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Summary

Samenvatting

Appendices I and II

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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 led 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).