically focused on avoidance behavior at the ED as a result of the implementation of the Hague protocol.

This study investigates the hypothesis that parents will avoid the ED as a result of implementation of the Hague protocol.

The Hague protocol

The Hague protocol prescribes how nurses and doctors working at an adult ED can detect child abuse based on three parental characteristics; (1) domestic violence, (2) substance abuse and (3) suicide attempt or self-harm. All patients seen as a result of these problems are asked, in accordance with the protocol, if they are responsible for children under the age of 18 years or if they are pregnant. If this is the case, the children will be referred to the RCCAN, even without the parents' consent. The current study is part of a large research project that addresses the effectiveness of the Hague protocol, the number of cases missed by the protocol, possible additions of parental categories to the protocol, and the care offered to the families after referral to the RCCAN following detection by the protocol. The study was submitted for evaluation to the Medical Ethical Committee (number 11– 040), who decided that their approval was not required. All these studies have already been published (Diderich et al., 2013, 2014a, 2014b, 2014c, 2014d).

Methods

To investigate the impact of the Hague protocol on ED attendance of parents included in the protocol's guidelines we carried out a retrospective study. Data were extracted from the ED data-base of the Medical Center Haaglanden (MCH) hospital. The MCH began implementation of the Hague protocol in December 2007. We collected data from patients who attended the ED between January 1, 2006 to December 3, 2011. We limited the data collection to those groups of patients (child carers and non-child carers) who were included in the protocol's guidelines (domestic violence, suicide attempt/self-harm and substance abuse). We searched for the following keywords in the medical diagnosis noted in the electronic patient files; "strangulation", "self-harm", "suicide attempt", "suicide", "self-intoxication", "drugs", "Gamma Hydroxyl Butyrate" or "GHB", "Ecstasy" or "XTC", "Heroin", "Cocaine", "alcohol intoxication", "domestic violence", "partner violence" and "abuse". The medical records found using these keywords were checked randomly as to whether they were indeed part of the patient's medical history. Finally, we compared the total number of patients (child carers and non-child carers) who attended the ED in the 2 years prior to implementation (2006–2007), with the number of patients attending after implementation (2008–2011) (Table 1).

Table 1: Total number of ED patients included in the protocol's guidelines.

	Prior to implementation of the protocol (2006 - 2007)		After implementation of the protocol (2008-2011)			
	2006	2007	2008	2009	2010	2011
Domestic Violence						
n/N	243 / 62,704	282 / 66,536	315 / 68,749	411 / 71,380	395 / 71,662	409 / 74,559
Number per 100,000	388	424	458	576	551	549
Substance abuse						
n/N	137 / 62,704	169 / 66,536	262 / 68,749	303 / 71,380	398 / 71,662	402 / 74,559
Number per 100,000	218	254	381	424	555	539
Suicide attempt						
n/N	160 / 62,704	138 / 66,536	205 / 68,749	232 / 71,380	265 / 71,662	301 / 74,559
Number per 100,000	255	207	298	325	370	404

Note: n = the number of ED patients within the category; N = total number of ED patients

We conducted telephone interviews with parents whose children had been referred to the RCCAN as a result of implementation of the Hague protocol guidelines to gain more insight into how parents had experienced this new procedure. During a 6 months period (April 1, 2012 to October 1, 2012), 37 referred parents (mother or father), whose children had been referred to the RCCAN, based on the Hague protocols' guidelines, were contacted by telephone. The parents were phoned 1 week after the RCCAN had contacted them, which was approximately 12 days after the ED referral. It was very difficult to contact the parents by telephone and convince them to take part in the interview. Only 14 parents agreed to participate. The parents were asked questions pertaining to their knowledge about the existence of the protocol and their opinion about the way they had been informed about the procedure (Table 2).

The results of the telephone interviews (n = 14) are shown in Table 2. The referrals were mostly conducted by ED nurses (n = 11). A total of 10 women and 4 men were interviewed, their ages ranged from 26 to 53 years (average age 34 years, SD = 8.5). The children of nine respondents were referred after domestic violence, of three as a result of substance abuse, of one parent after a suicide attempt and of one after a combination of substance abuse and suicide attempt. None of the interviewees were aware of the existence of the protocol prior to the referral and six parents indicated, that if they would have known, this would not have prevented them from attending the ED. Ten of the interviewees stated that they would visit the ED again even though they were now aware of the protocol's guidelines and five would positively advise family and friends about the procedure. Another five would not be able to advise others, because they preferred not to speak about their ED attendance. Ten parents had experienced the procedure in the emergency department as (fairly) acceptable; two parents stated they had experienced it as overwhelming. Nine interviewees said they were (very) well informed about the procedure by the ED nurses and doctors and four parents stated that they were (fairly) inadequately informed.

Table 2: Outcomes of telephone interviews of referred parents (N = 14).

	n (%)
Were you aware of the existence of the protocol?	
Yes	0 (0)
No	14 (100)
If you would have known about the protocol, would you still have attended the ED?	
Yes	6 (42)
No	3 (21)
Don't know	3 (21)
Other answer	2 (14)
How did you experience the procedure at the ED?	
Acceptable	9 (64)
Reasonably acceptable	1 (7)
Don't know	2 (14)
Other answer	2 (14)
How do you rate the degree to which you were informed about the procedure?	
Excellent	2 (14)
Good	5 (14)
Sufficient	2 (14)
Poorly	2 (14)
Bad	2 (14)
Other answer	1 (14)
Would you attend the ED in the future knowing about the protocol?	
Yes	10 (71)
No	1 (7)
Other answer	3 (21)
What would your advice be to others about the protocol's procedure at the ED?	
Positive	5 (36)
Negative	2 (14)
Don't know	1 (7)
Other answer	5 (36)
Missing	1 (7)

Discussion

The number of patients covered by the protocol's guidelines who attended the ED in the years after implementation remained very high and actually increased annually. There could be a multitude of reasons behind the apparent rise in attendances, a trend not limited to the EDs in the Netherlands, as shown by research on over-crowding at EDs in 15 countries, revealing rises in virtually all countries (Pines et al., 2011). First, it is important to note that there was no change in the number of hospitals with EDs in the region, their opening hours, changes in health care insurance policy or other factors which could explain this increase. Possibly, the increase may be the result of the increased vigilance of ED professionals concerning implementation of the new protocol. In any event, on the basis of our avoidance hypothesis, a change could have been

expected in the opposite direction. Thus, our results indicate no decrease in attendance for the three specific parental categories covered by the protocol, leaving no doubt that the avoidance hypothesis (parents avoiding the ED as a result of the Hague protocol should be rejected.

Regrettably, few parents (14 of 37) were willing to participate in our telephone interview. The reasons for not participating varied from 'unable to contact by phone' (after three attempts at various hours), 'unable to cooperate' (admitted to psychiatric hospital) or 'not willing to cooperate'. This raises the possibility of selection bias. Still, the information from those patients interviewed provides valuable insight into the patients' experience with the Hague protocol, although the small number of interviewees warrants caution regarding generalization. The information gained can help us modify the current guidelines to help parents better understand and accept the impact of the process. For example, only half of the parents indicated that they were well informed about the procedure.

This is an important finding: it is possible that some ED professionals give unclear or incomplete information. This means that it could be advisable to give parents an explanatory brochure explaining the procedure. As a result of this outcome, the ED doctors and nurses were made aware of the importance of giving an explanatory brochure to the parents.

Considerable research has been devoted to investigating the barriers that health care professionals experience in detecting and reporting child abuse cases (Cabana et al., 1999; Flaherty and Sege, 2005; Flaherty et al., 2000, 2008; Vulliamy and Sullivan, 2000).

These barriers include the uncertainty of nurses and doctors about the diagnosis of child abuse, and negative experiences with the Child Protective Services (CPS). Based on the numbers shown in Table 1, we can conclude that implementation of The Hague protocol does not lead to a decline in the number of patients who are covered by the protocol's guidelines who attend the ED. This may suggest that the fear of losing patients as a result of the protocol's implementation is unwarranted.

The relatively low number of telephone interviews may limit the conclusions which could be drawn from this part of the study. It is possible that the parents who agreed to be interviewed are not representative of the group of parents whose children were referred to the RCCAN and there is a risk the parents who refused to be interviewed are those who will avoid emergency care access in the future.

However, the majority of parents who agreed to be interviewed were positive and said that they would, if necessary, revisit the ED with the same complaints in the future, suggesting that EDs do not have to fear a decline in the attendance of this specific group of patients.

Although these outcomes are positive, the study also revealed some room for improvement. Four parents stated that they were not (or poorly) informed about the procedure following referral, which can have an adverse effect on motivation to collaborate with the RCCAN for voluntary help. If parents are well informed they could feel less anxious about the procedure and more willing to revisit the ED if they or their children need medical care. Providing an explanatory brochure to be given to parents may be a simple aid to providing clear information. This brochure should be available in several languages (appropriate to the hospital population) and contain easily understandable information about the Hague protocol and the follow-up by the RCCAN.

Conclusion

This study shows that ED nurses and doctors referring children to the RCCAN on the basis of parental characteristics do not have to fear losing these families as patients. Most of the interviewed parents experienced the procedure at the ED as acceptable and, if necessary, would return to the same ED in the future. Most referrals are conducted by ED nurses. Providing a suitable explanatory brochure about the procedure at the ED and the RCCAN for parents may improve the information parents receive (and remember), and increase their motivation to accept help.

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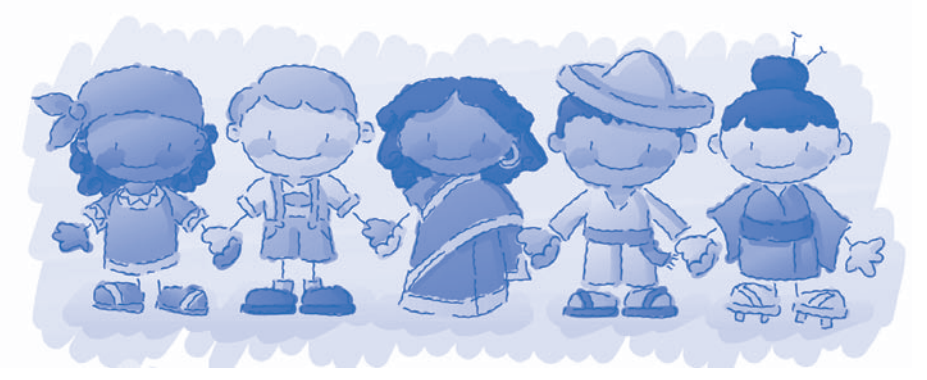
Chapter 8

General discussion



The goal of this thesis was to investigate whether the detection of child maltreatment at the Emergency Department (ED) could be improved by using a new protocol, called the Hague protocol, that aims to detect child maltreatment on the basis of parental characteristics.
Research shows that detecting child maltreatment based on child characteristics at the ED (e.g. age, repeat attendance and injury type) is not sufficiently accurate to be considered a reliable screening tool (Woodman et al., 2010). Therefore the goal was to develop an additional method for the detection of child maltreatment at the ED based on parental characteristics (The Hague protocol). This thesis reports on the effectiveness of the Hague protocol. It specifically concerns the predictive value of the Hague protocol, its implementation, the origins of the false negatives, the potential need to expand the protocol, the family support offered after referral, and the potential avoidance of the ED by parents as a result of implementation. Each of these issues has been addressed in a separate chapter of this thesis.

Tangible effects of these studies; Current state of affairs and future developments

Tangible effects

As a result of the promising outcomes of the research reported in this thesis, ZonMw granted the project group an extra financial impulse, providing the opportunity to implement the Hague protocol at all Dutch EDs and RCCANs in the Netherlands. This implementation has been completed.

After the first results of our study were made public at the beginning of 2013, the government of the Netherlands introduced an amendment in Dutch Law (appendix II) to make the detection of child abuse using parental characteristics, as outlined in the Hague protocol, mandatory for all professionals in the regular and mental health care sectors as well as those in the fields of social work and for professionals working in judicial institutions (Wet Meldcode 2013). This was followed by a national implementation. Currently all Dutch EDs, general practitioners' out of office co-operatives and ambulance services have started implementing these guidelines.

The government named this new approach 'Kindcheck' (Child Check) and expanded the categories of parental characteristics and the group of professionals. If a (para-) medical professional treats an adult patient or client who has severe mental, physical, social, or

financial problems (e.g. no housing), the professional is mandated to check the child's safety and well-being. This can be done by: 1) referring the children to the RCCAN in accordance with the guidelines of the Hague protocol (the RCCAN then takes over the responsibility) or 2) checking the child's safety and well-being, and if needed, arranging appropriate support services without involvement of the RCCAN. In the latter case, the professional remains responsible for the child's well-being until confirmation is received that the child and/or the parents have been accepted by the designated support services. By making this approach mandatory by law, the Dutch Government is the first in the world with legislation that leverages parental characteristics to detect child maltreatment.

In June 2013, we were awarded a 'Pearl' by ZonMw. This is an award for a study that yields striking results, is in line with current developments, and provides a fitting response to a question or problem in health care. We also received a grant in 2013 from the Ministry of Health, Welfare and Sports to implement the protocol (now named Child Check or Kindcheck) at all Dutch ambulance services and General Practitioners' out of office co-operatives.

Future developments

Because of the expansion of the parental groups and the professionals involved, we consider it important to evaluate the effectiveness of this expansion. We are currently negotiating for funding of the research of this effectiveness will start at the end of this year. We are also in contact with hospitals in Germany, which are prepared to start a pilot study on 'detecting child maltreatment at the ED', which includes the guidelines of the Hague protocol. Several Swiss hospitals will also start a pilot of the Hague protocol in 2016. The first hospitals in the United States have shown interest in implementing a pilot of the Hague protocol guidelines at their adult ED's. We hope many other countries will follow. To help determine how preventive these guidelines really are, a randomized control trial to test the effectiveness of the Hague protocol in combination with the outcomes of the provided family support is desirable. Up to now this has not been feasible.

Unsolved problems

Structural monitoring and follow up of the family and child situation are still unsolved issues. Our research showed that prior to referral by the ED, two thirds of these families were already known to organizations on account of their family and domestic problems. As described in chapter six, the only Dutch organization mandated to monitor the situation within six months after help is initiated, is the RCCAN. Professionals in the Netherlands are mandated to act when they fear for the child's welfare or safety. They have more options than only referral to the RCCAN. But if they choose to initiate help without intervention of the RCCAN, these families would be left without any form of monitoring. A solution to this problem could be that even if the professional chooses to initiate help without RCCAN intervention, they should inform the RCCAN about the family situation and the help they have organized. In this way the RCCAN can be held responsible for monitoring and the RCCAN will have a more complete overview of all child maltreatment victims. This could make the RCCAN the National Database, overseeing monitoring, follow up, overlap of services and failure of mobilized support, which could help to reduce recurrences of child maltreatment.

Another potential problem is best illustrated by events in Minnesota (USA) in 1999. A Minnesota legislature amended the definition of child neglect to include child exposure to intimate partner violence. As a consequence, referrals to child protection agencies expanded rapidly. Unfortunately, no state funding was provided and the support system became overloaded, resulting in very long waiting lists (Edleson, Gassman-Pines, & Hill, 2006). To prevent this 'Minnesota-effect' in the Netherlands, future research is necessary to give some insight into whether the expansion of child maltreatment detection guidelines will have the desired outcome for professionals and families and will not lead to flooding of the system. Therefore, we are currently in consultation with the Ministry of Health, Welfare and Sport to start an evaluation of the outcomes of the implementation of the Kindcheck (Child Check) among all the professionals involved. It will also be necessary to focus on a Kindcheck implementation program, similar to the program used for the GPs and ambulance services, to support these professionals during the implementation process.

Final conclusion

The overall conclusion of this thesis is that the addition of the Hague protocol to detect child maltreatment based on parental characteristics, together with the existing protocols based on child characteristics, leads to a significant increase in the identification of children who are victims of child maltreatment. It is striking that many of these children were not known to the Reporting Center for Child Abuse and Neglect (RCCAN) prior to referral by the Emergency Department (ED). The parental categories as described in the Hague protocol's guidelines have a high positive predictive value, a low number of false positives and there is no need to expand the protocol with more parental characteristics. After implementation of the Hague protocol at the ED a small number of child maltreatment cases may be missed (see Chapter 4, Missed cases in the detection of child abuse based on parental characteristics in the emergency department). Fortunately, the reasons for these non-identified cases should be relatively easy to address. When a referral is made to the RCCAN, ED professionals can be assured that the great majority of families are investigated within a reasonable time and they receive adequate support. This study also helps to dispel the myth that if ED professionals refer children to the RCCAN based on parental characteristics that parents themselves will avoid attending the ED.

Overall the combined outcomes of the present studies provide sufficient grounds to conclude that implementing the Hague protocol's guidelines may narrow the gap between the prevalence of child maltreatment and the number of detected child abuse victims. Therefore, we think that other countries may also be encouraged to take a close look at the feasibility of implementing a protocol for detecting child maltreatment based on parental characteristics in addition to their current protocols based on child characteristics. Detection of child maltreatment is critical in order to stop and further prevent this behavior, and to offer help and support to the child and family.

Summary

The goal of this thesis was to investigate whether the detection of child maltreatment at the Emergency Department (ED) could be improved by means of a new protocol called the Hague protocol. In contrast to previously used measures to detect child maltreatment, this protocol uses parental characteristics rather than child characteristics. The research in this thesis lead to the amendment in Dutch Law of using parental characteristics as criteria for the detection of child maltreatment, and the national implementation of these guidelines.

The research reported in this thesis concerns the predictive value of the Hague protocol, its implementation, the origins of the false negatives, the possible need to expand the parental characteristics, the family support offered after referral, and the possibility of increased avoidance of the ED by parents as a result of implementation. Each of these issues was addressed in a separate chapter of this thesis.

In the second chapter, we addressed the question 'Can the Hague protocol be used for screening adults presenting for care in the Emergency Department to identify children at high risk for maltreatment?' To answer this question, we developed a 'before and after study', conducted at nine EDs in three regions in the Netherlands (one intervention region and two control regions). It was observed that during the period January 2006 to November 2007, prior to the introduction of the Hague protocol, a total of four parents, out of 385,626 patients attending the ED in the intervention region (one per 100,000) were referred to the Reporting Center for Child Abuse and Neglect (RCCAN). In the period after introduction of the Protocol (December 2007 to December 2011), the number rose to 565 parents out of 885,301 patients at the ED (64 per 100,000). In the control region, where the Protocol was not implemented, these figures were two per 163,628 (one per 100,000) and 10 per 371,616 (three per 100,000) respectively (OR = 28.0 | 95 CI 4.6 – 170.7)). At assessment, child abuse was confirmed in 91% of referred cases. Hence, the Protocol has a high positive predictive value of 91%, and can substantially increase the detection rate of child abuse in an ED setting. It is clear that the parental characteristics under investigation are strong predictors of child abuse.

In the third chapter we investigated whether the Hague protocol guidelines can be successfully implemented at EDs in other regions outside the original intervention region. We also investigated the critical facilitators and barriers to implementation.

To do so, the original implementation region of the Protocol (The Hague) was compared to a new implementation region (Friesland) with regard to referrals, focus group interviews (*n* = 6) at the ED and at the RCCAN, as well as using questionnaires (*n* = 76) at the EDs. We found that implementing the Hague protocol substantially increased the number of referrals to the RCCAN in both regions. In Friesland, the intervention region, the number of referrals increased from two out of 92,464 patients (three per 100,000) to 108 out of 167,037 patients (62 per 100,000). However, in Friesland, child abuse was confirmed by the RCCAN in a substantially lower percentage of cases relative to the initial implementation region (62 % vs. 91% respectively). Follow-up analyses suggested that this lower positive predictive value may be due to a lack of training concerning the Hague protocol for RCCAN professionals. The focus group interviews and questionnaires identified time limitations as the main impediment for implementation, whereas an implementation coach has been mentioned as the most important facilitating factor for success. The Hague protocol can be a valuable tool for detecting child abuse in areas beyond the initial implementation region. However, this study shows that training of professionals at all levels and stages of involvement is essential in order to assure a consistent implementation.

In the fourth chapter we focused on missed cases in the detection of child abuse based on parental characteristics at the Emergency Department (the Hague protocol). To assess the number of 'missed cases' between July 1st, 2011 and December 31st, 2011, all referrals made to the RCCAN in The Hague were collected. We searched the database of the MCH to determine whether the parents of these children had attended the Emergency Department (ED) in the 12 months prior to the referral of their child to the RCCAN. In this way, we hoped to find those parents whose children should have been referred according to the guidelines. We found eight 'missed cases' out of 108 cases. Reasons for not referring were ED personnel forgetting to ask about patients' responsibility for children, and assuming that it was not required to refer children if parents indicated that they were already receiving some form of family support. These problems should be relatively easy to overcome. Regular training and a pop-up in the medical dossier may help prevent cases being missed in the future.

In the fifth chapter we focused on the parental characteristics that predict child maltreatment at the Emergency Department and considered expansion of the Hague protocol. We used a nested case control design, in which we compared (on various dimensions) parents identified as child abusers who were 'rightfully missed' by the protocol (n = 100) to a matched group of non-abusing parents (n = 100). We did not find distinguishing differences between the two groups. We found no additional patient criteria to identify child abuse on the basis of parental characteristics and will therefore not add other parental categories. Maintaining the Hague protocol with its current characteristics will avoid an unnecessary burden for parents, children, and professionals.

The sixth chapter comprised the subject of support and monitoring of families after child abuse detection based on parental characteristics at the Emergency Department. We investigated what had happened to the families three months after referral by the ED. We analyzed 100 ED referrals based on parental characteristics in which child abuse was confirmed after investigation by the RCCAN. Information was collected regarding the type of child abuse, reason for reporting, duration of problems prior to the ED referral, previous involvement of support services or other agencies, recurrence of the problems, and outcome of the RCCAN monitoring according to professionals and the families.

Out of the 100 referred cases, 68 families were already known to the RCCAN, the police or family support services, prior to the referral by the ED. Of the 99 cases where information was available, existing support was continued or intensified in 31, a Child Protection Services (CPS) report had to be made in 24, new support was organized for 27 cases and in 17 cases it was not necessary to organize help because the problems had already been solved (e.g. the parents had split up or parents were already enrolled in a program on their own initiative). Even though the RCCAN is mandated to monitor all referred families and to evaluate the situation after three months, 31 cases were referred internally to Bureau Jeugdzorg (BJZ can be compared with Youth Care in the United States of America or the Children's Social Care Services in The United Kingdom) and therefore were not followed up by the RCCAN. Because we found that before referral by the ED, two thirds of these families were already known to various organizations, monitoring may help provide a better, more sustained service and prevent these family problems continuing or recurring.

In the seventh chapter, we asked "does The Hague protocol cause parents to avoid the Emergency Department?" This research investigated a fear by ED nurses and doctors

that implementing this protocol will lead to parents avoiding medical care. To do so, we compared the number of patients (to whom the protocol applied) who attended the ED prior to implementation with those attending after implementation.

We also conducted telephone interviews (*n* = 14) with parents whose children were referred to the RCCAN. We found an increase and not (as feared) a decline in the number of at risk patients attending the ED during the four year implementation period (2008 - 2011). Most of the parents interviewed (*n* = 10 of 14 contacted) were positive and said that they would re-attend the ED with the same complaints in the future. Therefore, we can conclude that ED nurses and doctors referring children to the RCCAN based on parental characteristics do not have to fear losing these families as patients.

Overall the outcomes of these combined studies provide sufficient ground to conclude that implementing the Hague protocol's guidelines may narrow the gap between the prevalence of child maltreatment and the number of detected child abuse victims. Only when child abuse is detected can it be stopped and hopefully prevented in the future. On these grounds we advise other countries to take a close look at the feasibility of introducing a protocol for detecting child maltreatment based on parental characteristics to their current protocols based on child characteristics.

The results of these studies have had a great influence on official policy makers in the Netherlands and have led to changes in the laws on child protection (as discussed in Conclusions, tangible effects).

Nederlandstalige samenvatting (Summary in Dutch)

Het signaleren van kindermishandeling op de spoedeisende hulp op basis van ouderproblematiek.

Het Haaglanden protocol is ontwikkeld in het Medisch Centrum Haaglanden (MCH) in samenwerking met het voormalig Advies en Meldpunt Kindermishandeling (AMK)* in Den Haag. Het Haaglanden protocol is op 7 december 2007 geïntroduceerd op de Spoedeisende hulp (SEH) van het MCH en vanaf 2008 verspreid naar alle andere Haagse ziekenhuizen, Haagse ambulancediensten (2009) en Haagse huisartsenpost (2010). Volgens het Protocol wordt gesproken van 'oudermeldingen' wanneer de ouder patiënt is op de afdeling SEH, terwijl het kind (meestal) niet aanwezig is. Indien de ouder op de SEH komt met klachten die zijn te relateren aan huiselijk geweld, alcohol- of drugsgebruik, of ernstige psychiatrische problematiek, wordt een melding gemaakt bij het AMK ten aanzien van mogelijke kindermishandeling. Naast de meldingen op basis van kindsignalen - die al standaard gedaan worden op de SEH - wordt het AMK nu ook geraadpleegd bij ouderproblematiek.

Inmiddels is de werkwijze van het Haaglanden protocol in juli 2013 als verplicht onderdeel opgenomen in de Wet Huiselijk Geweld en Kindermishandeling ** en geldt het voor onder andere alle BIG geregistreerde professionals in Nederland. Dit zorgde dat niet meer alleen professionals die werken met kinderen kindermishandeling signaleren, maar de signalering ook de verantwoordelijkheid werd van alle andere professionals die werken met volwassen patiënten of cliënten.

Deze dissertatie richt zich op de effectiviteit van het Haaglanden protocol, met name op de positief voorspellende waarde, implementatie in een andere regio, 'missed cases', mogelijke uitbreiding van de drie oudercategorieën, de hulp die de gezinnen werd geboden en de angst voor zorgmijders als gevolg van implementatie. Hieronder volgt een samenvatting van de uitkomsten van de verschillende onderzoeken.

* Vanaf 1 januari 2015 is het AMK samen met het Steunpunt Huiselijk Geweld (SHG) opgegaan in Veilig Thuis.

** Zie appendix II

Na een eerste, inleidend hoofdstuk, wordt in het tweede hoofdstuk onderzocht of implementatie van het Haaglanden protocol leidt tot een toename in de signalering van mishandelde kinderen. Om deze vraag te beantwoorden werd een 'voor-en-na' studie uitgevoerd op negen SEH's in drie regio's in Nederland (de implementatie regio en twee controle regio's).

In de periode voorafgaand aan de implementatie (januari 2006 tot november 2007) werden de kinderen van vier patiënten (van totaal 385.626 SEH patiënten) gemeld bij het AMK op basis van ouderproblematiek (zogenaamde 'oudermeldingen'). Dat is omgerekend één per 100.000 patiënten. In de periode na invoering van het Protocol (december 2007 tot december 2011), steeg het aantal oudermeldingen naar 565 (van totaal 885.301 SEH patiënten), dit is omgerekend 64 per 100.000 patiënten.

In de controle regio werden twee oudermeldingen gedaan vóór de implementatie periode (op totaal 163.628 SEH patiënten), dat is omgerekend één per 100,000 patiënten. Tijdens de implementatie periode werden 10 oudermeldingen gedaan (op een totaal van 371.616 SEH patiënten, omgerekend drie per 100.000 patiënten (OR = 28.0, 95 CI 4,6-170,7). Na onderzoek van het AMK bleek in de implementatie regio dat kindermishandeling werd bevestigd in 91% van de gedane oudermeldingen. Kortom, de oudercategorieën die zijn opgenomen in het Haaglanden protocol zijn adequate voorspellers voor de detectie van kindermishandeling op de SEH.

In het derde hoofdstuk is onderzocht of het Haaglanden protocol ook succesvol is in een andere regio dan de oorspronkelijke implementatieregio (Haaglanden). Friesland fungeerde hierbij als de nieuwe implementatieregio. Eerst werd kritisch gekeken naar de verschillende faciliterende factoren en de barrières die tijdens en na implementatie van het Haaglanden protocol in de oorspronkelijke implementatie regio Haaglanden aan het licht kwamen. Om factoren te vinden en onderling te kunnen vergelijken, werden focusgroep interviews (*n* = 6) gehouden op de SEH's en bij de AMK's (*n* = 2).

Daarnaast werden vragenlijsten gemaakt voor alle artsen en verpleegkundigen van de 6 deelnemende SEH's (*n* = 76). Als laatste is gekeken naar het aantal oudermeldingen na invoering van het Protocol in de regio Friesland en de uitkomsten van het onderzoek naar deze meldingen door het AMK. Het aantal oudermeldingen steeg van twee van de 92.464 patiënten (drie per 100.000) tot 108 van 167.037 patiënten (62 per 100.000). Echter, in Friesland werd kindermishandeling bevestigd in een aanzienlijk lager percentage ten

opzichte van regio Haaglanden (62% versus respectievelijk 91%). Uit een follow-up analyse blijkt dat de lagere positieve voorspellende waarde veroorzaakt werd door het ontbreken van training inzake het Haaglanden protocol bij de AMK medewerkers. Scholing over oudermeldingen voor AMK medewerkers is belangrijk om bewustwording te creëren dat (in tegenstelling tot een kindmelding) een oudermelding zonder kindsignalen wel onder de noemer kindermishandeling geschaard kan worden.

Uit de focusgroep interviews en vragenlijsten bleek dat gebrek aan tijd de belangrijkste barrière vormde tijdens de dagelijkse uitvoering van het protocol Haaglanden. Een collega met als aandachtsgebied kindermishandeling en huiselijk geweld werd genoemd als de meest belangrijke faciliterende factor voor succes. De conclusie is dat het Haaglanden protocol succesvol geïmplementeerd kan worden in een andere regio, hoewel het scholen van medewerkers hierbij essentieel is.

Het vierde hoofdstuk is gericht op eventuele 'gemiste casussen'. Zijn, ondanks de duidelijke richtlijnen van het protocol Haaglanden, kinderen niet gedetecteerd, die op basis van de kenmerken van hun ouders, gemeld hadden moeten worden bij het AMK? Om het aantal 'gemiste casussen' te onderzoeken zijn alle kindmeldingen (dus op basis van kind-signalen, niet ouder-signalen) verzameld, die gedaan zijn bij het AMK tussen 1 juli 2011 en 31 december 2011. Deze gegevens zijn gebruikt om in de database van het MCH te onderzoeken of de ouders van deze kinderen de SEH hebben bezocht in de 12 maanden voorafgaand aan de AMK melding.

Op deze manier werden de ouders gevonden van wie de kinderen doorverwezen hadden moeten worden volgens de richtlijnen van het protocol. Van totaal 108 onderzochten meldingen bleken acht meldingen 'gemist'. Redenen voor het niet melden zijn: vergeten te vragen naar de aanwezigheid van kinderen, en de veronderstelling dat het niet nodig was om de kinderen te melden wanneer ouders aangaven al hulp te ontvangen. Deze redenen lijken relatief makkelijk aan te pakken. Regelmatige scholing van SEH medewerkers en een pop-up als reminder in het patiëntendossier kan helpen om te voorkomen dat deze casussen in de toekomst zullen worden gemist.

Het vijfde hoofdstuk is gericht op de ouderkenmerken die naast de drie die al in het protocol zijn opgenomen, goede voorspellers zouden zijn voor de signalering van kindermishandeling op de SEH: Is het mogelijk om de huidige oudercategorieën uit te breiden, om zo meer slachtoffers van kindermishandeling te signaleren met behoud van

de hoog positief voorspellende waarde? Hiervoor is gebruik gemaakt van een 'nested case control design', waarin ouders die geïdentificeerd zijn als dader van kindermishandeling (*n* = 100) in verschillende dimensies vergeleken werden met een groep van ouders die niet zijn aangemerkt als dader van kindermishandeling (*n* = 100). Significante verschillen tussen beide groepen werden niet gevonden. De huidige oudercategorieën worden daarom niet uitgebreid, om onnodige belasting voor ouders, kinderen en professionals te voorkomen.

In het zesde hoofdstuk staat het onderwerp 'Ondersteuning en monitoring van gezinnen door het AMK na een oudermelding vanaf de SEH', centraal. Onderzocht werd hoe het de gezinnen drie maanden na de melding vergaat. Hiervoor werden de 100 oudermeldingen onderzocht waarbij na onderzoek door de AMK, kindermishandeling werd bevestigd. Informatie werd verzameld over het type kindermishandeling, de duur van de problemen voorafgaand aan de oudermelding, eerdere betrokkenheid van hulpverlening instanties, aantal AMK meldingen na de oudermelding, en de conclusie van professionals en de families over de huidige stand van zaken. Van de 100 onderzochte casussen bleken 68 gezinnen al bekend te zijn bij het AMK, de politie of andere hulpverlening instanties, voorafgaand aan de oudermelding vanuit de SEH. Van de 99 gevallen waarbij informatie beschikbaar was, werd in 31 gevallen de bestaande hulpverlening voortgezet of geïntensiveerd en in 24 gevallen werd de melding overgedragen aan de Raad voor de Kinderbescherming.

In 27 gevallen werd nieuwe hulpverlening ingezet en in 17 gevallen bleek het niet nodig om hulpverlening in te zetten, omdat de problemen inmiddels waren verholpen of ouders zelf al hulp hadden gezocht. Hoewel het AMK verplicht is om na drie maanden te informeren hoe het gezinnen vergaat, werd dit in 31 gevallen niet gedaan. De reden hiervoor is dat intern overgedragen zaken aan Bureau Jeugdzorg of de Raad voor de Kinderbescherming niet worden opgevolgd door het AMK. Hierdoor verliest het AMK het zicht op deze gezinnen. Twee derde van de gezinnen was al bekend bij verschillende instanties (politie, AMK, Steunpunt Huiselijk Geweld) voor de oudermelding. Betere monitoring (frequenter en langer) door het AMK zou kunnen voorkomen dat de gezinsproblemen aanhouden en verergeren. Een nationale databank zou kunnen helpen om gegevens te koppelen, wanneer dezelfde kinderen of hun ouders worden gemeld bij verschillende hulpverleningsinstanties.

Het zevende hoofdstuk is gericht op de volgende onderzoeksvraag: Leidt implementatie van het Haaglanden protocol op de SEH tot zorgmijders? Om dit te onderzoeken, werd het aantal patiënten (geïncludeerd in de drie oudercategorieen van het protocol) die de SEH bezochten voor de implementatieperiode (2006-2007) vergeleken met het aantal SEH patiënten na de implementatie periode (2008-2011). Het aantal SEH patiënten geïncludeerd in het protocol daalde niet. Daarnaast werden 14 telefonische interviews gehouden met de ouders wiens kinderen gemeld zijn door de SEH bij het AMK. De meeste ouders (*n* = 10) waren positief en gaven aan dat zij in de toekomst de SEH opnieuw zouden bezoeken met dezelfde klachten. Verpleegkundigen en artsen die kinderen melden bij het AMK op basis van ouderproblematiek, hoeven niet te vrezen deze gezinnen als patiënt te verliezen.

Huidige stand van zaken

Naar aanleiding van de veelbelovende uitkomsten van dit onderzoek is in juli 2013 door de Tweede Kamer een motie aangenomen, waarin het Haaglanden protocol verplicht wordt ingevoerd door alle Spoedeisende Hulp afdelingen van ziekenhuizen, ambulancediensten en huisartsenposten. Ook kregen het onderzoeksteam financiële steun van het Ministerie van VWS om samen met de Augeo Academie implementatie binnen de ambulancediensten en de huisartsenposten te bewerkstellingen. In het zelfde jaar werd het onderzoeksteam verrast door een 'Parel' prijs van ZonMw, aan de projectleider overhandigd door Staatssecretaris van Rijn. ZonMw reikt deze prijs uit aan onderzoek dat meer dan gemiddeld resultaat oplevert, aansluit bij een actuele ontwikkeling of een passend antwoord lijkt te hebben op een vraag of knelpunt in de gezondheidszorg.

Het Ministerie van Volksgezondheid, Welzijn en Sport (VWS) heeft in de beschrijving van de Kindcheck* in de wet Meldcode Kindermishandeling en Huiselijk Geweld zich niet beperkt tot de oudercategorieën en de groepen professionals zoals beschreven en onderzocht in het protocol Haaglanden. Deze uitbreiding heeft tot doel het signaleren van een grotere groep kinderen die mogelijk slachtoffer is van kindermishandeling en het tijdig inzetten van hulp voor deze gezinnen.

*dit is de verplichting voor professionals om bij ernstige zorgen over een volwassen patiënt te vragen naar de aanwezigheid van minderjarige kinderen – zie appendix II

Of dit doel ook bereikt wordt en niet leidt tot het onnodig belasten van gezinnen en professionals is nog onduidelijk. Om deze eventuele onnodig belasting te voorkomen, dan wel tijdig te signaleren, is het belangrijk dat de effectiviteit van de Kindcheck onderzocht wordt. Een tweede belangrijke reden dit te onderzoeken is de internationale aandacht voor dit Nederlandse vooruitstrevende plan. Het is daarom belangrijk dat de resultaten als 'best practice' dienen en andere landen het voorbeeld van het Haaglanden protocol overnemen. Dit kan en zal alleen gebeuren als deze aanpak een wetenschappelijke basis heeft en eventuele kinderziekten tijdig worden aangetoond en bijgesteld. Begin 2016 zal dit onderzoek worden gestart met subsidie van ZonMw.

Vanuit verschillende landen is interesse in deze werkwijze en het onderzoeksteam is in overleg met een aantal ziekenhuizen in de Verenigde Staten, Zwitserland en Duitsland om een pilot van het Haaglanden protocol voor te bereiden. Vanuit het MCH is een jaarlijks budget beschikbaar gesteld waarmee deze nieuwe aanvulling op het signalering van kindermishandeling op internationale congressen onder de aandacht gebracht kan worden.

Appendices I and II

Appendix I: Parental categories

The specific characteristics of parents included in the Hague protocol are: 1) being a victim of domestic violence, 2) attempting suicide (or having other serious psychiatric disorders) and 3) substance abuse. The following studies support our theory that indicates these parental characteristics are associated with child abuse and neglect (Dube et al., 2001; Hurme, Alanko, Anttila, Juven, & Svedstrom, 2008; Kelleher, Chaffin, Hollenberg, & Fischer, 1994).

Domestic violence

Domestic violence can be labeled as an independent stressor/adverse event for children and as a marker for other forms of maltreatment. Domestic violence exposure can be acknowledged as a form of maltreatment itself. While these three concepts are clearly related, they are medically and legally distinct.

Witnessing domestic violence has been defined as "a child being present while a parent or sibling is subjected to physical abuse, sexual abuse or psychological maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behavior" (Higgins, 1998). Some countries classify witnessing domestic violence as a special form of emotional maltreatment. However, a growing number of professionals regard witnessing family violence as a unique and independent subtype of abuse (Higgins, 2004). Regardless of the classification used, research has shown that domestic violence is directly associated with child maltreatment. (Edleson, 1999; Thackeray, Hibbard, & Dowd, 2010; Wright, Wright, & Isaac, 1997). Children who witness domestic violence have a high risk of developing psychological problems such as developmental delay and posttraumatic stress disorder (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Lamers-Winkelman, De Schipper, & Oosterman, 2012; Wright et al., 1997). In addition, these children are more likely to be abused and neglected. Where boys exposed to domestic violence are more likely to engage in domestic violence as adults, girls are more likely to be victims (Brown & Bzostek, 2003). Felitti et al. found a strong graded relationship between exposure to domestic violence as a child and multiple risk factors for several of the leading causes of death in adults (Felitti et al., 1998).

Families with concurrent domestic violence and child maltreatment issues have high cumulative risk levels (e.g. substance abuse) and their children are 10 times more likely to be placed in foster care than children of families with low risk levels (Kohl, 2005). Early identification of domestic violence may be one of the most effective means of preventing child abuse and identifying caregivers and children who need extra support, care or therapy (Thackeray et al., 2010).

Severe Psychiatric Problems

Parental psychiatric problems are a well-known risk factor for child abuse (Hurme et al., 2008). Two thirds of women with mental illness are mothers (Nicholson, Beibel, Hinden, Henry, & Stier, 2001) and mental illness increases the risk of coercive or hostile parenting (Chung, McCollum, Elo, Lee, & Culhane, 2004). Parents with depression or undifferentiated mental illness are twice more likely to neglect and abuse their children than parents without mental illness (Brown, Cohen, Johnson, & Salzinger, 1998; Walsh, MacMillan, & Jamieson, 2003). Studies show that maternal depression is clearly linked to child neglect (Hien, Cohen, Caldeira, Flom, & Wasserman, 2010). Many low income mothers are diagnosed with a mental disorder only after the first maltreatment report of their child. This means that concerns about a child's welfare have opened the gateway to mental health services for the mother (Kohl, Jonson-Reid, & Drake, 2011).

Substance Abuse

For decades it has been well known that substance abuse has negative consequences for the unborn child (Bailey, Hill, Oesterle, & Hawkins, 2009; Bennett, 1999; Kuczkowski, 2007; McFarlane, Parker, & Soeken, 1996). Recent research has shown that mothers who are substance abusers react less adequately to their babies' needs than parents who are not substance abusers (Landi et al., 2011). A clear association has been found between substance abuse and child abuse or neglect (Dube et al., 2001; Hurme et al., 2008; Kelleher et al., 1994). Children of substance abusers are 50% more likely to be abused and, or, neglected than children whose parents are not substance abusers (Kelleher et al., 1994).

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Appendix II

Kindcheck in Wet Meldcode kindermishandeling en huiselijk geweld 2013 (Amendment in Dutch legislation on detecting child abuse based on parental characteristics, Dutch Law book, 2013):

Het signaleren en het indien nodig melden van kindermishandeling behoort ook tot het werkterrein van professionals die volwassenen als cliënt hebben. Bij ouders zijn risicofactoren bekend die de kans op kindermishandeling aanzienlijk verhogen. Ouders die hun kind mishandelen of verwaarlozen hebben relatief vaak last van psychische of psychiatrische problemen. Ook verslaving aan alcohol of drugs komt vaak voor als risicofactor: naar schatting 30 tot 90 procent van de verwaarlozende en 50 procent van de fysiek mishandelende ouders heeft verslavingsproblemen (bron: 'Risicofactoren en beschermende factoren voor kindermishandeling', Nederlands Jeugdinstituut, november 2010).

Naar aanleiding van de behandeling van de wet verplichte meldcode huiselijk geweld en kindermishandeling zijn door de Tweede Kamer twee moties aanvaard die gaan over oudermeldingen. De motie Kooiman (Kamerstukken II 2012/13, 33 062, nr. 12) verzoekt de regering om oudermeldingen in de reguliere en geestelijke gezondheidszorg te borgen. De motie Van der Burg – Hilkens (Kamerstukken II 2012/13, 33 062, nr. 15) verzoekt de regering het ouderprotocol Haaglanden[*] verplicht te stellen voor alle spoedeisende hulpafdelingen in ziekenhuizen, ambulancediensten en huisartsenposten in Nederland.

Ter uitvoering van de motie Kooiman wordt in dit besluit als verplicht element van de meldcode opgenomen dat, indien de situatie daarom vraagt, een Kindcheck moet worden uitgevoerd. Het gaat dan in de praktijk om cliënten waarbij de (medische) conditie of situatie een risico kan inhouden voor kinderen die afhankelijk zijn van de cliënt, zoals bij bepaalde vormen van psychische of verslavingsproblematiek en bij cliënten die te maken hebben met huiselijk geweld.

[*] In 2007 is een protocol ontwikkeld in het Medisch Centrum Haaglanden (MCH), waarmee kindermishandeling gesignaleerd wordt op basis van ouderkenmerken. Ouders van minderjarige kinderen of zwangeren die op de Spoedeisende Hulp (SEH) komen met klachten als gevolg van een overdosis drugs of alcohol, na een suïcidepoging dan wel automutilatie of slachtoffer zijn van huiselijk geweld wordt standaard gevraagd of zij verantwoordelijk zijn voor minderjarige kinderen. Als dit het geval is worden de kinderen van deze ouders gemeld bij het AMK.

De Kindcheck behelst nagegaan of kinderen onder de zorg van de cliënt staan en beoordelen of kan worden vastgesteld of de kinderen veilig zijn. Van de professionals wordt niet verwacht dat zij een uitgebreid onderzoek doen om te bepalen of sprake is van kindermishandeling. Professionals zullen
daarom niet altijd goed kunnen vaststellen of de kinderen veilig zijn. Bij twijfel is de professional op basis van stap 4 van de meldcode verplicht om contact op te nemen met het AMK (Veilig Thuis) voor consultatie. Wanneer vervolgens de inschatting is dat hulpverlening op vrijwillige basis het risico voor het kind voldoende kan afwenden, dan kan de professional kiezen zelf deze hulp te verlenen of deze elders in gang te zetten.

De combinatie van de verplichte Kindcheck en de verplichting om in geval van twijfel het AMK te raadplegen zorgt dat in dergelijke situaties een zorgvuldige toetsing van het belang van het kind plaatsvindt en daarnaar wordt gehandeld.

De Kindcheck met de beschreven vervolgstappen geldt niet alleen voor instanties uit de reguliere en geestelijke gezondheidszorg (zoals verzocht in de motie Kooiman), maar ook voor andere sectoren waar professionals te maken hebben met volwassen cliënten. Dit zal vooral instanties betreffen in de sectoren maatschappelijke ondersteuning en justitie.

De motie Van der Burg - Hilkens verzoekt de regering het ouderprotocol Haaglanden verplicht te stellen voor alle spoedeisende hulpafdelingen in ziekenhuizen, ambulancediensten en huisartsenposten in Nederland. Met het voorschrijven van de verplichte Kindcheck en de hierboven beschreven vervolgstap 4 wordt de strekking van de motie binnen de wettelijke kaders uitgevoerd.

Voor de in de motie genoemde beroepsgroepen geldt dat zij vaak te maken hebben met crisissituaties. Als het dan gaat om volwassen patiënten die de zorg hebben voor kinderen, kan van de betrokken professionals niet verwacht worden dat zij een goede inschatting kunnen maken van de thuissituatie van het kind. Raadpleging van het AMK, zoals voorgeschreven in stap 4 van de meldcode, is dan geboden.

Dankwoord

Dat ik als verpleegkundige zonder wetenschappelijke ervaring een dankwoord mag schrijven voor een eigen proefschrift heb ik aan vele collega's en professionals te danken. Graag had ik 400 pagina's in plaats van 400 woorden gehad om iedereen persoonlijk te kunnen bedanken…

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Natuurlijk was deze succesvolle implementatie niet mogelijk zonder mijn collega's van de SEH en de medewerkers van AMK Haaglanden. Met name Paul Baeten wil ik bedanken voor de inbreng van zijn expertise en Rob Huijsen en Ria Andrews die samen met mij alle Haagse en Friese SEH medewerkers hebben geschoold.

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Brigitte van der Burg, Tweede Kamerlid van de VVD, heeft de motie ingediend waarin de werkwijze van het Haaglanden protocol landelijk werd verplicht. Brigitte, dankzij jouw motie is de Kindcheck nu een feit, veel dank hiervoor.

Dit onderzoek was niet mogelijk geweest zonder de medewerking van het AMK in Friesland, Flevoland en Zuid-Limburg, de SEH's in Friesland en Haaglanden en de ouders die hebben meegewerkt.

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Allerliefste Jeroen, je bent de liefde van mijn leven, bedankt voor alles!

Curriculum Vitae

Hester Diderich-Lolkes de Beer werd geboren op 29 juli 1972 in Den Haag. In 1989 haalde zij haar HAVO diploma aan het Aloyisius College in Den Haag. Van 1990 tot 1995 heeft zij de A-opleiding tot verpleegkundige aan het Florence Nightingale instituut in Den Haag doorlopen, waar zij haar praktijk ervaring opdeed in het Bronovo Ziekenhuis. Deze opleiding heeft ze succesvol afgerond.

Van 1995-2000 heeft zij de IC-CCU opleiding in het Antonius Ziekenhuis in Nieuwegein met succes doorlopen, waarna zij in 2000 begon te werken op de afdeling Spoed Eisende Hulp (SEH) van het Medisch Centrum Haaglanden, locatie Westeinde. Hier behaalde zij in 2003 haar diploma als SEH verpleegkundige.

Vanaf 2008 combineerde zij haar functie op de SEH met het aandachtsfunctionarisschap kindermishandeling en huiselijk geweld. Vanaf 2010 heeft zij zich volledig toegelegd op het aandachtsfunctionarisschap en het uitdragen van de 'oudermeldingen' naar andere organisaties in binnen en buitenland.

In 2011 is zij gestart met het wetenschappelijk onderzoek naar de effectiviteit van oudermeldingen op de SEH. Dit onderzoek werd gevolgd door een implementatie onderzoek van deze oudermeldingen (de Kindcheck) voor alle SEH's, AMK's (tegenwoordig 'Veilig Thuis') in 2013 en voor alle ambulancediensten en huisartsenposten in 2014. Deze onderzoeken werden uitgevoerd met steun van ZonMw en het Ministerie voor Volksgezondheid, Welzijn en Sport.

Binnenkort zal zij samen met een onderzoeksteam starten aan een landelijk onderzoek naar de effectiviteit van de Kindcheck en een implemenatie onderzoek van de Kindcheck binnen de GGZ.

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