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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