Child maltreatment, parents & the emergency department
Hoytema van Konijnenburg, E.M.M.

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CHAPTER 5

NEW HOSPITAL-BASED POLICY FOR CHILDREN WHOSE PARENTS PRESENT AT THE ER DUE TO DOMESTIC VIOLENCE, SUBSTANCE ABUSE AND/OR A SUICIDE ATTEMPT

Eva M.M. Hoytema van Konijnenburg
Tessa Sieswerda-Hoogendoorn
Sonja N. Brilleslijper-Kater
Johanna H. van der Lee
Arianne H. Teeuw

ABSTRACT
Background: Child maltreatment is a major social problem with many adverse consequences, and a substantial number of maltreated children are not identified by health care professionals. In 2010, in order to improve the identification of maltreated children in hospitals, a new hospital-based policy was developed in Amsterdam, The Netherlands. This policy was adapted from another policy that was developed in The Hague, The Netherlands, in 2007. In the new Amsterdam policy, all adults presenting at the emergency department due to domestic violence, substance abuse and/or a suicide attempt are asked whether they have any children in their care. If this is the case, parents are urged to visit the outpatient pediatric department together with all of their children. During this visit, problems are evaluated and voluntary referrals can be arranged to different care organizations. If parents refuse to cooperate, their children are reported to the Dutch Child Abuse Counseling and Reporting Centre.
Objective: The two aims of this study are to describe 1) characteristics of the identified families and 2) the referrals made to different voluntary and involuntary care organizations during the first two years after implementation of the policy.
Methods: Data were collected retrospectively from medical records.
Results: 106 children from 60 households were included of which 68 children because their mother was a victim of domestic violence. Referrals to care organizations were arranged for 99 children, of which 67 on a voluntary basis.
Conclusion: The Amsterdam policy seems successful in arranging voluntary support for the majority of identified children.
INTRODUCTION

Child maltreatment is a worldwide social problem with many serious consequences, both short- and long-term. The prevention and early detection of child maltreatment is extremely important in order to intervene and improve the situation and to prevent repeated abuse, serious morbidity, or even death.

Over recent decades, awareness of child maltreatment has been increasing, together with the development of large-scale prevention policies. Despite these policies, there is no clear indication that the prevalence of child maltreatment has decreased. On the one hand, in the United States, there are some indications of a decrease in child maltreatment between 1993 and 2005; while, on the other hand, a recent study in six developed countries (including the United States, Sweden and England), showed no indications for such a decrease (except in the category of severe physical abuse). A large study in The Netherlands has also shown no decrease in child maltreatment between 2005 and 2010.

Unfortunately, the majority of maltreated children remain unknown to health and social care professionals. In hospitals, child maltreatment is underdetected by physicians as well as by nursing staff. A number of methods have been developed to improve detection of child maltreatment in children presenting at emergency departments, including checklists and training of personnel. A recent study showed that systematic screening of all children who visit emergency departments is effective in increasing the detection rate of suspected child maltreatment. However, the ability of these screening policies to detect true child maltreatment is unclear.

New policies

In 2007, a new policy was developed in The Hague, The Netherlands to improve detection of child maltreatment in hospitals. The identification of maltreated children in the ‘Hague policy’ is based on three important risk factors for child maltreatment by parents: domestic violence, substance abuse, and psychiatric problems. All adults presenting at the emergency department due to domestic violence, alcohol or drug abuse, and/or a
suicide attempt are asked whether they have any children in their care. If this is the case, all their children are referred to the Child Abuse Counseling and Reporting Centre (in Dutch: Advies en Meldpunt Kindermishandeling, AMK), which is part of the Dutch Child Protective Services (CPS). According to the AMK investigation, over 90% of these children suffer from maltreatment.

In 2010, in Amsterdam, The Netherlands, this policy was adapted to take into account the preference of the Amsterdam hospitals to offer families the opportunity to accept voluntary support before a referral to the AMK would be made. In this hospital-based policy, while children are identified in the same manner as in the “The Hague policy”, the emphasis is on supportive care for the family on a voluntary basis, preferably without the involvement of the AMK.

In place of immediate referral to the AMK, parents are urged to visit the outpatient pediatric department together with all their children. Only if the social situation is assessed as acutely unsafe for their children, is the AMK notified by the emergency department for immediate action. For all other children, the voluntary visit to the outpatient pediatric department is scheduled shortly after parental presentation at the emergency department. During this visit, the home situation is extensively discussed, and social, medical and mental health problems are evaluated. As part of this visit, all children are physically examined to identify any signs of physical maltreatment and neglect. Any other healthcare providers engaged with the family (including the AMK) are consulted. Parents receive counseling on the (negative) consequences of their behavior for their children and voluntary support is arranged when necessary. Several health care professionals may participate in this visit as appropriate: a pediatrician, a social worker, a child psychologist and/or a nurse. If parents do not attend the outpatient pediatric department despite a written reminder and a reminder by telephone, or if they refuse to cooperate with the offer of supportive care, or if the situation at home is considered unsafe, children are reported to the AMK or to another department of CPS for more severe (possibly involuntary) measures. All six hospitals in the Amsterdam region are committed to the Amsterdam policy, which reduces the chance that parents are able to choose a hospital not adhering to this policy.
Hypothesis and aims
We hypothesize that this hospital-based policy is effective in organizing support on a voluntary basis for the majority of children who are identified. This study has two aims:

1) To describe the characteristics of the children and parents who were identified in the Amsterdam policy during the first two years after implementation of this policy in our hospital and
2) To describe the proportion of referrals from the outpatient pediatric department in terms of i) voluntary support organizations, i.e., various social and (mental) health care organizations, and ii) (involuntary) the AMK/CPS.

METHODS
Study design
We conducted a retrospective study of the medical records of those patients referred according to the newly established Amsterdam policy to the outpatient pediatric department of the Emma Children’s Hospital, which is part of the Academic Medical Center in Amsterdam, The Netherlands.

Setting
Data were collected for the period between May 5, 2010 (the start of implementation of the Amsterdam policy in the hospital) and April 30, 2012. The Academic Medical Center is an academic hospital with 32,000 annual presentations at the emergency department. According to emergency department records, approximately 80 of these presentations are formally registered as caused by drugs or alcohol abuse and approximately 25 as suicide attempts. However, it is assumed that not all presentations are registered correctly and that these numbers are largely underestimated. The number of emergency presentations due to domestic violence is unknown due to the absence of a specific code for this type of presentation.
Participants
We included all children of 0-18 years old, who were referred to the outpatient pediatric department after a parent’s presentation at the emergency department due to one or more of the following indications: domestic violence, substance abuse, and/or a suicide attempt during the study period. Parents were defined as the person(s) who take care of the children and live (at least part of the time) in the same household. They do not necessarily have legal custody of the children.

Data Setting
Two researchers (EH, TS) extracted data from the hospital medical records for all children and parents identified during the study period. No other data sources were used. While it was common to find information on AMK/CPS involvement in the medical records, (and if this was the case, this information was used), it was not otherwise sought. The researchers collected the following information: 1) demographic characteristics of children and parents, 2) date and reason for emergency department presentation of the parent, 3) attendance at the outpatient pediatric department (at first call / after repeated call / no), 4) earlier child maltreatment (according to history given by parents and children and/or information listed in the medical records on results of an investigation by AMK/CPS), i.e., more than one year before the call at the outpatient pediatric department, 5) recent child maltreatment, i.e., less than one year before the call, 6) all nonroutine care organizations earlier or recently engaged with the child or family, and 7) any referrals to different care organizations that were initiated at the outpatient pediatric department.

Child maltreatment was defined according to the Dutch law and includes: physical child abuse, emotional child abuse, sexual child abuse, and physical and emotional neglect. Witnessing domestic violence was also considered child maltreatment. Referrals to care organizations were categorized into 1) family care, 2) individual therapy for the child, 3) individual support or therapy for the parent(s), and 4) referral to pre-existing social care. Family care was defined as all social care programs aimed at the family.
or parent-child interaction; individual therapy for the child was defined as any therapy specifically for the child (such as group therapy for children who witnessed domestic violence); individual support or therapy for the parent(s) was defined as any individual care for parents (such as psychiatric therapy or support by a social worker); and referrals to preexisting social care were defined as active referrals to any social care organizations that were already engaged, with a specific request to intensify or expand the existing care. If families did not attend the outpatient pediatric department, some information (based on the referrals from the emergency department and the referrals to care organizations) was still available in the medical record and could be used.

Ethical considerations
For this study, data were solely collected from existing patient files, and no contact was made with any other health care professionals (such as the AMK), nor was there access to any other data files.

Statistical analyses
Only descriptive statistics were applied using SPSS 18.0.2 (IBM 2010). Not normally distributed continuous variables are presented as median (range).

RESULTS
We identified 106 children from 60 households, who were referred to the outpatient pediatric department according to the Amsterdam policy during the study period. The median (range) age of the 60 parents was 32 (17–57) years at the time of presentation. At least two women were pregnant at the time of their emergency department visit. The median (range) number of children 0–18 years per household was two (1-4), 56 of the 106 children were female, and the median (range) age at the time of the parent’s visit to the emergency department was 7.1 (0.1 – 18) years. Table 1 summarizes all reasons for referral. The most common reason was
a mother presenting at the emergency department as a victim of domestic violence.

<table>
<thead>
<tr>
<th>Presentation at the emergency department due to:</th>
<th>Number of children (total 106)</th>
<th>Number of households (total 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother victim</td>
<td>68</td>
<td>38</td>
</tr>
<tr>
<td>Father victim</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By father</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>By mother</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol or drugs abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By mother</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>By father</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 1: Reasons for referral of children to the outpatient pediatric department.

Attendance
As shown in Figure 1, after referral to the outpatient pediatric department, 60 children of 34 households attended the outpatient pediatric department on the first call. Seventeen children from nine households did not attend the first call but did visit the outpatient pediatric department after one or two reminders. The other 29 children of 17 households either refused to attend or could not be traced.

Prevalence of maltreatment
Table 2 summarizes prevalence of earlier and recent child maltreatment. Fifty children were recorded as having experienced earlier maltreatment (more than 1 year previously), 39 children were recorded as not having experienced earlier maltreatment, and for 17 children, no information on earlier maltreatment was recorded. Eighty-four children were recorded as having experienced recent maltreatment (less than one year previously), 19
Figure 1: Flow diagram of the children in this study.

1: AMK, Child Abuse Counseling and Reporting Centre
2: CPS, Child Protective Services
children were recorded as not having experienced recent maltreatment, and for three children (who did not attend the outpatient pediatric department), no information on recent maltreatment was recorded. Twenty-six of the 29 children who did not attend the outpatient pediatric department were recorded as having experienced recent maltreatment, based on the report by the emergency department or based on information from the AMK/CPS.

<table>
<thead>
<tr>
<th></th>
<th>Maltreatment recorded in file</th>
<th>Statement of no maltreatment in file</th>
<th>Unknown (missing in file)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier (&gt; 1 year previous)</td>
<td>50 (21)</td>
<td>39 (29)</td>
<td>17 (10)</td>
<td>106 (60)</td>
</tr>
<tr>
<td>Recent (&lt; 1 year previous)</td>
<td>84 (48)</td>
<td>19 (10)</td>
<td>3 (2)</td>
<td>106 (60)</td>
</tr>
</tbody>
</table>

Table 2: Earlier and recent maltreatment. Number of children (number of households).

Types of maltreatment

Table 3 shows (combinations of) types of earlier child maltreatment. Thirty-six children had been confronted with one type of earlier maltreatment and 11 children had been confronted with two types of earlier maltreatment. For 11 children, a statement of earlier maltreatment was recorded in the file, but specification of the type(s) of maltreatment was partly (eight children) or completely (three children) missing. The various types of earlier child maltreatment were: witness of domestic violence (29 children, 15 households), emotional abuse and/or neglect (14 children, eight households), physical neglect (seven children, four households), physical abuse (six children, three households), and sexual abuse (two children, one household).
Table 3: Combinations of types of earlier maltreatment (presented in numbers of children, 50 children in total): one or two types of maltreatment (total 47 children, earlier maltreatment recorded, but type completely unknown for three children).

Table 4 shows (combinations of) types of recent child maltreatment. Sixty-one children had been confronted with one type of recent maltreatment, 19 children had been confronted with two types of recent maltreatment and four children had been confronted with three types of recent maltreatment. The various types of recent child maltreatment were: witness of domestic violence (63 children, 36 households), emotional abuse and/or neglect (28 children, 17 households), physical neglect (14 children, eight households), physical abuse (three children, three households) and sexual abuse (three children, two households).

The 19 children who were identified as not being recently maltreated could be divided into the following groups: there had only been a single episode of domestic violence during which the children were not present (nine children); there had been a first suicide attempt of mother without any involvement of the children or any other signs of child maltreatment (seven children); the suspicion of domestic violence at the emergency department
was not confirmed (two children); there had been only a single episode of violence between mother and a neighbor who was no longer involved in the family (one child).

One or 2 types of maltreatment (total 80 children).

<table>
<thead>
<tr>
<th>Witness of domestic violence</th>
<th>Single type of maltreatment</th>
<th>Second type of maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+ Emotional abuse and/or neglect</td>
<td>+ Physical neglect</td>
</tr>
<tr>
<td>Emotional abuse and/or neglect</td>
<td>46</td>
<td>5</td>
</tr>
<tr>
<td>Physical neglect</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Three types of maltreatment (total 4 children).

<table>
<thead>
<tr>
<th>Witness of domestic violence</th>
<th>+ emotional abuse and/or neglect &amp; physical neglect</th>
<th>+ emotional abuse and/or neglect &amp; physical abuse</th>
</tr>
</thead>
</table>

Table 4: Combinations of types of recent maltreatment (presented in numbers of children, 84 children in total).

Of the 84 children who were recorded as having experienced recent maltreatment, 46 were recorded as having also experienced earlier maltreatment, 24 were recorded as not having experienced earlier maltreatment, and information was missing for 14 children. Of the 71 children (40 households) who were referred because their parents presented at the emergency department due to domestic violence, 12 children (six households) had not witnessed recent domestic violence.
For 68 children of 39 households, some form of nonroutine supportive care was already engaged with the child, with another child in the household, or with a parent at the time of the visit to the outpatient pediatric department, or had been engaged earlier. For 24 children (12 households), supportive care had never been engaged, while for 14 children (nine households), no information on previous care involvement was found. Of the 84 children who were identified as having experienced recent maltreatment, 58 children had previously been engaged with a form of supportive care, 13 children had never been engaged, and information regarding previous involvement of supportive care was not available for the remaining 13.

As shown in Figure 1, for 99 children, various forms of care were arranged at the outpatient pediatric department. For six children (three households), no intervention was arranged, and information was missing for one child. Voluntary care was arranged for 67 children. Twenty-five children (15 households) were referred to the AMK and seven children (three households) to more serious measures within the Dutch CPS (for example, via an legal guardian previously appointed).

**DISCUSSION**

During the first two years of implementation of the Amsterdam policy, 106 children of 60 households were referred to the outpatient pediatric department for investigation of possible maltreatment. Two-thirds of these children were referred because their mother presented at the emergency department as a victim of domestic violence. Only two of all referrals from the emergency department were because of a presentation of the father; in both cases, the father was a victim of domestic violence. This is remarkable because in Dutch hospitals, a large majority of alcohol- and drug-related admissions concerns men. Furthermore, in The Netherlands, the annual number of suicide attempts is divided approximately equally between men and women, and although the majority of victims of domestic violence are...
women, 35% are men. These data suggest that when handling presentations because of domestic violence, substance abuse, or a suicide attempt, the personnel at the emergency department may be more inclined to ask women than men whether they care for children.

A large majority of all the referred families (43 of 60) did attend the outpatient pediatric department voluntarily. The remaining group was either unwilling to cooperate or were untraceable, usually because telephone numbers had been cut. It seems reasonable to assume that families avoiding contact with the healthcare system are at increased risk for child maltreatment. In the case of domestic violence, extreme trivialization or denial of the violence is associated with an increased risk for recidivism. However, although a hospital-based intervention was not feasible for a subgroup, the majority of identified parents were willing to cooperate voluntarily in the Amsterdam policy.

Child maltreatment was common in the children identified this way. Earlier child maltreatment (more than one year previously) was recorded for almost half of all children based on AMK/CPS investigation and/or history given by parents and children. However, this might be underestimated, as earlier child maltreatment and previous AMK/CPS involvement were not systematically recorded in the medial files. Recent child maltreatment was recorded for the large majority of children. The most common type of child maltreatment was being a witness of domestic violence; however, other types of child maltreatment were also identified during the visit to the outpatient pediatric department. This finding confirms those of prior studies and of the Hague experience as well: domestic violence, psychiatric problems and substance abuse are serious risk factors for child maltreatment. However, it should be noted that we do not have a control group, and therefore, we do not know the prevalence of child maltreatment in children whose parents visit the emergency department for reasons other than domestic violence, psychiatric problems, or substance abuse. Ten percent of Dutch high school children report to have been a victim of child maltreatment during the past year. This number could be higher in our hospital
service area because many risk factors for child maltreatment are overrepresented in the surrounding regions, such as a low socioeconomic status and unemployment.

The majority of identified households was already engaged with some type of nonroutine supportive care at the time of presentation at the outpatient pediatric department or had been at some time in the past. In most cases, supportive care was already engaged before the emergency department presentation of the parent because of many prolonged social problems in the family. On the one hand, this could mean that the form of supportive care was inadequate to prevent escalation resulting in an emergency department visit of a parent. It could also mean that the problems in these families are long lasting and that without the present supportive care the problems would be even more serious.

We hypothesized that for the majority of children, the Amsterdam policy could initiate supportive care on a voluntary basis, without involvement of the AMK. For 67 of 106 children, voluntary supportive care was indeed started or extended and they were not referred to the AMK. For approximately one-third of the children, this was not possible, and they were referred to the AMK or to another part of CPS. Thus, based on this study only, our hypothesis seems correct.

To our knowledge, this is the first study to describe the Amsterdam policy. There are several limitations to this study. Most importantly, being a retrospective study of medical records, study variables were not recorded in a standardized way. This may have led to under- or overestimation. For example, during the visits at the outpatient pediatric department, emphasis was on determining which interventions were necessary. Whether or not a certain type of child maltreatment was present according to definitions was not always recorded. This probably resulted in underestimation of the prevalence of child maltreatment. A second limitation is that the number of children included is relatively small and that this study took place in a single hospital. The parents who were referred from the emergency department to the outpatient pediatric department may have been a selected
sample. During the first months after implementation of the Amsterdam policy, only a few children were referred, most likely because emergency department personnel were not yet familiar with the policy. Also, it could be that a selection of parents was made at the emergency department based on the assumed severity of the social problems. This could result in a bias of more seriously affected families included in the Amsterdam policy. In contrast, the most severely affected families were excluded from the policy (because of an acute unsafe situation requiring immediate AMK involvement at the emergency department). Another possibility is that adults at the emergency department may have concealed that they have children in their care. Pregnant women without children in their care were not included in the Amsterdam policy. However, at least two mothers whose children were referred to the outpatient pediatric department were pregnant during their presentation at the emergency department. Since maternal exposure to domestic violence and maternal substance abuse are associated with adverse pregnancy outcomes, it may be important to also arrange a form of social intervention for pregnant women without children in their care who visit the emergency department due to domestic violence, substance abuse, or a suicide attempt. Although the results of this study imply that it is possible to arrange social care on a voluntary basis, an important limitation is that follow-up data are unknown. Therefore, we do not know what the different effects are on families in the Amsterdam policy compared to families who are referred to the AMK directly. For example, it is unknown whether children who were initially referred to voluntary social care did actually receive this care. Furthermore, we do not know the proportion of children referred to the AMK in the period after presentation at the outpatient pediatric department. If this number is high, it could be that the referral to the outpatient pediatric department is delaying AMK involvement. Further prospective studies on this policy will be performed to establish these long-term effects.
CONCLUSION

The results of this first study show that supportive care on a voluntary basis was initiated at the outpatient pediatric department for the majority of potentially maltreated children who were identified due to a parental emergency presentation.
REFERENCES


