Child maltreatment, parents & the emergency department
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Citation for published version (APA):

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CHAPTER 1

INTRODUCTION
CHILD MALTREATMENT

Child maltreatment, also referred to as child abuse and neglect, is defined by the World Health Organization (2014) as: ‘all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power’. Different subtypes of child maltreatment can be distinguished: physical abuse; sexual abuse; physical- and emotional neglect; emotional abuse; and exploitation. Also, exposure to intimate partner violence of parents or caregivers is considered to be a form of child maltreatment. In The Netherlands, in the Youth Act (2014, in Dutch: Jeugdwet), child maltreatment is defined as: ‘Every form of threatening or violent behavior towards minors of a physical, psychological or sexual nature. This behavior is forced on minors actively or passively by parents or other persons towards whom minors feel dependent and lack freedom, and (threatens to) cause serious harm in the form of physical or psychological damage’. The Dutch Civil Law (2007, in Dutch: Burgerlijk Wetboek) also states that it is mandatory for parents to take care of their children and to raise them without using either mental or physical violence or any other type of humiliating treatment.

PREVALENCE

Child maltreatment is a worldwide problem, but it is difficult to determine the exact prevalence. Rates vary widely, depending on the study methods that are used. Child- and parent-reported prevalence rates of child maltreatment are much higher than rates of maltreatment reported by professionals. In a large prevalence study in 2010 in The Netherlands, 9.9% of high school students (age 11 to 17 years) reported to have been maltreated during the past year. In contrast, only 2% of Dutch children in that age category (and 3.4% of all Dutch children) were known to be maltreated by professionals, a five-fold lower rate. Studies about trends in prevalence rates of child maltreatment are not consistent. In The Netherlands, there was
no change in the prevalence of self-reported maltreatment in 2010 relative to 2006. A large study in six developed countries reported no real changes either between 1979 and 2010 and another study reported no change in hospitalization rates for abuse from 1997 to 2009 in the USA. In contrast, other studies from the USA have found declines of child maltreatment rates between 1993 and 2011, especially in physical- and sexual abuse, both self-reported and reported by professionals. In The Netherlands, according to reports of professionals, physical and emotional neglect are the most prevalent types of child maltreatment; in almost half of the maltreated children, more than one type of maltreatment occurs.

**RISK FACTORS**

Several, often clustered factors that increase the risk of child maltreatment have been identified. In The Netherlands, both in the 2007 and the 2011 prevalence studies, a very low education and unemployment of parents were identified as the main risk factors. Furthermore, children raised by a single parent, large families (3 or more children) and newly immigrated families were found to have an increased risk for maltreatment. In addition, other risk factors were found in international studies, including poverty and socioeconomic inequality, young parents, unintended pregnancy, poor social network, intimate partner violence, substance use, depressive symptoms and other psychiatric problems of parents, low birth weight, disability and lower mental development of children. Although childhood maltreatment of one of the parents is often reported as a risk factor, a recent study showed that intergenerational transmission of child maltreatment is complex, and the extent depends largely on the study methodology used. There are also protective factors for child maltreatment, including a supportive family environment and social networks.
CONSEQUENCES
Child maltreatment has many, short- and long-term, negative consequences for children and their families. In pregnancy, infancy and early childhood, severe or prolonged exposure to trauma without the protection of a supportive adult can induce a toxic stress response leading to permanent changes of the brain, and the cardiovascular, immune and metabolic systems. Child maltreatment is associated with lower education and employment, increased aggression and crime rates, mental health problems, and decreased physical health. Many adult diseases origin in early childhood. A landmark study called the Adverse Childhood Experiences (ACE) study, conducted among 13,494 middle-aged adults undergoing a standardized medical examination between 1995 and 1996, showed a strong, graded relationship between maltreatment and household dysfunction during childhood and the leading causes of death in adulthood. A study in the USA found that child maltreatment has a large impact on healthcare costs for children, even when additional societal costs were not taken into account. Fortunately, not all children experience impairment as a consequence of maltreatment. Factors promoting resilience following childhood maltreatment include a stable family environment and supportive relationships.

SCREENING
In 2012, the American Academy of Pediatrics stated that the reduction of toxic stress in young children should be a high priority for medicine as a whole and for pediatrics in particular. Early identification of children who are maltreated or at high risk for maltreatment is the first step to intervene, prevent recurrence of maltreatment and improve outcomes. However, several studies have shown that it can be very difficult for hospital staff to identify maltreatment. To improve identification of child maltreatment, several screening methods, such as training of personnel, checklists and a screening physical examination have been implemented in hospitals. In addition, in 2007, a screening method
based on risk factors for child maltreatment in parents was implemented at emergency departments in the Hague region, The Netherlands. This ‘Hague’ protocol states that all adults attending the emergency department after intimate partner violence, substance abuse or a suicide attempt should be asked whether they care for children under 18 years. If so, these children are reported to the Child Abuse Counseling and Reporting Centre (in Dutch: Advies en Meldpunt Kindermishandeling, AMK) 29. In 2010, an adapted version of this protocol was implemented in emergency departments in Amsterdam, The Netherlands. In this ‘Amsterdam’ protocol, children are identified in the same manner as in the Hague protocol, but instead of an AMK report, children are referred to the outpatient pediatric department for an evaluation and, if necessary, referrals to support services. In The Netherlands, it has become mandatory to use a screening instrument for maltreatment in all children attending the emergency department in early 2009 30; and in 2013 it became mandatory to screen children of parents with serious risk factors for child maltreatment who come to the attention of a (health) care professional, which is called the ‘child check’ (in Dutch: kindcheck) 31.

**DUTCH CHILD PROTECTIVE SYSTEM**

In The Netherlands, child maltreatment is approached primarily as a family, medical or psychosocial problem, and the child protective system is child and risk focused 32. Child protective services are focused on prevention of abuse and safeguarding of children, while family support is organized separately 32. Professionals who work with families and suspect child maltreatment are required to use a reporting code and ask for advice 31. However, no legal obligation to report child maltreatment exists 33. During the time of the research of this thesis (2011-2015), the AMK was the agency that advised professionals and citizens and investigated reported suspicions of child maltreatment 33. Since January 2015, the Dutch youth care system has been decentralized and transformed, and municipalities have become responsible
for all youth care. The former AMK’s and Support Centers for Intimate Partner Violence (in Dutch: Steunpunt Huiselijk Geweld, SHG) are now combined into one organization called ‘Safe Home’ (in Dutch: Veilig Thuis). Safe Home is a non-judicial organization and advises on, investigates and tries to find solutions for (suspicions of) child maltreatment in cooperation with children and parents. Child and family support can be arranged with many different services; if cases are too serious or parents refuse to cooperate, they are handed over to the Child Care and Protection Board (in Dutch: Raad voor de Kinderbescherming, RvdK), which is a division of the Ministry of Security and Justice.

CONTENTS
This thesis describes research to assess screening methods for child maltreatment at the emergency department with an emphasis on screening based on parental risk factors and the wellbeing of families of which a parent visited the emergency department due to intimate partner violence, substance abuse or a suicide attempt.

GENERAL OUTLINE
In Chapter 2 we provide an overview of screening methods for child maltreatment across Dutch emergency departments, and we assess their evidence base. We then evaluate the diagnostic value of one of those screening methods, a physical examination, by reviewing the literature (Chapter 3). Following this, we assess parents’ opinion about screening tools for child maltreatment in Chapter 4, first by reviewing the literature and secondly by conducting a questionnaire study about parents’ opinion of a physical examination of their children when visiting the emergency department. Chapters 5-8 deal with screening for child maltreatment based on risk factors of parents attending the emergency department. In Chapter 5, in a retrospective study, we describe the characteristics of families who
were identified in the Amsterdam protocol and their referrals to services during the first two years after implementation in one hospital. We then describe a multicenter, prospective study to evaluate the Amsterdam protocol. Results are compared to results of the Hague protocol in Chapter 6, in which we explore and try to explain similarities and differences between both protocols. In Chapter 7, we assess the levels of psychological symptoms of children identified in the Amsterdam protocol. Subsequently, in Chapter 8, we assess the wellbeing and involvement of support services of these families at one-year follow-up. To compare our results to the Hague protocol, we include families from a hospital using the Hague protocol in Groningen, The Netherlands as well. In Chapter 9, we describe and discuss two cases of the child check at the emergency department. Chapter 10 discusses the use of personal data of children in studies about maltreatment without obtaining informed consent. We end with a summary and general discussion of our findings in Chapter 11.
REFERENCES

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