Chapter 6

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

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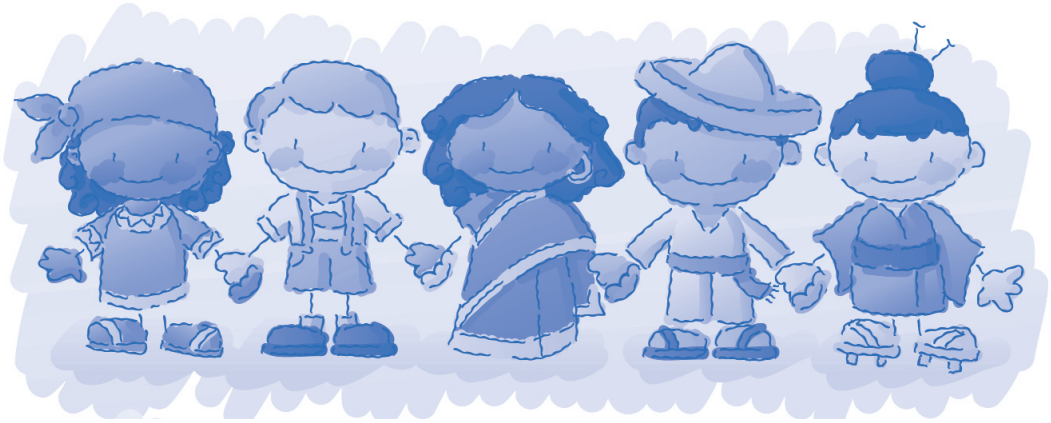

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ABSTRACT

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.

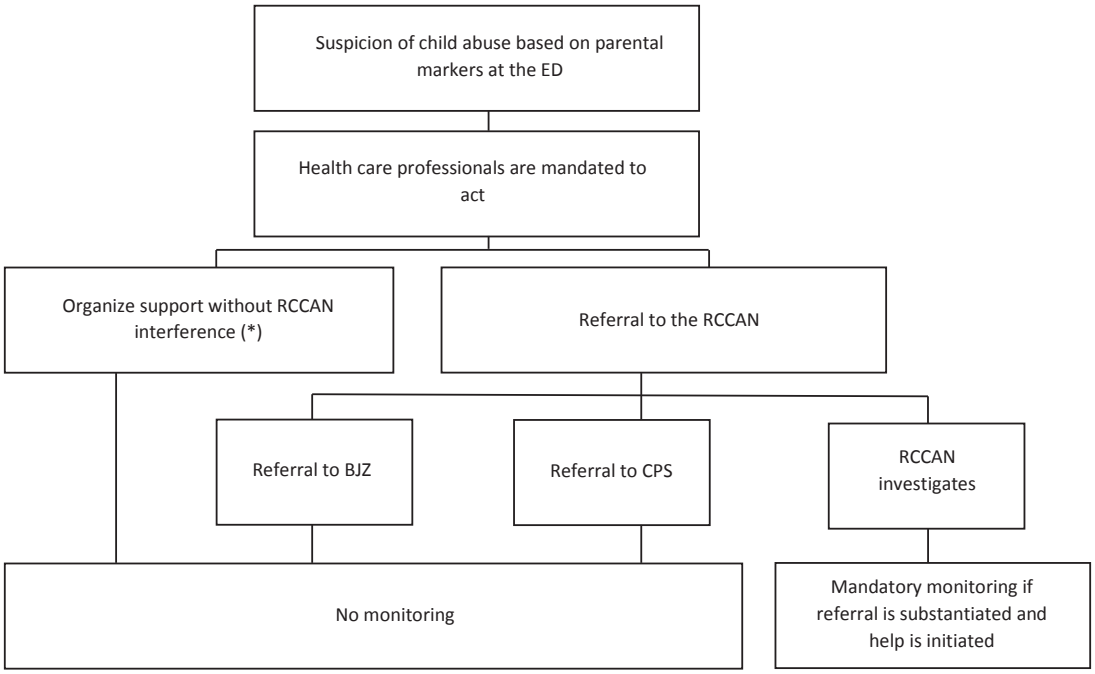

Figure 1. Steps to be followed by health care professionals.

*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).

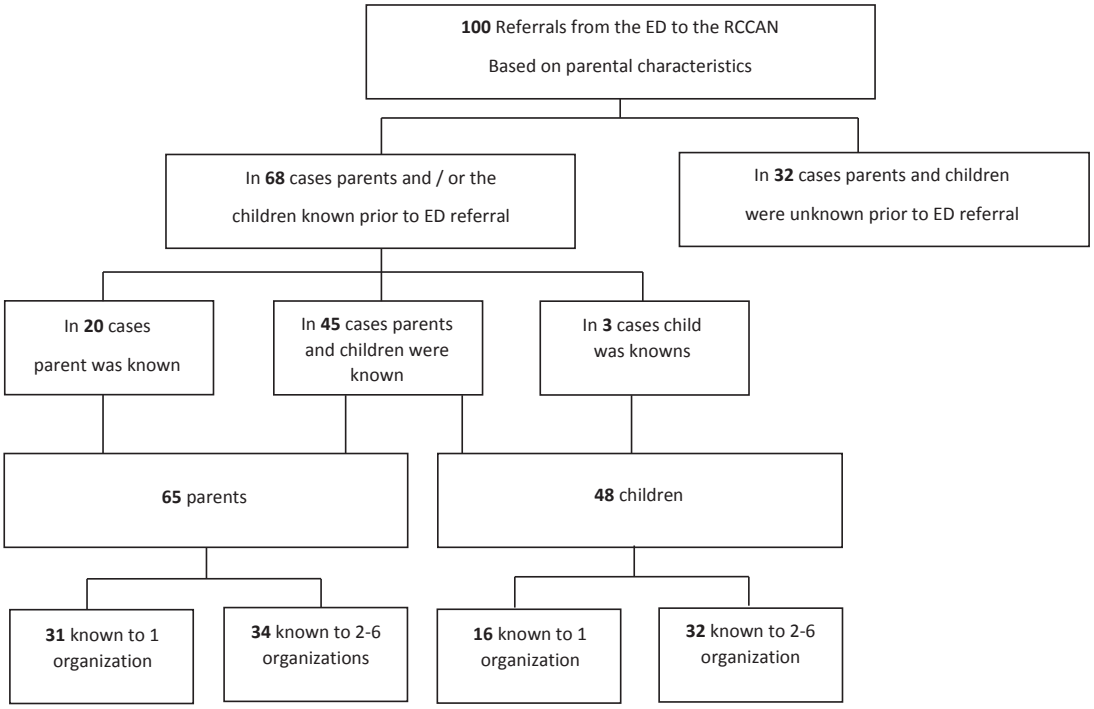

Figure 2. Families known or unknown prior to ED referral.

*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.

Reason for ED referral	Duration of the problems			
	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).

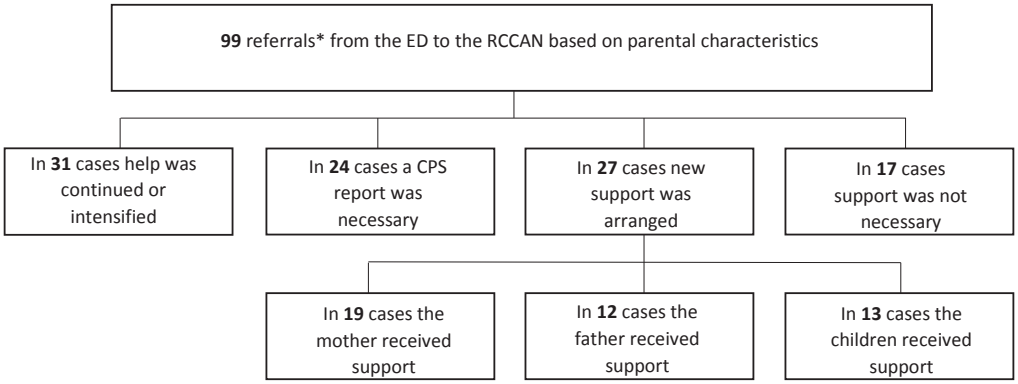

Figure 3. Overview of support arranged after ED referral.

* 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).

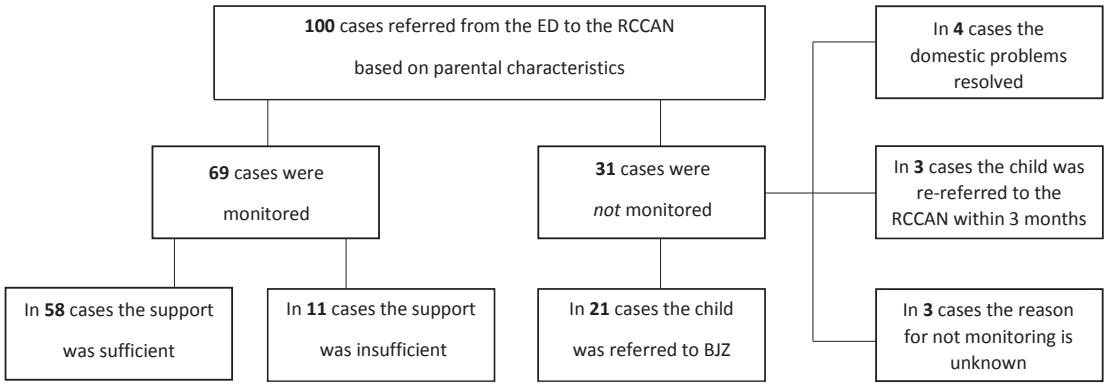

Figure 4. Overview of follow-up by the RCCAN after three months.

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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