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Variation in prevention of child maltreatment by Dutch child healthcare professionals

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ABSTRACT

Child maltreatment (CM) is a common condition with a large impact on the victim and society. In the Netherlands, the preventive child healthcare (CHC) aims to protect children against such threats. However, several studies indicate that the efficacy in this area may be suboptimal for many CHC professionals. Therefore, this study aims to map the practice variation in the primary and secondary prevention of CM, by CHC physicians and nurses. This mixed-methods study used interviews to identify relevant topics and develop an online questionnaire. All CHC organizations in the Netherlands (n = 45) were asked to forward this questionnaire to their professionals. Practice variation was described with domain scores and item response distributions. Multi-level analysis was used to assess case mix-corrected variance between organizations. Interview participants (n = 11) expected suboptimal care in 35 topics which they considered important for prevention of CM, resulting in a 15 min questionnaire. Nearly two-thirds of the organizations (n = 29) agreed to forward the questionnaire to their employees. The response rate was 42% (n = 1104). Suboptimal care and practice variation was found in all domains (i.e. communication, medical expertise, collaboration, involvement in prevention of CM, and improvement opportunities), mostly caused by intra-organization variance. Significant inter-organization variance was found for collaboration (variance partition coefficient 6–7%) and involvement (2–3%). Furthermore, the majority of the respondents (96%) reported fear in acting upon suspicions of CM. Substantial suboptimal care and practice variation in prevention of CM warrant action from authorities, CHC training institutes, CHC organizations, and professionals.

1. Background

Child maltreatment (CM) is a common condition (Euser et al., 2013; Gilbert, Widom et al., 2009; Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn, & Alink, 2013; Stoltenborgh, Bakermans-Kranenburg, & van IJzendoorn, 2013; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), with numerous negative consequences for the individual (Coelho, Viola, Walss-Bass, Brietzke, & Grassi-Oliveira, 2014; Fergusson, McLeod, & Horwood, 2013; Gilbert, Widom et al., 2009; Maniglio, 2009; Norman et al., 2012; Thomas, 2014) and society (Cuijpers et al., 2011; Fang, Brown, Florence, & Mercy, 2012). In the Netherlands the

Abbreviations: CHC, preventive child health care; CM, child maltreatment (i.e. physical child abuse or neglect emotional child abuse or neglect or sexual child abuse); CPS, Child Protective Services; 95% CI, 95% confidence interval

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prevalence of CM is 3.4% (Euser et al., 2013), which is comparable to common childhood conditions such as obstipation and atopic dermatitis (Diemel et al., 2010; Dirven-Meijer et al., 2014; Bindels et al., 2014; Brown, Cai, & DasGupta, 2001). However, most cases are not detected. This is demonstrated by the fivefold prevalence that was found, when self-report was used, based on the same criteria (Euser et al., 2013).

In contrast to these high figures, preventive child health care (CHC) aims to protect all children living in the Netherlands against health threats (House of Representatives, 2000). Correspondingly, CHC is legally defined as the active complement of the reactive curative care (House of Representatives, 2008). Its two main tasks are primary prevention (e.g. administering vaccines, offering parenting advice) and secondary prevention (e.g. screening for sensory deficits, CM, etc.) (Schäfer et al., 2010; Ministry of Health, Welfare and Sports, 2014). In contrast to many other countries, CHC is performed by exclusively allocated CHC-physicians and -nurses, instead of general practitioners or paediatricians (Wieske, Nijhuis, Carmiggelt, Wagenaar-Fischer, & Boere-Boonekamp, 2012; Wolfe et al., 2011). CHC-professionals may have completed a two-year specialisation in CHC, but this is not mandatory. The main part of their work consists of performing regular check-ups at the CHC-centre. On average, children visit the clinic fifteen times between 0 and 4 years, with a high coverage of 97% (Schols, de Ruiter, & Öry, 2013). After that (4–19 yr), at least three more check-ups are offered at school, where the CHC-professionals are usually called “school doctor (or nurse)”. Other tasks include, but are not limited to: conducting home visits (mostly by CHC-nurses), and advising other occupational branches (e.g. schools and local authorities; mostly by CHC-physicians). If the child’s development is considered to be at risk, extra check-ups or home visits may be performed (Schols et al., 2013). Overall, the near-complete coverage provides CHC-professionals with a unique outlook on the normal range of children and their caregivers. This also enables them to identify deviations from the normal situation, such as in CM (Gilbert, Kemp et al., 2009). This combination of expertise and frequent contact, gives the CHC-professional the opportunity to detect or identify children at risk of or suffering from CM. The national guideline requires all professionals working with children to follow a 5-step guide when suspecting CM: from getting more information, consulting a colleague, talking to the persons involved, deliberation, to reporting to the Child Protective Services (CPS). Reporting is not obligatory but decided upon by the professional.

According to a report (Youth Care Netherlands, 2014) from CPS, only a small proportion of reported cases of child maltreatment originate from the CHC. Although the report suggests that part of the cases may be handled by the CHC-professionals themselves (and are therefore not reported), three studies indicate that the quality of care is suboptimal as well (Fleuren, van Dommelen, & Dunnink, 2015; Konijnendijk, Boere-Boonekamp, Haasnoot-Smallegange, & Need, 2014; Schols et al., 2013). Fleuren et al. studied the self-reported adherence to core recommendations of the CHC-guideline for secondary prevention of CM. They found that 14% of the CHC-professionals and their assistants were not aware of the existence of the guideline. Of those who were aware, 26% did not use all five core elements of the guideline (Fleuren et al., 2015). Konijnendijk et al. especially described knowledge of the more *specific* recommendations of the guideline as *‘poor’*. In their study, based on focus groups, 22 impeding factors for adherence to the guideline were identified. The most common ones were poor knowledge of its contents, poor cooperation with parents and/or other agencies, and low ability to carry out the recommendations (Konijnendijk et al., 2014). Another qualitative study, from Schols et al., found similar results, as well as other opportunities for improvement of the quality of care, such as personal fears and lack of communicative skills. One participant is quoted, saying: *‘I think we are just not able to have a difficult conversation with parents.’* (Schols et al., 2013). Studies substantially addressing the quality of care in the primary prevention of CM were not found. Nonetheless, these studies raise the question if some professionals may provide better care than others; so-called practice variation (Corallo et al., 2014). More importantly, we wanted to know what the extent is of the variation, which specific items vary the most, and what improvement opportunities can be identified (Nuti & Seghieri, 2014).

Therefore, this study aims to map the variation in skills, knowledge, methods and improvement opportunities, among Dutch child health care physicians and nurses and between CHC-organizations, in the primary and secondary prevention of child maltreatment.

2. Methods

2.1. Study design

For this study, a mixed methods design was used. First, interviews were conducted with experts and professionals, to determine which topics were most relevant for studying its variation. Then a cross-sectional survey among physicians and nurses from different CHC-organizations was done, to study the variation of the resulting topics. According to Dutch law, no ethical review is needed for surveying health care professionals.

2.2. Selection of survey topics

Eleven experts on CM were interviewed to determine which topics were most relevant for inclusion in the questionnaire. The interview transcripts were verified by the participants and analysed using NVivo 10. The precise methods for the selection of experts, the interviewing process and the qualitative data-analysis, are included in the accompanying *Data-in-Brief* article. The resulting topics were divided in five categories: communication, medical expertise, collaboration, involvement and improvement opportunities.

The first category of topics concerned communication skills. All interview participants asserted that maltreatment does not so much result from malice as from pedagogical incompetence. Hence, optimal care is not to secretively “collect evidence against the enemy”, but to openly communicate one’s worries. This should be done in a factual non-threatening manner, which is only feasible if the overall communicative competence is trained to the highest level. This will make the parents realize that the professional only wants to help, after which they will may feel safe enough to elaborate on their shortcomings, and accept help. If, on the other hand,