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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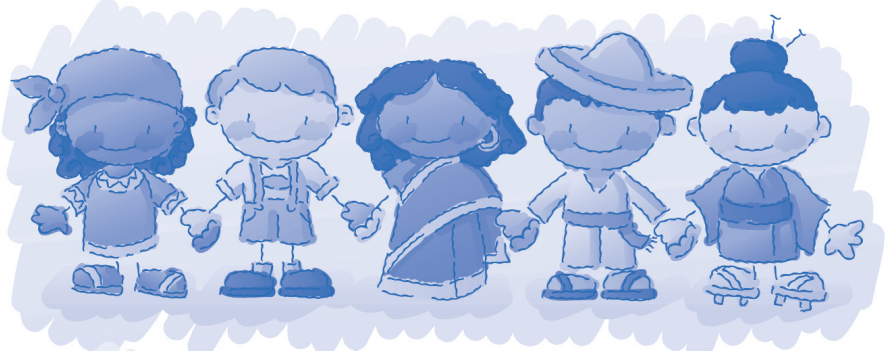

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ABSTRACT

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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