CHAPTER 6

COMPARING POLICIES FOR CHILDREN OF PARENTS ATTENDING HOSPITAL EMERGENCY DEPARTMENTS AFTER INTIMATE PARTNER VIOLENCE, SUBSTANCE ABUSE OR SUICIDE ATTEMPT

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ABSTRACT

Background: To improve identification of child maltreatment, a new policy (‘Hague protocol’) was implemented in hospitals in The Netherlands in 2007, stating that adults attending the hospital 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 referred to the Reporting Center for Child Abuse and Neglect (RCCAN), for assessment and referrals to support services when necessary. An adapted, hospital-based version of this protocol (‘Amsterdam protocol’) was implemented in another region, in 2010. Children are identified in the same manner, but, instead of a RCCAN referral, they are referred to the pediatric outpatient department for an assessment, including a physical examination, and referrals to services.

Objective: We compared results of both protocols to determine if they can serve as fully commutable alternatives.

Methods & Results: We included 565 families from the Hague protocol (study of RCCAN records and telephone interviews with parents) and 212 families from the Amsterdam protocol (cohort study with reports by pediatric staff and parents). We found that the RCCAN identified more maltreatment than pediatric staff (98% versus at least 51%), but referrals to services were similar (82% versus 80% of the total sample) and parents were positive about both interventions. Physical examination revealed signs of maltreatment in 5%.

Conclusion: We conclude that, despite the differences, both procedures can serve as suitable methods to identify and refer children at risk for maltreatment by screening adults presenting with their own medical problems at the emergency department.
INTRODUCTION

To stimulate prevention of, and early intervention in, child maltreatment, a new policy called the ‘Hague protocol’ was first implemented in the city of The Hague in The Netherlands in 2007. This protocol states that all adults attending the emergency department seeking medical care for their own medical problems caused by intimate partner violence, substance abuse or a suicide attempt, are asked whether they are responsible for the care of minor children (under the age of 18 years). It has been shown that children of parents with these problems are at increased risk of child abuse and neglect. If so, the identified parents, together with all their children, are referred to the Reporting Center for Child Abuse and Neglect (RCCAN, in Dutch Advies en Meldpunt Kindermishandeling, AMK). The RCCAN is a non-judicial organization where everyone can ask for advice and can report suspicions of child maltreatment. The RCCAN evaluates the situation of the family and refers them to voluntary support services when deemed necessary. Serious cases and cases in which parents refuse to cooperate are handled 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.

Following the introduction of the Hague protocol, some Dutch hospital emergency departments started to use modified versions of the original protocol. Hospitals in the city of Amsterdam began with their own protocol modification in 2010. Using this ‘Amsterdam protocol’, children are identified in the same manner as in the original Hague protocol on the basis of parental characteristics, but instead of a RCCAN referral, children are referred to the outpatient pediatric department for a consultation. Only when parents refuse to visit the outpatient pediatric department, or the situation is deemed very serious, are children referred to the RCCAN. Furthermore, children in the Amsterdam protocol undergo a physical examination, which is not part of the Hague protocol.

The Hague protocol has been evaluated and was found to greatly increase the detection of child maltreatment and the initiation of support for the
families involved. The Amsterdam protocol has not been evaluated prospectively but a single-center, retrospective study of medical records showed that the majority of families were referred to support services. However, due to the retrospective nature of the study, information was not recorded systematically for each child, which potentially could have caused information bias. Furthermore, the study sample was relatively small and no information from parents or the RCCAN was included. To address these issues, and gain more insight into the consequences of the implementation of the Amsterdam protocol, a prospective multicenter cohort study was performed. The results of this study will be presented here and compared to results of the Hague protocol, most of which have been published earlier. We will explore and try to explain any similarities and differences between both protocols. This can help to determine if the two protocols could serve as fully commutable alternatives for the same problems, dependent on, for instance, hospitals’ preferences or local practical considerations.

METHODS
Study design
This study is a cross-sectional analysis of data gathered in two separate studies, in the regions of The Hague (Hague protocol) and Amsterdam (Amsterdam protocol). Data of the Hague protocol have been previously published, although some data are presented in more detail in this paper; data of the Amsterdam protocol are new. Details of the two protocols are described in Figure 1 (Hague protocol), Figure 2 (Amsterdam protocol), Table 1 and below under procedures (both protocols). Study methods are described in Table 2, in earlier publications and below (Study populations, data sources and measures).

Procedures
(See also Table 1.) In both regions, parents are identified at the hospital emergency department when they attend because of complaints due to
intimate partner violence, substance abuse (all substance abuse in the Amsterdam protocol, only serious abuse in the Hague protocol) or a suicide attempt (also self-harm or serious psychiatric problems in the Hague protocol, not in the Amsterdam protocol). Subsequently, all minor children in their care are referred to the RCCAN according to the Hague protocol, or to the outpatient pediatric department according to the Amsterdam protocol.

The Hague protocol
In the Hague protocol, after referral by the hospital emergency department,
parents and their children are invited to the RCCAN office, or visited at home for an evaluation of family problems, and the RCCAN staff collects information from informants around the family, e.g. school teachers, family doctors. Based on all the information available, the RCCAN assesses whether child maltreatment is present. Referrals to various support services are made, when judged appropriate. The RCCAN monitors the effects of the services, by re-assessing the situation of the family after three months. When parents are unwilling to cooperate, or if there is severe maltreatment, children are referred to the RvdK.
<table>
<thead>
<tr>
<th>Aspects of protocol</th>
<th>Hague protocol</th>
<th>Amsterdam protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start</td>
<td>7-12-2007</td>
<td>22-9-2010</td>
</tr>
<tr>
<td>Patients are all children &lt; 18 years of parents who attend the ED due to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>Any</td>
<td>Any</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>Any</td>
<td>Any</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Only when serious</td>
<td>Any</td>
</tr>
<tr>
<td>Self-harm</td>
<td>Any</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric disorder</td>
<td>Only when serious</td>
<td>No</td>
</tr>
<tr>
<td>Intervention</td>
<td>Reporting to RCCAN&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Referral to outpatient pediatric department</td>
</tr>
<tr>
<td>Examination of family situation by speaking to parents and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>When &gt; 6 years</td>
<td>When deemed possible</td>
</tr>
<tr>
<td>Informants around family</td>
<td>Yes</td>
<td>When deemed necessary</td>
</tr>
<tr>
<td>RCCAN&lt;sup&gt;a&lt;/sup&gt; staff (social worker, medical doctor, behavioral specialist)</td>
<td>Pediatric staff (pediatrician (in training), social worker, pediatric nurse, child psychologist)</td>
<td></td>
</tr>
<tr>
<td>Examiner</td>
<td>RCCAN&lt;sup&gt;a&lt;/sup&gt; office or home visit</td>
<td>Outpatient pediatric department</td>
</tr>
<tr>
<td>Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical examination of children</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussion in hospital child protection team</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Necessary support offered in voluntary setting.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>If parents do not cooperate or situation is too serious</td>
<td>Report to RvdK&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Report to RCCAN&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Monitoring</td>
<td>RCCAN&lt;sup&gt;a&lt;/sup&gt; after 3 months</td>
<td>Pediatric staff can monitor or ask another service; no set moment</td>
</tr>
</tbody>
</table>

<sup>a</sup> RCCAN = Reporting Center for Child Abuse and Neglect (in Dutch Advies en Meldpunt Kindermishandeling)

<sup>b</sup> RvdK = Child Care and Protection Board (in Dutch Raad voor de Kinderbescherming)

Table 1: Aspects of the protocols.
The Amsterdam protocol
In the Amsterdam protocol, after referral by the hospital emergency department, parents and their children are invited to the outpatient pediatric department for a consultation. At this (usually single) consultation, depending on the policy of the individual hospital, families are seen by one particular pediatrician (two hospitals); a team consisting of a specialized nurse and a specialized pediatrician (one hospital); a team consisting of a dedicated pediatric resident, a specialized child psychologist and a social worker (one hospital); various pediatricians (one hospital) or a combination of various pediatricians and one dedicated child psychologist (one hospital). During the consultation any social, medical or psychological problems in the family are evaluated. Furthermore, a complete physical examination is performed on all the minor children in the family, to identify possible signs of physical abuse or neglect. Informants around the family (e.g. family doctor, staff of already involved support services) are contacted for information, when judged necessary. To determine appropriate next steps, the situations of all the families are discussed anonymously in hospital child protection teams, in which RCCAN doctors participate. Referrals to various support services are made when judged appropriate. Outpatient pediatric staff either monitor the effects of support services themselves, or they ask the services to monitor the effects, but there is no set timeframe. When parents are unwilling to cooperate, or if there is severe maltreatment, children are referred to the RCCAN. After investigation, the RCCAN can refer children to the RvdK when deemed necessary.

Study population, data sources and measures
(See also Table 2.)
The Hague region
The methods of the study evaluating the Hague protocol have been previously published. In short, this was a multicenter study with a quasi-experimental pretest-posttest design, with an intervention group and a non-randomized control group to assess the ability of the protocol to identify child maltreatment. In the current paper, we report only the data of the
Methods of study | The Hague region | Amsterdam region
---|---|---
**Period** | 7-12-2007 – 31-12-2011 | 1-7-2012 – 28-2-2014 (start of study differed per hospital, latest 1-3-2013)
**Place** | The Hague | Amsterdam
**Setting** | 5 hospitals, RCCAN⁷ | 6 hospitals, RCCAN⁷
**Design** | Review of records | Cohort study
**Data sources are records of emergency department, RCCAN⁷ and**
- questionnaires for outpatient pediatric department staff | No | Yes
- telephone interview with parents | Yes (sample) | No
- questionnaire for parents (PDRQ-9) | No | Yes

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⁷RCCAN = Reporting Center for Child Abuse and Neglect (in Dutch Advies en Meldpunt Kindermishandeling)

Table 2: Study methods.

intervention group. Data on all families reported according to the Hague protocol between December 7th 2007 and December 31st 2011 were gathered from the records of the RCCAN and five hospital emergency departments. Of these, a selection of 100 RCCAN records of children reported by one emergency department in 2011 were analyzed separately to assess referrals to support services. In addition, during a six month period in 2012, all parents of children referred to the RCCAN from one hospital according to the Hague protocol were contacted by telephone for an interview concerning their opinion of the protocol.

Amsterdam region
The study in the Amsterdam region is a multicenter cohort study including all families of which a parent attended the emergency department of one of the six hospitals in Amsterdam between July 1st 2012 and February 28th 2014.
because of intimate partner violence, substance abuse or a suicide attempt. The date of the start of the study differed per hospital, from July 1\textsuperscript{st} 2012 to March 1\textsuperscript{st} 2013. Data were collected from 1) emergency department records (demographic data), 2) a questionnaire that was filled in by outpatient pediatric staff (demographic data, results of physical examination, presence of maltreatment, referrals to support organizations, 3) RCCAN records (prior RCCAN involvement) and 4) the Patient-Doctor Relationship Questionnaire-9 (PDRQ-9), filled in by parents after visiting the outpatient pediatric department. This is a 9-item self-report questionnaire developed to assess the relationship between patients (parents in this study) and doctors. Scores range from 1 (lowest satisfaction) to 5 (highest satisfaction), and are summarized as a mean total score. It has been reported to have good reliability and validity \textsuperscript{10,11,12}.

Ethical approval
The studies were presented to the Medical Ethics Committees of Zuidwest Holland (Hague protocol) and the Academic Medical Center (Amsterdam protocol), who decided that the Medical Research Involving Human Subjects Act did not apply and their approval was not required \textsuperscript{9}. According to the Dutch Civil Code, deviation from the informed consent requirement is allowed under particular conditions \textsuperscript{13}. Parents gave verbal informed consent for participating in the telephone interview or completing the PDRQ-9 questionnaire.

Statistics
IBM SPSS Statistics version 21 was used for descriptive statistics. According to published guidelines, missing values of the PDQR-9 were replaced by the mean of the answered questions if up to two items were missing; if more than two items were missing, scores were excluded from the analyses \textsuperscript{12}. 


RESULTS
Results are shown in Table 3.
Demographics
In total, 1332 children from 777 families were included in this study, of whom 972 children (565 families) were referred by the hospital emergency department according to the Hague protocol and 360 children (212 families) according to the Amsterdam protocol. The majority of parents eligible for inclusion in this study because of complaints due to intimate partner violence, substance abuse or a suicide attempt attending the emergency department were female (86% Hague protocol, 80% Amsterdam protocol). The most frequent reason for visiting the emergency department was intimate partner violence. Most of the children of referred parents were not known to the RCCAN prior to the emergency department attendance of their parents.

Implementation of the protocols
In the analysis of 100 children referred by the hospital emergency department according to the Hague protocol, the RCCAN investigated 79 of these for the first time. Seven children were already being investigated by the RCCAN. The remaining 14 families were not contacted by the RCCAN, but instead directly referred to other services (crisis intervention team, legal guardian, youth care office). Of the 212 identified families referred by the hospital emergency department according to the Amsterdam protocol, 132 attended for the consultation at the outpatient pediatric department (62%). The other 80 families did not attend for the following reasons: not invited by the outpatient pediatric department (47) (usually because hospital staff decided it was unnecessary because services were already involved with the family, or they could not manage the workload and referred families directly to services), refusal by family (18), living too far away (8) or the hospital could not contact the families (7). Of the families not attending the consultation at the outpatient pediatric department, 74 were directly referred to new or already involved services (youth care office, community
support services, family doctor, RCCAN) and six were not referred to any services (because this was not considered necessary). The median (range) number of days between the emergency department attendance of parents and consultation with the RCCAN (Hague protocol) or outpatient pediatric department (Amsterdam protocol) was seven (60) and 29 (179) in the Hague and Amsterdam protocol, respectively.

Child maltreatment
After evaluation, health care professionals (RCCAN staff in the Hague protocol and pediatric outpatient department staff in the Amsterdam protocol) assessed whether maltreatment was present. Proportions of assessed maltreatment differed between the Hague protocol and the Amsterdam protocol: confirmed maltreatment in 91% versus at least 39%; suspected maltreatment in 7% versus at least 12%; no maltreatment in 2% versus at least 26%; and maltreatment status unknown in 1% (n = eight families) versus 23%, respectively (proportions of the Hague protocol are of families with a known maltreatment status; proportions of the Amsterdam protocol are of the complete sample, including children of whom maltreatment status was unknown). In both groups, being a witness of intimate partner violence was the most common type of maltreatment, followed by pedagogical neglect in the Hague protocol and emotional neglect in the Amsterdam protocol. The majority of the maltreated children experienced a single type of maltreatment (70% and minimal 36%). However, 27% and minimal 14% experienced two or more types of maltreatment in the Hague and Amsterdam protocol, respectively.

Referrals to support services
After assessment at the RCCAN or outpatient pediatric department, children and parents could be referred to various types of support services. Information about referrals was available for the complete study population in the Amsterdam protocol and for a subsample of 100 children in the Hague protocol. Of all referrals, 27% (Hague protocol) and 45% (Amsterdam protocol) were first referrals; 31% and 27% were referrals to support services
<table>
<thead>
<tr>
<th>Results of study</th>
<th>The Hague region</th>
<th>Amsterdam region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents n</td>
<td>565</td>
<td>212</td>
</tr>
<tr>
<td>Sex (female) n (%)</td>
<td>485 (86)</td>
<td>170 (80)</td>
</tr>
<tr>
<td>Reason for emergency department visit n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>269 (48)</td>
<td>111 (52)</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>161 (28)</td>
<td>59 (28)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>78 (14)</td>
<td>42 (20)</td>
</tr>
<tr>
<td>Other</td>
<td>40 (7)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Combination</td>
<td>17 (3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>First or recurrent hospital attendance for this problem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| First time | 27 (27)  
| Recurrence | 57 (57)  
| Unknown | 16 (16) |
| Number of minor children in family median (range) | 1 (1-5) | 2 (1-4) |
| Time from ED to first RCCAN contact or pediatric consultation (days) median (range) | 7 (0-60) | 29 (0-179) |
| Children n | 972 | 360 |
| Ethnicity n (%) | | |
| Dutch | 238 (42)  
| Non-Dutch | 281 (50)  
| Unknown | 46 (8) |
| Prior investigation by RCCAN of child (yes) n (%) | 153 (27)  
| 79 (79) newly investigated by RCCAN, 14 (14) referred to other services, 7 (7) already under investigation by RCCAN | 30 (8) |
| Effectuation of the policy n (%) | | |
| Child maltreatment n (% of families with known maltreatment status (The Hague); % of complete sample (Amsterdam)) | | |
| Confirmed | 509 (91)  
| Not Confirmed | 36 (7)  
| No child maltreatment | 12 (2)  
| Missing (The Hague), unknown (Amsterdam) | 8 (1) |
| Type of maltreatment (confirmed plus not confirmed) n (%) | | |
| Total witnessing intimate partner violence | 147 (41) | | |
| limited to witnessing intimate partner violence | 225 (40) | 108 (30) |
| Total pedagogical neglect limited to pedagogical neglect | 98 (17) | 1 (0) |
| Total emotional neglect | | 33 (9) |

Table 3: Results.
Table 3: Results (continued).

| Number of types of maltreatment (confirmed plus not confirmed) n (%) | 0   | 1   | 2   | 2 or more | 3   | 4   | 5   | 6   | unknown | RCCAN\(^b\) | RvdK\(^c\) | Total new referrals | Total for parents support services follow-up by family doctor | Total for child support services follow-up by pediatrician | Total for child support services follow-up by family doctor | Only existing support intensified or continued | No referrals to existing or new support | Parents' opinion n (%) | Response rate | Mean (95% CI) score |
|---------------------------------------------------------------|-----|-----|-----|-----------|-----|-----|-----|-----|---------|-----------|-----------|-------------------|-----------------------------------------------|-----------------------------------------------|-------------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------|----------------------|
|                                                               | 15 (3)\(^e\) | 398 (70)\(^e\) | 152 (27)\(^e\) | 11 (3)\(^f\) | 6 (2)\(^f\) | 1 (0)\(^f\) | 3 (1)\(^f\) | 84 (23)\(^f\) | 27 (8)\(^f\) | 24 (24)\(^ae\) | 27 (27)\(^ae\) | 23 (23)\(^ae\) | 22 (22)\(^ae\) | 1 (1)\(^ae\) | 0 (0)\(^ae\) | 12 (12)\(^ae\) | 0 (0)\(^ae\) | 1 (1)\(^ae\) | 31 (31)\(^ae\) | 17 (17)\(^ae\) | 14 (38)\(^j\) | 82 (62) | 4.32 (4.17 – 4.47) |

\(^{*}\) Based on a subsample of 100 children; \(^{\dagger}\) RCCAN = Reporting Center for Child Abuse and Neglect (in Dutch Advies en Meldpunt Kindermishandeling); \(^{\ddagger}\) RvdK = Child Care and Protection Board (in Dutch Raad voor de Kinderbescherming); \(^{\ast}\) For 13 children, earlier (but not recent) maltreatment was recorded; \(^{\ddagger\ddagger}\) Measured per family (n = number of families); \(^{\dagger\dagger}\) Measured per child (n = number of children); \(^{\dagger\ddagger}\) Definition is the main cultural attitude in the family; \(^{\ast\ast}\) Definition is according to Statistics Netherlands; \(^{\ast\ast\ast}\) These combinations mainly exist of pedagogic neglect, witness of intimate partner violence, and psychological violence; \(^{\dagger}\) Based on a subsample of 37 parents.
already involved with the family, who were asked to intensify the support. Due to the severity of the problems or refusal of families to cooperate, in the Hague protocol 24% of families were referred to the RvdK; in the Amsterdam protocol, 8% were referred to the RCCAN. For 17% (Hague protocol) and 20% (Amsterdam protocol), it was decided that there was no need for a referral.

Parents’ opinion
It was attempted to assess parents’ opinion about the emergency department referral and RCCAN contact in a subsample of all parents referred from one hospital during six months according to the Hague protocol, and parents’ opinion about their relationship with the doctor in all parents attending the consultation at the outpatient pediatric department in the Amsterdam protocol. In the Hague study, 14 of 37 eligible parents participated in a telephone interview (participation rate 38%) of whom the majority (n=10, 71%) rated their experience with the Hague protocol as acceptable or reasonably acceptable, and they indicated that this would not deter them from attending the emergency department again even now when they knew about the protocol. In the Amsterdam study, 82 of 132 eligible parents filled out the PDRQ-9 (participation rate 62%). The mean summary score was 4.32 (SD 0.68, 95% CI 4.17 – 4.47), median 4.44 (range 2.11 – 5), indicating high satisfaction with the relationship with the clinician at the outpatient pediatric department.

Physical examination
Of a total of 197 children who underwent a physical examination (Amsterdam protocol only), signs of maltreatment were found in 10 children (5%) (physical neglect in six children, physical abuse by a child and a parent was confirmed in one child, unconfirmed physical abuse in one child; details of two children are missing).
DISCUSSION

In this study we compared results of two policies for children whose parents attended the hospital emergency department seeking medical care for their own problems caused by intimate partner violence, substance abuse or a suicide attempt: the Hague protocol and the Amsterdam protocol. The main difference between both policies is that children in the Hague protocol are referred to, and assessed by, the RCCAN, while children in the Amsterdam protocol are assessed at the outpatient pediatric department. Due to differences in study methods, a one-to-one comparison between the policies is not possible, and this should be kept in mind in the interpretation of the results.

Implementation of the protocols
A marked difference between the two policies was that families in the Hague protocol were seen more rapidly than families in the Amsterdam protocol. Furthermore, following the referral from the emergency department in the Hague protocol, all families were assessed with the RCCAN (86%) or were assigned to other support services (14%). Even though the Amsterdam protocol stated that all families should be assessed at the outpatient pediatric department, 38% did not attend. The main reason for not attending was that hospitals referred families directly to already involved support services, without a consultation at the outpatient pediatric department; only 8% of the families refused. This was in contrast with the concerns at the beginning of the study, that many families would not voluntarily agree to having an assessment at the outpatient pediatric department. However, arranging consultations for families at the outpatient pediatric department required a lot of effort from hospitals: many families had to be called repeatedly, and sometimes hospitals could not manage that workload. An organization such as the RCCAN might be better suited to reach out to families and organize a rapid evaluation.
Child maltreatment

The most notable result that we found is the large difference in the proportion of children identified as being maltreated. In the Hague protocol, maltreatment was suspected or confirmed in 96% of the children, compared to (at least) 51% in the Amsterdam protocol. This large difference is surprising, because children are to a large extent identified in the same manner, with only some small differences in parental problem categories and possibly some geographical differences, which we do not think could explain our results. We think that there are several possible explanations for the differences. First, although on paper the same definition of child maltreatment was used in both interventions, we think that the RCCAN staff in The Hague region has interpreted the definition more broadly than the outpatient pediatric staff in the Amsterdam region. This difference has also been described during implementation of the Hague protocol in another Dutch region. Second, we think that it is possible that hospital staff is less focused on, and experienced in, assessing emotional types of maltreatment, resulting in under detection of emotional abuse and neglect, and pedagogical neglect. In contrast, RCCAN staff may be less able to detect physical abuse and neglect (but this type of abuse is less prevalent). Third, in the Amsterdam protocol, the maltreatment status was unknown in 23% of cases (versus 1% in the Hague protocol). These are children who were referred to another service without attending the outpatient pediatric department, and where insufficient information was available assess maltreatment. It is probable that some of these children are victims of child maltreatment.

Referrals to support services

Although there was a large difference in the proportions of children identified as being maltreated, the proportions of children and parents being referred to various services were much more similar. Families were referred to new services in 51% of cases using the Hague protocol (referrals from the RCCAN, including to the RvdK) and 53% using the Amsterdam protocol (referrals from the outpatient pediatric department, including to the RCCAN). Families in the Amsterdam protocol were referred to their
family doctor (only if the family doctor agreed to initiate support), or to other support services, and in 8%, children were referred to the RCCAN. With 24% being referred to the RvdK, families in the Hague protocol were referred to a different, more serious level of services than families in the Amsterdam protocol. However, since hospital staff do not directly refer children to the RvdK, it could be that some children in the Amsterdam protocol were ultimately referred to the RvdK via another service, but this was not assessed.

It must be emphasized that in Dutch child protective services, legal action is taken only in extreme circumstances. The proportions of families referred to existing support and the proportions of families who were not referred were very similar with both policies. It seems that, although different definitions of maltreatment are used in practice, the actions taken are fairly similar and the difference in practice between the two policies is limited in this regard.

Parents’ opinion
Although study methods differed (telephone interview and PDRQ-9 in The Hague and Amsterdam, respectively), we found that parents were mostly positive about both procedures. PDRQ-9 results indicate high satisfaction and are comparable to large community samples rating their primary care doctors in Germany 12 and in Spain 16. Our response rate of the PDRQ-9 is similar to response rates in earlier studies using the PDRQ-9 10 12. However, only families visiting the outpatient pediatric department were eligible for participation in this questionnaire survey, which possibly caused selection bias. Furthermore, there could be selection bias because parents who were not satisfied with the interventions may have been less likely to participate and parents may have given socially desirable answers. Finally the sample of the Hague protocol is small, making results less precise. However, taking these limitations into account, it seems that many parents are positive about the procedures, even though they have been imposed on them.

Physical examination
The diagnostic value of a complete physical examination (‘top-to-toe inspection’) as a screening instrument for child maltreatment is unknown 17.
A physical examination is valuable if signs of maltreatment are revealed and documented, but it requires time and trained medical staff. During the physical examinations in this study, signs of maltreatment were found in 5% of the examined children in the Amsterdam protocol. Although not all cases were confirmed to be abuse or neglect by self-report or a reference standard such as a forensic report, the clinicians who examined the children only classified their findings as signs of maltreatment if they had a high level of suspicion. It is possible that physical neglect and abuse were missed in children who were not physically examined, however, we do not know if actions taken (such as referrals to support services) were influenced by results of the examination.

Implications
Firstly, results from both the Hague protocol and the Amsterdam protocol show that a large proportion of children identified because their parents attended the emergency department due to intimate partner violence, substance abuse or a suicide attempt are victims of maltreatment. If other hospital emergency departments implement similar interventions, it may help stop the maltreatment of the children of these parents and improve their situation. Secondly, compared to the Hague protocol, fewer referred families from the hospital emergency departments are seen and assessed using the Amsterdam protocol and identified as being maltreated. Despite this discrepancy, the proportion of referrals to support services was equal for both interventions, 80%-82% was referred to existing or new support services. We therefore suggest that, despite the different numbers of child maltreatment cases identified by the two policies, both the (RCCAN-based) Hague protocol and the (hospital-based) Amsterdam protocol can serve as a suitable method to refer children at risk for maltreatment to services by screening adults presenting with their own medical problems at hospital emergency departments. Thirdly, possibly contrary to expectations, participating parents expressed a relatively positive opinion about the procedure (Hague protocol) and reported high satisfaction with their patient-doctor relationship (Amsterdam protocol). Although we suspect
some bias in these results, this predominantly positive opinion of parents indicates that fears for the reaction of parents should not impede implementation of an intervention.

**CONCLUSION**

In conclusion, this study shows that a large number of children, whose parents attended the hospital emergency department with complaints due to intimate partner violence, substance abuse or a suicide attempt, can be identified as (possible) victims of child abuse and neglect. We encourage other hospital emergency departments to implement a similar procedure for these families. Compared to the Hague protocol, the Amsterdam protocol identified less maltreatment. However, the proportion of subsequent referrals to support organizations was equal. We therefore conclude that both protocols are suitable methods to identify and refer children at risk for maltreatment by screening adults presenting with their own medical problems at hospital emergency departments. Depending on their setting, resources and preferences, emergency departments could use a RCCAN-based, or a hospital-based protocol.
REFERENCES