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Brief communication

Detection of child abuse by Dutch preventive child-healthcare doctors and nurses: Has it changed?☆

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Introduction

Child maltreatment (i.e., abuse and neglect) is a major cause of child morbidity and death. UNICEF estimates that it leads to 3,500 deaths annually in member states of the Organization for Economic Cooperation and Development (OECD), constituting an annual mortality rate of 6.1 per 100,000 (UNICEF, 2003). Furthermore, the total number of cases of maltreatment is probably 150–2,000 times higher than the number of deaths (May-Chahal & Cawson, 2005; Scher, Forde, McQuaid, & Stein, 2004; Theodore et al., 2005; UNICEF, 2003). Risks of death from maltreatment are found to be highest in infants and then gradually decrease to the point where they are mostly replaced in adolescence by other sources of violence (Jenny & Isaac, 2006; UNICEF, 2003). These decreasing death rates by age may not fully reflect decreasing rates of maltreatment, however, because the likelihood of fatality in cases of maltreatment is probably highest among the very young (UNICEF, 2003). Evidence is now growing that in addition to its short-term effects, child maltreatment also has major long-term adverse effects (Dubowitz & Bennett, 2007). Examples of these effects include a higher likelihood of smoking and substance abuse (Newton & Vandeven, 2005), of adverse psychological symptoms (Briere & Elliott, 2003), and of a number of adult diseases such as ischemic heart disease, chronic obstructive lung disease and cancer (Felitti et al., 1998).

Attention to child maltreatment is growing among child-healthcare professionals (Dubowitz & Bennett, 2007). An example of this is that professional associations in several countries have issued protocols both on the detection and on the management of child abuse (AAP, 2001; Baeten, 2002; Kairys et al., 1999; Narayan, Socolar, & St Claire, 2006). In addition, between 1998 and 2003 the percentage of US pediatricians who thought that screening for domestic violence should be incorporated in routine health examinations increased from 66% to 72% (Trowbridge et al., 2005).

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In the Netherlands, the preventive child-healthcare system offers an ideal opportunity for the early detection of child maltreatment because it reaches virtually all children. In this system, child health professionals (henceforth: CHP), comprising child-specialized doctors and nurses, offer routine well-child clinics free of charge, based on a legally endorsed national scheme (Minister of Public Health, 2001), which includes the early detection of adverse child environments (Brugman, Reijneveld, Verhulst, & Verloove-Vanhorick, 2001; Reijneveld, Brugman, Verhulst, & Verloove-Vanhorick, 2004). For all ages, coverage is more than 95% of the total population (Minister of Public Health, 2001). Since they are mainly preventive, these services do not provide treatment except for short-term parenting support, in contrast to the system found in many other countries, including the USA, where preventive child-healthcare is embedded in the general setting of community pediatrics.

In the Netherlands, national guidelines for the detection of child abuse were issued in December 2002, aimed at all professionals working with children (Baeten, 2002). They were disseminated with a great deal of publicity to all preventive child-healthcare organizations. There were four main points to these guidelines. First, in any case of suspicion of child maltreatment, the facts underpinning the suspicion should be registered systematically and, if possible, these facts should be discussed with the child and its caregivers. Next, these suspicions should be shared with colleagues and with the regional child protection service ("Advies- en Meldpunten Kindermishandeling," AMK), and should lead to a working plan. The AMK has regional services throughout the country, which anyone suspecting child maltreatment can contact. Third, further investigation should be initiated, such as additional interviewing of the child and additional diagnostics. Finally, additional childcare and legal procedures should be initiated in cooperation with the AMK service. The fact that these guidelines were issued reflects the growing attention now being paid to child maltreatment among professionals (Schoenmakers, van Veen, Lindemann, Mehlkopf, & van Bostelen, 2006), including those in preventive child-healthcare.

Because of this growing attention, one might assume that there has been an increase in the rate of detected child maltreatment in Dutch child preventive healthcare, leading to the issuing of such guidelines. However, in reality little is known about any trends in the actual detection of suspected child abuse and neglect in community preventive health services. The aim of this paper is to provide information about these trends and about those characteristics of parents and children that might increase the likelihood of detection.

Methods

In a standardized way, trained CHPs registered data on child maltreatment for two national community-based samples of children in 1996/1997 (ages 2–12 years) and in 2002/2003 (ages 14 months to 12 years). Data were collected from October till May in both periods, using an identical methodology of the Dutch national child-healthcare monitoring system (Brugman et al., 2001; Reijneveld, Brugman, et al., 2004; Reijneveld, van der Wal, Brugman, Hira Sing, & Verloove-Vanhorick, 2004) and with the same supervisor (SAR).

Samples

Both samples were obtained by means of a two-step procedure. In the first step, a random sample of all child-healthcare services was drawn, after stratification by region, by degree of urbanization of their district and by ethnicity. The number of participating child-healthcare services varied per age group from 16 to 20 in 1997/1998, and from 12 to 15 in 2002/2003; in addition, due to mergers, the average size of these services had increased during this 5-year period. In the second step, each clinic was asked to provide a random sample of about 75 children in 1997/1998, and 100 children in 2002/2003, for each of several age groups included in the national well-child visits program. Preschool children (in the Netherlands, those under the age of 4) were selected from the clinics' lists per age group (variation allowed in months between brackets): 14 months (±2 months; only in 2002/2003), and 3 years and 9 months (±3 months), using random numbers (Reijneveld, Brugman, et al., 2004; Reijneveld, van der Wal, et al., 2004). For school-aged children each child-healthcare service provided a sample for each of two grades (second grade and one grade in the range 5–8 of primary school) (Brugman et al., 2001). Since they were anonymous, we cannot know the exact proportion, but relatively few of the CHPs are assumed to have participated in both studies.

Response rates were high, 92% in 1996/1997 (number of respondents (n) = 3,781), and 84% in 2002/2003 (n = 4,479; out of these 3,607 aged 3(1/2) to 12 years). After correction for stratified sampling, the samples were representative for the entire Dutch population in terms of income, type of family and parental educational level. Both studies were approved by the relevant medical ethical committees, including verbal informed consent by the parents.

Procedure

CHPs checked the medical histories of each child in their child-health records, performed a routine interview with the child and its accompanying parent or other caregiver, and also conducted a physical examination. Based on this and using a pre-coded registration form, they registered data on the background characteristics of the child and its family, and on the occurrence of any mental or social problem (designated as a psychosocial problem). For psychosocial problems, after each assessment they filled out the following question: "Does the child have a psychosocial problem at this moment?" (yes, no) and scored the type of identified problem(s) on a pre-coded list, which included those categories related to maltreatment. For both periods, physical neglect, physical abuse and sexual abuse were mentioned as categories in an identical way. Moreover,