KCE REPORT 269

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

HOW TO IMPROVE THE DETECTION OF CHILD ABUSE IN BELGIUM?

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HEALTH SERVICES RESEARCH

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HOW TO IMPROVE THE DETECTION OF CHILD ABUSE IN BELGIUM?

IRM VINCK, WENDY CHRISTIAENS, PASCALE JONCKHEER, GENEVIÈVE VEEREMAN, LAURENCE KOHN, NICOLE DEKKER, LIEVE PEREMANS, ANNE-MARIE OFFERMANS, ANNA BURZYKOWSKA, MICHEL ROLAND

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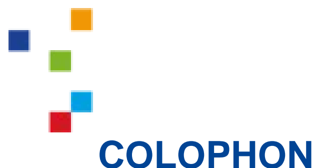

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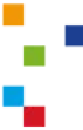

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Acknowledgements: Daniel Dinant (Sozial-Psychologisches Zentrum Eupen), Julien Ligot (infographist, Fedopress), Vanessa Schmitz (Jugendhilfedienst Eupen), Alain Uyttendaele (Analyst in statistics at the prosecutor's office of the Court of Appeal Brussels) and Flore (5 years old) for the drawing on the cover.

Other reported interests: Membership of a stakeholder group on which the results of this report could have an impact: Emmanuel de Becker (member of CAEM, of the Fédération des équipes SOS Enfants), Kristof Desair (Several discussion groups in Youth Care in Flanders), Hilde Lauwers (kindvriendelijk 1712), Anne-Marie Offermans (SSMG), Patrick Schlesser (SOS Familles – Service de pédiatrie), Remy Vink (Dutch division of ISPCAN), Marc Vranckx (BESEDIM)

Fees or other compensation for writing a publication or participating in its development: Anne-Marie Offermans (Recommendation de bonne pratique Maltraitance Infantile), Remy Vink (Several publications but not conflicting)

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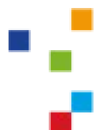

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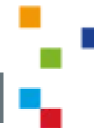
Publication date:	6 June 2016
Domain:	Health Services Research (HSR)
MeSH:	Child Abuse; Child Welfare; Domestic Violence; Child, Abandoned
NLM Classification:	WA 325
Language:	English
Format:	Adobe® PDF™ (A4)
Legal depot:	D/2016/10.273/54
ISSN:	2466-6459
Copyright:	KCE reports are published under a “by/nc/nd” Creative Commons Licence http://kce.fgov.be/content/about-copyrights-for-kce-reports.
How to refer to this document?	Vinck I., Christiaens W., Jonckheer P., Veereman G., Kohn L., Dekker N., Peremans L., Offermans A-M., Burzykowska A., Roland M. How to improve the detection of child abuse in Belgium?. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2016. KCE Reports 269. D/2016/10.273/54. This document is available on the website of the Belgian Health Care Knowledge Centre.



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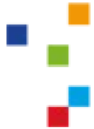

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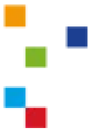

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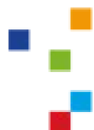

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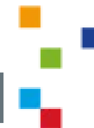
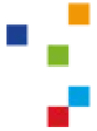
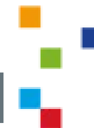


LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AMO	Aide en milieu ouvert
AFIU	Association Francophone des Infirmier(e)s d'urgence
BDMS	Medical Social Data Base
CARES	Child abuse recognition and evaluation study
CAW	Centres for General Welfare
CGG	Centres for Mental Health Care
CKG	Centres for Child Care and Family Support
CLB	Centres for Pupil Guidance
CPAS	Centre Public d'Action Sociale
CPMS	Centre psycho-medico-social
CPS	Child protective services
DGAJ	Administration for youth welfare
Expoo	Knowledge centre for parental support
FEMANP	Formons Ensemble à propos de la Maltraitance les Nouveaux Professionnels
GP	General practitioner
IVArp	Independent Agency
K&G	Agency for Child and Family
MPI	Medico-pedagogical institute
MPS	Medico-psycho-social
NFP	Nurse-family partnership
OCJ	Support centres youth care
OCMW	Public service for general welfare
ONE	Office for Birth and Childhood
PMS	Psycho-Medical-social centres
PSE	Health promotion at school
SAJ	Youth welfare services
SDJ	Social service of judicial youth care
SOS Enfants	Confidentiality teams for child abuse and neglect



SSMG	Société scientifique de médecine générale
SPJ	Youth protection service
TMS	Medical-social worker
VK	Confidentiality teams for child abuse and neglect
VOS	Alarming situation



■ SCIENTIFIC REPORT

1 BACKGROUND AND PROBLEM DESCRIPTION

1.1 Child abuse is a frequent, but mostly hidden problem…

Child abuse or the physical, sexual or emotional maltreatment or neglect of a child or children, is a frequent problem. We know that child abuse is prevalent in every society, but it is usually a hidden form of violence that may go undetected by professionals leading to serious consequences[1]. In most European countries, detection and surveillance systems are either non-existent or failing. A survey among health ministries of 41 European countries revealed that only 12 countries routinely provided official statistics on child maltreatment[2]. Data from countries[a] which do have a reliable detection and surveillance system suggests that up to 90% of child maltreatment remains unnoticed[3, 4].

Evidence from population surveys confirms the unacceptably high prevalence worldwide and suggests a ten-fold difference between official data and those reported in surveys. Population surveys resulted in global estimates of prevalence ranges between 4-47% for moderate to severe physical abuse, 15-48% for emotional and 20% for sexual abuse in girls and 5-10% in boys[2]. Projections based on a conservative estimate that at least 10% of all children suffer from maltreatment suggest that about 18 million children in the European region have experienced some kind of maltreatment (http://www.endcorporalpunishment.org/). However, the gap varies between countries and not all unascertained child maltreatment warrants interventions by child protection services. Sometimes families benefit more from support programs[1].

1.2 … with far reaching consequences…

The consequences of child abuse are diverse but cause most often far reaching problems for the psychological development of the victim and can potentially result in death. In the European region annually at least 850

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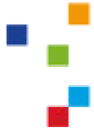
[a] Countries with officially recorded cases from child protection services are Austria, Belgium, Iceland, Lithuania, Latvia, Malta, the Netherlands, Portugal, Serbia, Spain, Slovakia and the United Kingdom (England).



children aged under 15 die from child abuse. Rates are highest in children under 4 years[1]. However, deaths are the tip of the iceberg. UNICEF[5] estimated that for every death, there are between 150 and 2400 substantiated cases of physical abuse.

A lack of nurturing relationships in childhood leads to a range of problems that continue into adulthood[1]. Documented consequences of child abuse are psychiatric disorders, suicide, depression, anxiety disorders, smoking, alcohol and drug abuse, aggression and violence towards others, risky sexual behaviours and post-traumatic stress disorders[6], also lower educational attainment, school attendance and likelihood to finish high school or attend university[7, 8].

In addition to individual costs, child abuse entails also a huge societal and economic burden. Short term costs include health care costs, missing school, professional losses, costs associated with child welfare services and the criminal justice system, and lives lost to fatal child maltreatment. Long-term costs are an increased use of health care and social welfare services, and productivity losses[1]. Few studies of the economic impact of child maltreatment have been published.

Long-term consequences has a double meaning in this context: firstly, victims of child maltreatment carry the consequences throughout their life-course, secondly violent behaviour is transmitted to next generations, which leads to a never ending chain of violence. Exposure to violence in childhood, increases the risk of becoming both a victim and perpetrator in adolescence and later in life[9, 10].

1.3 …calling for prevention, detection and intervention

An appropriate intervention and prevention of child abuse starts with the identification of children or families characterised by risk factors. The accurate identification of (potential) child abuse does not always result in reporting. Literature shows that professionals are rather reticent to notify suspected child abuse. Large numbers of professionals fail to report, even in countries with mandatory reporting such as the USA. Zellman's[11] national survey revealed that as many as 40% of mandated reporters have violated the reporting laws at some time.

1.4 Scope of the study

The initial research question was introduced by medical professionals in the field. The point of departure was the finding that professionals in the medical sector, in particular general practitioners report relatively few (presumed) child abuse cases. This is surprising as they encounter a lot of children during their daily work and they have a pivotal role in the relation with the family. Yet, the role of the general practioner in the process of detection and reporting can not be isolated and should be faced to the dynamic process of interactions among disciplines and services. Therefore, it was decided to enlarge the scope and to identify the building blocks of an efficient handling of child abuse cases in Belgium. Therefore, an overal assessment of barriers in the management of presumed child abuse cases, experienced by professionals involved in the healthcare, educational and judiciary sector was performed. The phases in the management of presumed child abuse case are detection, the first approach of the problem before reporting, reporting (to judiciary authorities as well as non-judiciary specialised services, i.e. services that have an official and specific mandate in the area of child abuse: VK and SOS Enfants), intervention and long-term follow-up. Prevention was not considered as a phase in the management process of an individual case. However, as it is interwoven with the management of child abuse, it is part of the report.

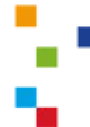
For a good understanding of the report, the terminology used is defined as follows:

Prevention: action to prevent occurrence or development of a health problem and/or its complications.

In the report "child abuse" prevention corresponds to primary prevention: any action taken to avoid or remove the cause of a health problem in an individual or a population before it arises; reduces incidence of the health problem; includes health promotion.

Detection: corresponds to secondary prevention. Detection includes both direct detection through direct contact with a child or youngster, but also indirect through contact with a family member

First approach of the problem: to avoid semantic and theoretical debates about the related concepts of primary (health) care, first level or first line care, etc. the term "first approach" is used to define the professional or the



service/practice where the problem of child abuse is initially deposited and supported before a reporting to specialized services; includes discussions, consultations and meetings between colleagues.

Reporting: any officially registered reporting of child abuse to judiciary authorities as well as non-judiciary specialised services. To report refers to giving an account of an observation or suspicion to a person or a service in order to protect the child, help the family or intervene and stop the abusive situation. This can be a request for advice to a specialised service as well as an official reporting to a specialised service or to judiciary authorities. As such reporting is a comprehensive term that groups different actions leading to different procedures.

Intervention after reporting :

- Short term actions,
- Follow-up (long term actions).

The interventions after reporting may relate to actions of the specialised services, the judiciary authorities but also the services or professionals that were referred to in the trajectory after reporting. It merely concerns the stopping of child abuse and ensuring (acute and long term) safety of the child, treatment of physical/psychological injuries and prevention of recidivism.

Note that intervention and long term follow-up may be considered as a single step in the trajectory.

Professionals involved in the study are general practitioners, paediatricians, psychiatrists, emergency doctors, health care professionals in schools (PMS/CLB), school directors, professionals working in (youth) care services, police and judiciary authorities. All of them are potentially involved in the trajectory of child abuse cases. Some of these persons or services can have several complementary roles. PMS for instance is involved in the medical as well as the educational aspects. It should also be stressed that the report primarily focusses on care and protection of the child and his/her family from the vioint of the service providers/(care) professionals. The point of view of the child/youngster and his/her family towards the care and services provided or the functioning of the trajectory was not studied. Furthermore, the attitudes of services/(care) professionals towards the perpetrator – although he/she can also be part of the family, are not addressed.

The report studies the following research questions:

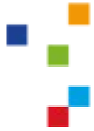
- **Which are the barriers encountered by professionals dealing with (suspected) child abuse and neglect (e.g. general practitioners, paediatricians, emergency doctors, professionals from educational sector or services involved in prevention, police and judiciary services) in the following phases:**
    - **Detection**
    - **First approach of the problem**
    - **Reporting to specialised non-judiciary services or judiciary authorities**
    - **Intervention after reporting**
- **How can these phases be improved, using the existing structures and networks, in order to strengthen medico- psycho- social care for abused and neglected children and their families?**

1.5 Methodology

This study applied the following research approaches:

Each of the methods are extensively described in the following chapters.

- Review of the international and Belgian scientific literature related to barriers in the detection and reporting of child abuse cases.
- In order to translate the results of the literature review within the Belgian context, the actors involved in the management process of child abuse cases were described based on grey literature, information from websites and contacts with key persons in the field.
- Individual, semi-structured interviews with 29 professionals from the medical, psycho-social, judicial, welfare, youth protection and educational sector were performed to get a better view on their daily practice. This qualitative research permits to confront results stemming from literature with the perception of Belgian respondents and allows to transpose the information into the Belgian context. The professionals involved were interviewed on the experienced barriers (and the possible solutions) in the detection, the first approach of the problem before reporting, reporting (to specialised non-judiciary as well as to judiciary

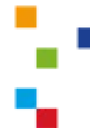


authorities), intervention and long-term follow-up of child abuse cases. Furthermore they were asked to identify the currently existing elements facilitating an efficient approach in the management of child abuse cases. We opted for a broad sample rather than focussing on the medical professionals because many barriers can be found in the collaboration of different disciplines and services. These barriers also impact medical professionals' willingness and the competence to detect and report.

- Based on the literature research and the qualitative research, recommendations and action points were drafted. The acceptability and feasibility was tested with a group of stakeholders via an online survey. Furthermore several stakeholder meetings were organised.
- Finlally, the report was validated by 4 experts in the domain. In the colofon a detailed list of the participants of the study and the validators is included.

1.6 Report structure

In the second chapter of this report, the notion of child abuse is defined and related concepts are described. Chapter 3 illustrates the particularities of the organisation of child abuse management in the Belgian context. In the annex of the report a summarised overview of the Belgian organisational context of institutions and services providing medical, psychological and social care (medico-psycho-social: MPS) in case of (suspected) child abuse and the structure of the judiciary authorities involved is described. In chapter 4, the currently available data on child abuse cases are presented. In chapter 5 the results of a literature review on the determinants of professionals' decision-making in child abuse cases are discussed. The main solution elements to improve the reporting of child abuse mentioned in the literature are included in chapter 6. Chapter 7 summarizes the results of a qualitative research, focussing at the barriers encountered by professionals in the Flemish Community and in the French Community (Fédération Wallonie-Bruxelles) (e.g. general practitioners, paediatricians, emergency doctors, professionals from educational sector or services involved in prevention, professionals from specialised services, police and judiciary authorities) in the different phases of the trajectory. Chapter 8 includes the report's general conclusions. The summary of the opportunities and the solutions for an adequate handling of (presumed) child abuse cases stemming from the literature and the qualitative research, and the recommendations and action points for Belgium are described in the synthesis of the report, which is a separate document.



2 DEFINITIONS AND CONCEPTUAL ISSUES REGARDING CHILD ABUSE

2.1 Definitions

There is no uniform definition of the notion “child abuse”. In the following paragraphs a selection of definitions used in different sectors is listed to illustrate the varying underlying paradigms. It is of an utmost importance to fully understand the sector specific focus as this will also be reflected in the reported barriers (see 7.5). Several definitions of child abuse can be found in different sources: there are medical definitions, legal and judicial definitions, definitions used in and “research” definitions. Depending on the sector and the purpose, different elements will be emphasised and the criteria to label child abuse will differ. In the medical sector, physicial symptoms of the child will be focussed on, rather than for instance the underlying aspects that make parents abusive. In the definitions used in the sector of , the description of child abuse is very general and broad to avoid that potential victims would be excluded from help and to allow early intervention. The definitions used for criminal procedures contain a specific description of the actions that could lead to criminal prosecution. Overall, all definitions attemps from their perspective to fit in the States’ obligations mentioned in art. 19 of the Convention on the Rights of the Child to guarantee measures to protect children from all kinds of harm. For this report we refer to the definition of the Convention when using the notion of child abuse, except stated differently.

2.1.1 WHO

The *World report on violence and health* defines child maltreatment as:

“All forms of physical and/or emotional or sexual abuse, deprivation and neglect of children or commercial or other exploitation resulting in harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power” (Krug et al., 2002)2.”

2.1.2 Convention on the Rights of the Child

The United Nations issued a resolution on November 20, 1989 based on the Universal Declaration of Human Rights of December 10th, 1948 Article 19 of the Convention on the Rights of the Child states that State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from *all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child*[12]. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement. In policy documents in Flanders and the Fédération Wallonie-Bruxelles, the definition of the Convention on the Rights of the Child is referred to as standard definition.

2.1.3 Definitions used in youth care

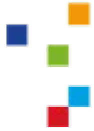
In the Decree related to integral youth care [b] (Flanders), child abuse is defined as: “Any form of physical, psychological or sexual violence against minors, either actively by the harmful acting, either passively by a serious neglecting by the parents or by any other person with respect to whom the minor is in a relationship of dependency”. The Decree related to care for victims of child abuse[c] (Fédération Wallonie-Bruxelles) defines child abuse as: “Any situation of physical violence, sexual abuse, psychological violence ou serious neglect which jeopardize the physical, psychological or emotional development; an action or abusive behavior can be intentional or unintentional”.

2.1.4 Operational definition for police, magistrates and the staff of the secretariat of the Prosecutors’ officices

In the Circular COL 3/2006 of the “Parket Generaal” a description of interfamily violence and extrafamily child abuse is formulated[15]. It concerns

[b] Art. 2, 32°[13]

[c] Art. 1, 4°[14]



an operational definition, that is used as a common reference for police, magistrates and the staff of the secretariat of the Prosecutors' offices.

Child abuse is any form of physical, sexual, psychological or economic violence on children. Violence includes:

- All criminal facts causing damage to a victim due to an act or an ommission. Violence can be physical (e.g. intentional battery and assault, sexual (e.g. rape), psychological (e.g. Insulting, defamation, stalking) or economic (e.g. abandoning of children) and
- all acts, that are, although they do not seem to be a criminal act, usually described as "family dispute" or "child in danger".

2.1.5 Penal Code

Child Abuse is a generic notion that covers several criminal offences. In the penal code, sexual abuse, physical abuse and neglect of minors are defined as criminal offences. Sexual abuse of children can be categorised and sanctioned under "rape" (art. 375-375 Penal Code), sexual assault (372-374 Penal Code, and provocation of sexual offence (379-380 Penal Code). Physical abuse includes: battery and assault (art. 392 – art. 396 – art. 405bis Penal Code), female genital mutilation (art. 409 Penal Code), torturing minors (art. 417ter Penal Code), treating minors in an unhuman way (art. 417quater Penal Code). Neglect includes the abandoning of children (art. 423 Penal Code), the omission to take care of the child (art. 425 Penal Code). The Penal Code does not provide any specific sanction for the psychological abuse and neglect of children. Since 2012, psychological abuse of minors could possibly be sanctioned via 442quater §1 Penal Code. In this article, psychological abuse is described a "untruthfully and intentionally misusing someone's physical or psychological weakness to make him or her do things or omit things and this affects the physical or psychological integrity of the person". This definition is not specific for minors and is far more restrictive than the definition of the WHO or the Convention on the Rights of the Child, where all forms of psychological abuse resulting in harm for the child are considered.

2.2 Theoretical perspectives in the study of child abuse

In the literature we found three approaches to child abuse: child abuse as a social problem, as a medical problem and most recently as a wicked problem.

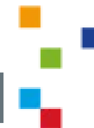
2.2.1 Child abuse as a social problem

A social problem stems from the (dys)functioning of society. It is about conditions which are experienced and defined as problematic because they constitute a threat to the dominant social values. Rubington and Weinberg[16] define a social problem as "*an alleged situation that is incompatible with the values of a significant number of people who agree that action is needed to alter the situation*" (p. 4). Because different people hold different values, their views differ on social problems. Also some people are more empowered than others in determining whether or not a particular situation is a social problem.

Child abuse is a socially troublesome and deleterious situation commonly recognised as a social problem by the general public, because it violates children's rights and the belief that children should be respected, nurtured, and be given the best possible chances to develop into healthy and balanced adults. In addition, there is a clear call for action, as institutions are formed and laws and regulations are enacted to prevent, detect, manage and treat child maltreatment.

2.2.2 Child abuse as a medical problem

Some authors (e.g. Feng et al. 2010[17]) question whether child abuse is a social or medical problem and others (e.g. Krugman, 2008[18]) have advocated the medicalisation of child abuse. Child abuse was claimed to be a medical problem for the first time in 1962 with Kempe et al.'s landmark article "The battered-child syndrome"[19]. With this article, the authors established the view that physicians have the responsibility to help keep children safe, sometimes even from their own parents.



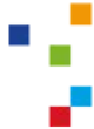
2.2.3 Child abuse as a wicked problem

Devaney and Spratt[20] reflect on child abuse as a complex and wicked problem. They refer to a class of problems for which “there are no ‘solutions’ in the sense of definitive and objective answers”[21]. Wicked problems cannot be solved by the conventional approach to ‘rational policy making’ breaking social problems down into smaller components which are then tackled.

Devaney and Spratt[20] apply the characteristics of wicked problems as described by Rittel and Webber[21] to child abuse:

- There is **no definitive formulation** of child abuse. It can be conceived as an interlocking set of issues and constraints. Different stakeholders hold different views as to the nature of the problem and what constitutes an acceptable solution.
- Since there is no definitive formulation of the problem, there is **no definitive solution** of the problem.
- **Solutions to wicked problems are not right or wrong**, but rather ‘better’ or ‘worse, ‘good enough’ or ‘not good enough’. Since there are different perspectives, the determination of the quality of a solution is not objective, and thus require a different approach to dealing with these ‘messy relationships’.
- Every wicked problem, hence also child abuse, is **essentially unique**. By consequence solutions are always tailored individually. “Over time key people may acquire the experience and skills for dealing with wicked problems, but they are always a novice in the specifics of a new wicked problem” [20].
- Every wicked problem can be considered a **symptom of another problem**. Wicked problems are often dependent on one another. Attempts to change one problem may result in the emergence of another unanticipated problem.
- There is **no opportunity to experiment** and to adapt potential solutions in a process of trial and error. Every attempt counts and can bring about significant costs if it is not good enough.
- There are **no given alternative solutions**. It is a matter of creativity to devise potential solutions and a matter of judgement to determine which are valid and should be implemented.

Child abuse as a complex problem implies that it consists of parts which interact in ways that heavily influence the probabilities of later events[22]. The complexity is evident in the multiple layers of decision-making. The decisional process of reporting child maltreatment is influenced by other , implicit, decisions[23]. For example, the likelihood of reporting is influenced by the perceived severity of the abuse. Hence one sub-process within the larger decision-making process, is the process of determining severity[23].



3 PARTICULARITIES RELATED TO THE ORGANISATION OF CHILD ABUSE MANAGEMENT IN THE BELGIAN CONTEXT

To understand the barriers in reporting from a perspective of the professionals and the hurdles in an efficient management of child abuse situations in general, it is essential to consider some particularities in the Belgian context. First of all, the structure of the Belgian State must be kept in mind to understand the organization of services and actors involved in the management of child abuse situations. Furthermore, the state structure where different aspects of child abuse management reside within the competence of either the Federal State, either the Communities, also impacts the policies and current approaches to the management of child abuse. On the individual professionals' level, the decision to report or not is obviously impacted by the Belgian legal framework.

3.1 The organisation of services and actors involved in the management of child abuse cases is addressed by Community- and Federal competences.

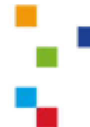
The structure of the Belgian State has a major impact on the organisation of the handling of child abuse. Belgium is a federal state composed of 3 Communities (the Flemish Community, the French Community and the German speaking Community) and 3 Regions (the Flemish Regions, the Walloon Region and the Brussels-Capital region). The Communities are competent for person related matters such as healthcare, and education. This implies that regulations regarding the organization of public services providing assistance in child abuse cases, (preventive) healthcare, and education differ in all Communities. Each child abuse case can therefore involve several actors which differ depending on the Community where the child is domiciled or has its factual place of living (cfr. infra).

Child abuse also relates to criminal practices, which makes the services of justice involved. The organization of the courts in Belgium is a solely federal responsibility which implies that actors involved in the process of handling child abuse cases, their roles and procedures in a trajectory of child abuse cases once it has been reported to the judiciary authorities are uniform for the Belgian territory. The measures imposed by the respective competent judges and the services implementing them, however may differ according to the Communities. Furthermore, protection measures that are imposed by a Court decision are offered by services that are organised on a Community level (see annex).

3.2 Philosophy of dejudiciarisation and subsidiarity

The protection of- and care for minors in (presumed or potential future) child abuse cases can be handled in a voluntary care trajectory (i.e. with the consent and collaboration of parents or those responsible for the education of the minor and the minor[d]) and/or in a mandatory care trajectory implying that a protective measure was imposed by a Youth judge. Although both trajectories can be addressed, "dejudiciarisation", which implies that voluntary assistance should first be exhausted before addressing to judiciary authorities, is a common philosophy in the Decrees of all Communities. The underlying idea is the principle of subsidiarity. According to this principle priority should be given to the extrajudicial system, as child abuse is considered to be a health and welfare problem for the minor and his/her family. Hence, if there is no urgency and the persons involved are willing to collaborate- preference should be given to the least radical measure, i.e. a voluntary care trajectory[24]. Subsidiarity also plays a role within a voluntary care trajectory. In the Belgian context, child welfare and child protection are perceived as a "comprehensive array of policies that form a pyramid": from a broad array of indirect preventative child welfare services (such as a range of family support oriented services) to, at the top of the pyramid, more specific and reactive child protection services[24]. An overview of the services involved and the possible trajectories of a child abuse case can be found in the annex of the report. The idea is that child welfare services should be the first point of intake before minors address to the system of child protection

[d] The Flemish Decree related to integral youth care states that minors older than 12 years old need to consent for assistance. Minors younger than 12 years old can consent if they are mature enough, if not they need to be heard. (art. 6[13]).



services. The rationale is that child protection services and practices are seen as more intrusive and expensive than the services and practices provided by this child welfare perspective[25]. The difference between child protection and child welfare orientations is that from a child protection perspective, the focus typically lays on investigative procedures to legitimize rather intrusive interventions, whereas, from a child welfare perspective, problems are located in the broader social context in order to realize child welfare[26].

In all Communities specific assistance services exist to protect the child from harm, in particular for child victims of abuse. In principle, their intervention does not depend on a judicial order and may take place before, during and after any proceedings.

In Flanders, the Confidential centre for child abuse and neglect (Vertrouwenscentrum kindermishandeling - VK) is the first contact point and assistance service for the child victim of abuse. It provides initial support, examination of the situation and refers to adequate specialised help. The Offices (Ondersteuningscentra Jeugdhulp – OCJ) provide assistance to children in distress or danger as well as to their families. These two organizations also have the mandate to intervene in a more mandatory way or to transfer the cases to the judicial services. As such they can act from a child welfare perspective as well as from a child protection perspective.

In the French Community, SOS-enfants is a service specialized in the detection of child abuse and care of such victims. It provides a tailored assistance to children have been victims or who are at risk of risk of abuse. The Service (Service d'Aide à la Jeunesse - SAJ) is a public authority providing assistance to children in distress or danger as well as to their families. The service works in collaboration with the child and his/her family. Its work is done on a voluntary basis, with the consent and participation of the child and her/his family. It provides support for children in danger or experiencing any sort of difficulties, for children whose health, educational circumstances, and/or safety are compromised or when primary support services have difficulty to help the child. The service will reach out to the child and his/her family to negotiate a solution, which may include a referral to another service. If necessary or if the child and his/her family refuse to collaborate, referral to the public prosecutor is possible. Whereas SOS enfants mainly acts from a child welfare perspective, the SAJ focusses on a child protection perspective.

3.3 No mandatory reporting

In Belgium, there is no obligation to report (presumed) child abuse cases to the judicial authorities[e]. Yet, professionals as well as any citizen in the society have a moral responsibility to ensure childrens' wellbeing and to act accordingly. Although there is a legal general duty, imposed to any citizen to help a person in great danger (art. 422bis), imposing mandatory reporting has been judged not to be necessary, however[31, 32]. The opponents of an obligatory duty to report argued that offenders as well as victims would be reluctant to appeal to care providers because they would fear prosecution. Furthermore, a confidential relationship patient-care provider would be problematic if the victim or the offender would have opted to consult a care provider. An obligation to report could also lead to a de-responsibilisation of the care by professionals, shifting the problem to the instances of Justice[33]. Finally, a lessened feeling of responsibility could also lead to an increase of unjustified reporting.

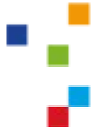
Duty to help people in great danger

According to art. 422bis Penal Code anyone has a legal duty to help in the following conditions:

- The victim must be in great danger
- The person required to intervene must have knowledge of the great danger either because he/she has ascertained the danger or because it has been described to him by the person(s) calling for help, and there is no serious danger to oneself or others in intervening.

In the context of child abuse, professionals are thus hold to help children in a (presumed) case of child abuse and in great danger either by themselves

e Several Community Decrees address the issue regarding the obligatory reporting of crimes committed to minors (Art. 57 Decreet 4 maart 1991 inzake de hulpverlening aan de jeugd[27]; Décret du 16 mars 1998 relatif à l'aide aux enfants victimes de maltraitances[28]; Decreet 19 mei 2008 over de jeugdbijstand en houdende omzetting van maatregelen inzake jeugdbescherming[29]). As there are no sanctions to this obligation to report, they need to be considered as moral obligations. Anyhow, federal rules prime to the regional rules[30].



or with the help of others, for instance by contacting specialised services (VK or SOS Enfants). In certain circumstances, however, the only way to help a person in great danger is to report the situation to the public prosecutor. Anyhow, it is to the holder of a duty of professional confidentiality to judge whether in the given circumstances, the reporting is the sole solution to offer help. As such, there is no absolute duty to report. As the notion of great danger is not defined, it might be difficult for some professionals, in particular the less experienced ones, to judge on the most appropriation action.

Duty of professional secrecy

Article 458 of the Penal Code imposes a duty of professional secrecy on physicians and other medical professionals and on necessary confidents who due to their status or profession obtain knowledge or secrets entrusted to them. Hence, professionals in a patient- or other confidential relationship with a child, victim of abuse, have a legal obligation not to disclose confidential information which he/she learns in the course of his professional practice.

This obligation of non-disclosure applies not only to information acquired directly from the person concerned, but also to person related information which the professional learns from other sources in his character as the confident of the person concerned. The rationale of this duty of confidentiality is to protect people's privacy and it enables people to feel confident to seek the help they need, without fearing that confidential information is transmitted.

Under certain conditions, however, this obligation can be set aside.

Legal exceptions

Article 458 of the Penal Code provides for two exceptions to the duty of professional secrecy. There is no offence if a physician discloses confidential information during a testimony before a court or before a Parliamentary Committee, neither when a law obliges him to divulge such information.

Shared professional secrecy

Under certain conditions the sharing of confidential patient information between professionals bound by professional secrecy is accepted. This is called the 'shared professional secret'. According to jurisprudence[34], the application of the shared professional secrecy needs to meet the following conditions:

- The information transfer is necessary and pertinent for the task of the professional concerned
- The professional needs to 'treat' the same person and with the same objective

Doctrine added the requirement that the person concerned also needs to have priorly consented (at least implicitly) to the information exchange or needs to be at least informed on the information transfer. In order to facilitate collaboration in team, doctrine further adapted the conditions defined by jurisprudence. As such all patient related information relevant for the professional treatment or assistance can be shared between professionals (subject of professional secrecy) of a team[35, 36].

If professionals submitted to professional secrecy report a case to the specialised child abuse services (VK, SOS Enfants, SAJ), there is no violation of professional secrecy. As both the reporting professional and the professional of the specialised child abuse service are bound by art. 458 Penal Code, the concept of shared professional secrecy can be applied if the above mentioned conditions were fulfilled[37].

The idea of shared professional secrecy was also inserted in the legislation of the Communities.[f] In art. 74 of the Flemish Decree integral for instance the actors of the Intersectoral Access Gate, the mandated services, the social services, the pupil guidance centers, the providers and other persons and services providing youth care can share personal data of the person for whom help was organised. The sharing needs to be necessary for the care

[ff] See also art. 3 Décret du 12 mai 2004 relatif à l'aide aux enfants victimes de maltraitance[14], art. 11 and 12, al. 6 Code de déontologie de l'aide à la jeunesse[38] and art. 61 medical deontological code[39]

providing, in the interest of the person(s) for whom the is organise and as much as possible with the consent of the person concerned.

It is important that professionals that share confidential information act within the same purpose. Police officers for instance are on the one hand submitted to professional secrecy, but on the other hand, they have a duty to report according to their mandate[g]. The sharing of confidential information between professionals in the sector, police and the judiciary context can not take place within the application of the shared professional secrecy as parties serve another finality. The boundaries of the professional secrecy in the collaboration between assistance, justice and police has been tested in several experimental projects in Flanders (e.g. Protocol van Moed (http://www.dsb-spc.be/doc/pdf/Protocol_van_Moed.pdf), the CO3-project (http://www.provincieantwerpen.be/aanbod/dwep/dwg/geweld--en-slachtofferbeleid/CO3-project.html), the LINK project (http://www.wissel.be/joomla/index.php/projecten/link) and the Korte Keten project (http://www.provincieantwerpen.be/aanbod/dwep/dwg/geweld--en-slachtofferbeleid/korte-keten.html**)**. In Antwerp, the so-called 'Protocol van Moed' wants to enable collaboration between youth care, justice and/or police in chronic or acute situations related to (presumed) child abuse or neglect, where the exchange of information could have an added value to decide on the next steps in the trajectory. One of the conclusions of the legal analysis in the Protocol van Moed project was that a legal ground should be created to justify the sharing of confidential information between the youth care and the judiciary authorities as the existing exceptions to professional secrecy may be insufficient to cover all possible settings proposed in the Protocol. At the moment of the writing of the report, the possible options are being studied at the federal level.

Professional secrecy towards parents

Professionals also have a duty of professional secrecy towards the minor's parents. As legal representatives of the minor, however, parents also have a right to confidential information they might need for instance to sue someone for civil injury. Sometimes, a conflict of interest can arise, for instance, if a parent is also an offender. A minor can request not to pass on the information to his/her parents. As a minor gets older and is more able to make well-considered decisions, one accepts that parents do not necessarily need to intervene[h]. For the youngest age categorie of children it can be problematic that a parent-offender can have access to the child's (medical) file.

Grounds of justification and 458bis

Grounds of justification are special circumstances that make an act or omission lawful, that justify the conduct, although they violate the literal terms of criminal law (state of emergency). When the patient is a victim of a crime, e.g. in case of child abuse, the same reasoning is often made in the literature. The conflict between the duty to professional secrecy and the duty to help a person in great danger (422bis) may result in a right (not an obligation) to notify a case of child abuse to the competent authorities. In this particular case, the professional needs to balance the harm that (probably) will be caused by not notifying and the impact of a breach of confidentiality in the patient-practitioner relationship[43, 44]. As personal physical integrity is considered to be the most important value in the legal community, the Court of Cassation accepted the breach of professional secrecy as a justification if it is the only way to preserve a person's physical integrity[45].

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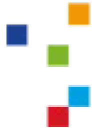
g Article 29 Code related to Criminal Proceedings[40] and article 40 Law 5 August 1992 related to the Police mandate[41].

h See for instance in art. 23 of the Decree related to the legal status of the minor in youth care, the minor's right to (if motivated) withhold some information to his/her parents is explicitly recognised. See also art. 12§2 Patients' rights act of 22 August 2002[42]



This reasoning has been confirmed in Article 458bis of the Penal Code. Since 2001, holders of a duty of confidentiality[i] who are aware of the abuse[j] of a minor could inform the public prosecutor, on condition that the person has examined the victim, has gained the trust of the victim, in case a serious and threatening danger exists for the psychological or physical integrity of the person concerned and in case the integrity cannot be protected by the person or with the help of others. In 2011, this right to notify has been extended[46]. Apart from minors, the list of protected persons has been extended to 'vulnerable persons'. Furthermore, it is no longer required that the holder of a duty of professional confidentiality has examined the victim him- or herself, or has been consulted by the victim. Having acknowledged the crime, regardless the source, allows the holder of a duty of professional confidentiality to report the abuse to the public prosecutor. This implies that in principle that information obtained from offenders can be reported to the public prosecutor by the respective healthcare professional. This may result in a situation where offenders will no longer appeal to healthcare professionals because they fear non-confidentiality.[k] Moreover, apart from the reality of a serious and threatening danger ("ernstig en dreigend gevaar"), the crime can also be reported if there are *indications* of a real and important danger for the integrity of other minors or vulnerable persons. The evaluation of the situation is up to the respective professional. This implies that less experienced care providers may be less efficient in the proper recognition or assessment of a serious and threatening situation than experienced professionals. There are no specifications in law to what extent the care provider needs to check the indications.[l] As reporting is also allowed based on indications of a real and important danger, prevention of new criminal events as well as potential crimes to other minors or other vulnerable persons is possible. This preventive reporting can only be done, however, if in the past a criminal event to a minor or other vulnerable person took place.[m] Finally, the reporting of child abuse based on art. 458bis can only be done if the respective professional could not protect the integrity of the minor himself or with the help of others (by means of shared professional secrecy for instance) in order to preserve the confidential patient-care professional relationship. It has to be noted that if the conditions of art. 458bis are not fulfilled, the professional can still appeal to the state of emergency to justify the disclosure of confidential information[48].

Patient's consent

The Belgian jurisprudence remains divided regarding the possibility to allow that a professional can be released from the obligation keep information confidential if the patient consented. According to the Court of Cassation, a physician cannot be released from the duty to secrecy because the patient has consented to the disclosure of confidential information. [n] In the Court's opinion the duty of medical secrecy is of public order and thus it is not to the disposition of the patient. Article 64 of the medical deontological code is in lign with this opinion[39]. In the mean time the Court of Cassation recognised

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[i] The notion of holder of confidentiality is presumed to be larger than the holder of professional secrecy

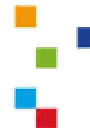
[j] The criminal offences listed in art. 458bis cover sexual assaults, rape, murder, parricide, voluntary manslaughter, physical violence, genital mutilation, abandonment, deprivation of care and kidnapping of minors.

[k] A. Tans en J. Put, Het beroepsgeheim uitgehold? Een versoepeld meldrecht voor geheimplichtigen, p. 15[30]

[l] The existence of guidelines enabling the recognition of child abuse situations (cfr. guideline Domus Medica – "Aanpak vermoeden van kindermishandeling" http://www.domusmedica.be/documentatie/richtlijnen/overzicht/kindermishandeling.html) may play an important role in the interpretation of situations of potential child abuse.

[m] H. Op de Beeck, J. Put, A. Tans, S. Pleysier en K. Hermans, *Samen werken tegen kindermishandeling*, p. 102[47]

[n] Cassatie 20 februari 1905, *Pas.* 1905, I, 141; **See for more jurisprudence and doctrine sharing this opinion:** Brussel 8 maart 1972, *RDP* 1971-72, 922; Arbeidshof Bergen 5 september 1980, *RDP* 1981, 99. C. Braas, Précis de droit pénal, Brussel, Et. E. Bruylant, 1936, 154-155, nr. 227; L. Nouwynck, La position des différents intervenants psycho-médico-sociaux face au secret professionnel dans un contexte judiciaire – cadre modifié, principe conforté, Revue de Droit Pénal et de Criminologie, 2012, 589-641; **Recognise professional secrecy in the interest of the client/patient**: Advies van de Nationale Raad van de Orde der Geneesheren van 30 april 2011 – Informatie aan de VDAB betreffende de arbeidshandicap[49]; Advies van de Nationale Raad van de Orde der Geneesheren van 30 april 2011 – Informatie aan de VDAB betreffende de arbeidshandicap[49]



that professional secrecy serves the interest of the client/patient[50]. Lower tribunals,courts of appeal and more recent doctrine have recognized that the consent of the patient may release a physician of his duty of medical secrecy if consent relates to a clearly defined part of the information and an identified receiver[51]. Furthermore, consent needs to be free, informed and explicit[52].

Professional secrecy and duty of discretion in schools

Teachers are, unlike members of the CLB[53] / PMS[o], not bound by the professional secrecy as defined in Art. 458 of the Penal Code since they are no professional caregivers[55, 56]. Yet, they have a duty of discretion. Consequently school staff cannot invoke the right to silence towards their superiors or colleagues. In case of information transfer, the interest of the pupil always needs to be taken into account. If information is exchanged with the CLB/PMS they can rely on their duty of discretion to refrain from transmitting all information. They will have to consider whether the information is relevant enough to share. For the exchanging of information between CLB/PMS staff and other welfare, care institutes and professionals the consent of parents or the (mature) child is always needed[57-59].

Keypoint

Healthcare professionals and welfare professionals are obliged to help a child in a situation of child abuse (in great danger), either by handling the situation him/herself, either by seeking help from others (for instance SOS Enfants or VK). The reporting to a VK is not considered as a breach of professional secrecy but as an application of the concept of shared professional secrecy. If it is impossible or insufficient to handle the case him/herself or with the help of others, the public prosecutor must be informed.

4 NO OVERVIEW OF THE SIZE OF THE PROBLEM

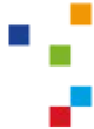
In 2015, the size of the Belgian population was 11.209.044 persons, of which 2.277.158 were minors. Since there is no national registration of child abuse cases nor any studies on the incidence or prevalence of child abuse in Belgium, the size of the problem in Belgium is unknown. Estimations can be based on the figures of several sources, such as studies based on surveys, figures from the specialised centers (VKs and SOS Enfants) and data from the department of justice. Yet, this will probably always represent the tip of the iceberg, as many child abuse situations remain unreported.

4.1 Data from the Belgian Health Questionnaire

As in many countries statistics on violence are scarce in Belgium. The Belgian Health Questionnaire 2013 (which takes place every 4 or 5 years) included a set of questions on violence to remedy this lack of statistics on the population level[60]. This Belgian population based study in persons over 15 years of age reports that 4.6% have been the victim of some type of violence at home, 4.2% at work or at school during the past 12 months. Women (5.2%) were more often victims of violence in the home than men (3.9%). In public places, such as work or school, there were no differences between men and women. Violence in the home seems to be increasing: 3.1% in 2004 and 4.6% in 2013, while the percentages remained stable for public places. The offender was a member of the family in 29% of the cases.

Almost a quarter of the victims remained silent about the act(s) of violence, the percentage being higher among men (30%) than women (17%). When seeking help, the police is contacted in 33%, family in 29% or friends in 28%. About 10% of the victims reports to a trusted party at work or at school or a confidentiality centre.

o Art. 12 Décrèt du 14 juillet 2006 relatif aux missions, programmes et rapport d'activités des Centres psycho-médico-sociaux[54]; Conseil supérieur de la Guidance psycho-médico-sociale et de l'Orientation scolaire et professionnelle, avis n°13/1205: Le Secret professionnel des membres du personnel des Centres Psycho-médico-sociaux.



4.2 Data from the survey of the Flemish Office of the Children's Rights Commissioner on the prevalence of violence against children

In a 2011 survey of the Flemish Office of the Children's Rights Commissioner, 2000 children (10-12 years old) and young adults (12-18 years old) in Flanders were asked to report their experiences with violence in the family, at school and in leisure time[61]. The results indicate that all forms of violence are present in all settings (family, school, leisure). Furtermore all forms of violence and child abuse correlate. Victims of violence are often victims of several forms of violence. The results of violence in a school environment are striking. About 85% of the pupils suffered humiliation. An extrapolation to the general population indicates that 225.000 to 300. 000 pupils (10-18 years old) are confronted with at least 3 forms of physical and psychological violence in a school context and about 33% is confronted with sexually unacceptable behaviour. In a family and leisure context 70% of the interviewees has experienced verbal violence. About 5 % of the interviewees was victim of serious physical abuse (threatened with a knife, beaten with an object, forced to stay in the same position) in a family context.

4.3 Data from the department of Justice

Statistics of the prosecutors' offices and statistics on the number of convictions related to child abuse are available, but limited. On the level of the penal courts, it concerns on the one hand the instream of cases related to child abuse at the prosecutors offices of first instance and on the other hand the dossiers related to major offenders at the the correctional prosecutors' offices. In the latter, one can find data related to the prevention codes/accusation codes[p] "paedophile" and "child abuse". Furthermore the context codes "extra family child abuse" and "intra family violence against descendants" can be registered to indicate child abuse related facts (independent of the accusation code registered).

There is however a lack of uniformity in the registration of child abuse. Child abuse is a container concept including several categories of criminal offences (rape, battery and assault, murder, neglect, abandon of children,…). Although there is a specific prevention code for 'child abuse', cases are sometimes registered under other categories such as 'battery and assault' or 'child in danger'. Moreover, there is no legal label for emotional or psychological abuse in the Penal code. As such, these types of abuse are not included in the databases.

Statistics on the cases registered at the prosecutors' offices of the juvenile court include the instream of the dossiers "VOS" (Verontrustende situatie – alarming situation). The concept of VOS relates to each situation where a minor's physical, psychological or sexual integrity or opportunities for affective, moral, intellectual or social development suffer. Each case of child abuse is a VOS, but each VOS is not a case of child abuse. As from the implementation of the circulars nrs. COL3/2006 en COL4/2006 related to intrafamily violence and extrafamily child abuse, a VOS dossier is systematically started for children in families where violence between partners was at stake and children that are victim of extrafamily abuse are systematically registred in a VOS dossier.

4.4 Data from police

The lack of a uniform registration of the phenomenon of child abuse also plays at police level. Actually it is not possible to set-up a database of the number of minutes related to child abuse. In the computer program ISLP, that is used by all police zones to create minutes, only criminal acts included in the Penal Code can be registered. Hence it is impossible to have an overview of all child abuse cases, unless one lists all criminal acts that can be related to child abuse. As psychological and emotional child abuse is not labelled as a criminal act, one also misses these cases. In daily practice psychological or emotional abuse is described in the minutes and registered under a different label, such as VOS. A possible option could be to install an 'eyecatcher'. This is already common practice for priorities from the national/zonal safety plan. If a phenomenon included in the safety plan (e.d. intrafamily violence), an obligation to label this phenomenon as 'eyecatcher' can be imposed. A circular sets the operation mode and the content of the

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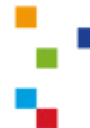
[p] Prevention codes or accusation codes (tenlasteleggingscodes) are used by the prosecutors' officices to label the types of the facts. The are based on the criminal offences defined in the penal code but they are further specified. In one case several accusation codes can be registered.



list of eyecatchers. This is no magic solution, however, since individual police officers still need to have the reflex to point the case as an eyecatcher.

4.5 Data of the specialized services (VKs and SOS Enfants)

4.5.1 Number of reported cases of child abuse to specialized centers (SOS Enfants and VKs)

The data registered by the Confidentiality Centres for Child Abuse and Neglect and the Centres SOS Enfants provide valuable information[24]. It should be noted that it is hardly possible to compare the data of the VKs and SOS Enfants, as there is no uniform registration. The categories often do not cover the same elements and there are differences in the level of detail.

Reported cases to the VK or SOS enfants concern a communication by any person (professional or not) of a request for information or advice, a concern, a reported child abuse case or a risk for abuse. Therefore the data represent suspected as well as confirmed abuse.

In the **Flemish Community** 70.7 children per 10 000 were reported to the VKs in 2014[62] The number of reports made at the VKs have shown a steady growth in the Flanders up to 2005 but levelled or showed a slight decline thereafter. In 2014, 7 311 reportings related to 9472 children (one reporting can relate to several children) were reported to the VKs. This is a modest decrease compared to 2013. Following the implementation of the hotline "1712", some of the cases were probably reported to the hotline instead of to the VKs. The hotline can refer the cases they receive to the VKs, which in 2014, was the case in 4.3% of the reported cases (See Table 3). At the time of writing of the report, there are no publicly available data on the number of reportings to the hotline "1712". It is remarkable that 15 % of the children reported to the VKs in 2014 was already reported in an earlier year. In 7.4 % of the cases, the VKs were contacted as a mandated service. When a case is reported to a VK (or OCJ) as a mandated service, they are entitled to start an investigation to assess whether there is a "social exigency" (maatschappelijke noodzaak) to start . The notion of social exigency refers to the necessity to deal with alarming situations or environments. A situation can be alarming when the development of the minor is threatened or his/her integrity is affected (e.g. child abuse, drug use, minor runs away from home,..). Requests to start this procedure can also come from the public prosecutor's office or via internal referral from the VK staff members. The latter took place in 1.3 % of the cases. Data on diagnosed child abuse cases by the VKs are not available at the moment of the drafting of the report.

In the **French Community** the number of reports at SOS Enfants increases steadily[24]. In 2014, 5619 reported cases related to 5056 children (the same child can be reported several times) were reported to centres SOS Enfants. For each reported case the SOS Enfants team assesses whether a consultation with the child and the family is necessary. If the a consultation seems necessary, the team SOS Enfants proceeds to a multidisciplinary evaluation of the child's situation. In 2014, a precise diagnosis of the type of abuse was available fo 3243 cases: the suspected abuse was not confirmed in only 6 %, 31 % were in living conditions putting the children at risk for abuse and 63% were indeed abusive situations. This confirms that at least 2053 children were victims of abuse in the the French Community during the year 2014. The type of abuse was physical in 22%, sexual in 36%, neglect in 22%, psychological in 17 % and other in 3% of the cases[63].

In the German speaking community the Jugendhilfedienst dealt with seven cases of reported sexual abuse and the SPZ (http://www.spz.be) recieved thirteen referrals of minors from the judiciary authorities in 2014[q].

4.5.2 Age classes of children

In Flanders more than 1/3 of the reported children is younger than 6 years old of which almost 15% is younger than 3 years old. Children aged between 6 and 12 years old are most frequently reported victim of (presumed) abuse (36.2%), followed by the age class between 12 and 18 years old (27.2%). There are only few reportings related to unborn children.

[q] Personal Communication

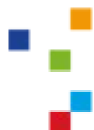


Table 1 — Percentage of reports to VKs per age class – Flanders (2014)

	Flanders
Age class (2014)	2014 (%)
Unborn	0.4
< 3 years old	14.9
3<x<6 years old	17.7
6<x<12 years old	36.2
12<x<18 years old	27.2
Extended minority	0.1
Unknown	3.5

In the French Community , children aged from 6 tot 15 years old are most frequently reported as victim of abuse. Children between 3 and 6 years old are reported in 15% of the cases and children under 3 years old represent 10% of the cases.

Table 2 — Percentage of reports to SOS Enfants per age class – French Community (2014)

	French Community
Age class (2014)	2014 (%)
< 3 years old	10.0
3<x<6 years old	15.0
6<x<9 years old	19.0
9<x<12 years old	19.0
12<x<15 years old	19.0
15<x<18 years old	14.0
18+	4.0

4.5.2.1 *Who reports to the confidentiality centers/SOS Enfants?*

Most reports originate from professionals, with 74.4% in Flanders and 54.6% in the French Community (see Table 3). Stratification by the type of professionals shows large differences between the Flanders and Wallonia, but also some similarities. Note that not all categories are comparable.

Data from VKs and the centres SOS Enfants show that reports by **medical professionals** are limited: they constitute 20.6% in the Flanders[62] and 8.7% in the French Community [64]. In the Flanders only 2.8% of cases is reported by the general practitioner and 6.5 % were reported by the hospital sector (hospital physicians and social services of hospitals). [r]

[r] Personal Communication Kind & Gezin

In the French Community , the **Services d'Aide à la Jeunesse** (SAJ - Services) accounts for the largest percentage, i.e. 15.1%, of all reportings to SOS Enfants, which confirm the good collaboration between SOS Enfants and the SAJ. **Judiciary institutions** (Juvenile court, prosecutor's office, Houses of Justice, other,..) and police are responsibe for 5.4% of all reports in the French Community , compared to only 3.7% in Flanders. For Flanders, this is a slight increase compared to 2013 (1.0 % in 2013). This is probably due to the new position of the VKs (from March 2014) as mandated service. The prosecutor's offices of the juvenile court can request the VK for an assessment based on "social exigency". 32% of total number of requests for social exigency comes from the prosecutors' offices.

In the Flanders the largest category of reporters are **the school and afterschool environment** (22.6%), whereof 18 % by the CLBs. In the French Community , the school environment (PMS, PSE and teachers – afterschool environment is not taken into account here) does 9,6% of all reporting. In Flanders, almost 15% of the cases in are reported by **welfare organisations** (CAW, OCMW, CKG, Residential care for disabled persons, non-residential care for disabled persons, VKs). The part of the VKs in this (1,3%) relates to cases that were reported to the VK and then internally referred to the mandated service role of the VK for an assessment 'social exigency'. In the French Community , the psycho-social network (Services Santé Mentale, therapists, CPAS, sickness funds, AMO, family help organisations,…) is responsible for 6.5 % of the reportings.

Child care centres report rarely: 1.4 % for the Flanders.[s] This is surprisingly low, especially when considering that children under 3 years old are a particularly vulnerable group.

[s] In the French Community, data on the reportings of the child care centers are included in the category 'others'

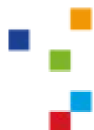
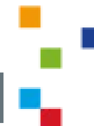


Table 3 — Percentage of reports to VKs or SOS Enfants by type of reporter 2013-2014

	Flanders		Fed. Wall-BXL	
Type of reporter (%)	**2013**	**2014**	**2013**	**2014**
Close environment of the child – Lay people (mother: Fl:10% - W-BXL:54%)	32.4	24.4	43.9	44.5
Person from the environment of the perpetrator	0.7	0.3		
Unknown/anonymous	0.9	0.8	0.9	0.9
Not filled in	0.0	0.1		
Professionals	66.0	74.4	55.8	54.6
Medical professionals	18.1	20.6	8.6	8.7
School and afterschool environment (incl. CLB's with 18%)	22.5	22.6	10.3	9.6
Psycho-social network			6.2	6.5
Child care centres or non-defined	1.5	1.4		
Residential care institutions/institution d'hébergement			2.7	2.8
Welfare organisations (of which VK: 1.3 % in 2014)	13.7	14.8		
Bijzondere jeugdbijstand (Flanders)	6.3	7.1		
Medico-social workers ONE			1.5	1.6
Services/ Service de l'aide à la jeunesse – SAJ (Wallonia)		-	16.5	15.1
Hotline for abuse, violence and child maltreatment/ Meldpunt geweld, misbruik en kindermishandeling (Flanders only)	2.8	4.3		
Hotlines (Télé-accueil, Téléphone Vert, Child Focus)		-	0.2	0.3
Juridiciary actors/ Justitiële instanties	1.0	3.7	5.5	5.4
Other professional			4.3	4.6
Total N of reports	7477	7311	5439	5619

Sources: "Het Kind inVlaanderen 2013[65] ; Het Kind in Vlaanderen 2014[62], annual report ONE 2013[66], annual report ONE 2014[63]



4.5.3 What are the most frequently reported/diagnosed problems?

In Flanders, for each child solely the most important problem is registered, even if several problems were reported. Table 4 shows that most of the reported problems relate to physical or emotional abuse or neglect. In 15.2% of the reported cases the most important problem is (a presumption of) sexual abuse and for 13.8% of the reported cases a risk situation is at stake. In 7.7% of the reported cases, it concerns a coping problem ("verwerkingsproblematiek") or another unknown or unclear problem and 4.3% of the reported children was (presumably) confronted to problematic (sexual) behaviour ("grensoverschrijdend gedrag") by another minor. Data on the diagnosed cases are not publicly available at the time of the writing of the report. Within the group of children under 3 years old, risk situations and physical neglect score much higher that in all age categories older than 3 years old. The youngest age class is also less reported to be victim of sexual abuse than the categories from 3 years and older. The older age classes are primarily reported for (presumed) cases of abuse or neglect.

Table 4 — Number and percentage of children per REPORTED to VKs problem in Flanders (2014)

	(N)	(%)
Physical abuse or neglect	3324	30.7
Emotional abuse or neglect by adult	2964	28.6
Sexual abuse	1563	15.2
Risk situation for the physical or psychological integrity of the child	1421	13.8
Coping problem of the child	105	1.0
Unknown	689	6.7
Physical, emotional abuse or problematic behaviour by minor	443	4.3
Not filled in	30	0.4
Total	10283	100

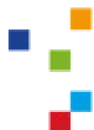


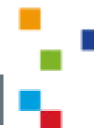
Table 5 — Percentage of children per age class/per problem reported to VKs in Flanders (2014)

	<3years old	3<x<6	6<x<12	12<x<18
Physical abuse by adult offender	16.6	17.4	19.9	19.2
Physical neglect by adult	20.6	13.4	9.9	5.9
Emotional abuse or neglect by adult	24.9	27.4	31.4	28.4
Sexual abuse and incest by adult	4.0	18.0	14.7	21.3
Risk situation for the physical or psychological integrity of the child	27.5	13.1	12.0	8.5
Coping problem of the child	0.1	0.4	1.0	2.0
Unknown	5.9	8.0	6.3	5.7
Physical, emotional abuse or problematic behaviour by minor	0.1	1.1	3.1	6.2
Sexual abuse (a.o incest) by minor	0.3	0.4	0.5	0.2

In the French Community , sexual abuse is the most diagnosed problem (36%), neglect is diagnosed in 22%, psychological in 17 % and other in 3% of the cases.

Table 6 — Number and percentage of children per DIAGNOSED problem in the French Community (2014)

	N	(%)
Physical abuse	458	22.31
Neglect	454	22.11
Sexual abuse	729	35.51
Psychological abuse	352	17.15
Other	60	2.92
Total	2053	100



5 THE DETERMINANTS OF PROFESSIONALS' DECISION-MAKING IN CHILD ABUSE

5.1 Introduction

A narrative literature review on the determinants of the decision-making in child abuse cases was carried out in indexed literature. Information for the Belgian context has been obtained from mainly grey literature.

5.2 Methods used

5.2.1 Methods used for the narrative literature review

5.2.1.1 *Search in the indexed literature*

The MESH terms used to explore the barriers and facilitators professionals experience in reporting suspicions of child abuse, were child abuse and child welfare.

We searched Medline (through Ovid) and Web of Knowledge with the following search terms: general practitioner, primary care, child abuse, child maltreatment, reporting, child protection and child safeguarding. The Cochrane Library was searched in order to find systematic reviews on child abuse reporting.

5.2.1.2 *Inclusion and exclusion criteria*

The selection criteria are summarized in Table 7. No a-priori criteria for the study design were defined. Both qualitative and quantitative research designs were taken into account.

Table 7 — In- and exclusion criteria

Selection criteria	Inclusion criteria
Population	Health care professionals
Intervention	Decision-making process of reporting child abuse Barriers and facilitators of professionals' reporting behaviour Solutions for underreporting
Outcome	Reporting and follow-up of suspicions of child abuse
Design	All types of design
Language	English, Dutch

5.2.1.3 *Quality appraisal*

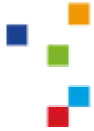
No quality appraisal was performed

5.2.1.4 *Search in the grey literature*

Information from the grey literature was included for Belgium. Grey literature was mainly searched on the internet by common search engines such as Google and Google Scholar.

5.2.1.5 *Selection process*

The selection of relevant articles and reports was based on title and abstract was done by one reviewer. After this first selection, the full-text of the selected abstracts was retrieved.



5.3 Determinants of health care professionals' decision-making regarding child abuse identified from the literature

The identification, reporting and follow-up of the suspicion of child abuse are conceptualised as a chain of responses or a decision-making process (e.g. Warner and Hansen, 1994[67]; Eisback and Driessnack, 2010[68]). The literature on the difficulties encountered by health care professionals in reporting and following-up of child abuse provides insights in every step of the decision-making process. Baumann et al. (2011)[69] distinquish between factors influencing assessment and factors influencing the threshold for action. The former refers to when health care professionals become suspicious (should I worry about this child?), the latter is about taking action (should I take care of this child, report the child?). This distinction between assessment and taking action will be used both in the literature review and the findings of the qualitative research part (See Chapter 7). Several steps precede reporting, hence make reporting more or less likely and should therefore be taken into account. Warner and Hansen[67] describe in a review article the physicians' role in the identification and reporting child abuse as a 3-step process. Physicians evolve from assessment and evaluation of injuries, to diagnosis and reporting the abuse. A fourth step in the process could be the validation of the report by child protective services (CPS) to whom the report was addressed.

In addition, authors (e.g. Jankowsky and Martin, 2003[23]; Fraser et al., 2010[70]) researching the decision-making process of reporting child maltreatment refer to the complex interaction between individual reporters' or health care professionals' characteristics, client/case characteristics and situational factors. **Professionals' characteristics** include for example world view, attitudes and previous clinical and life experiences. **Client/case characteristics** refer to all the features particular to the child, parent, family or injury, including the type of maltreatment, such as demographic information and personal history. **Situational characteristics** encompass for example the type and severity of abuse and the amount of evidence presented. Jankowski and Martin[23] add a fourth group of variables: **interactional factors**, such as willingness to cooperate on the part of adult clients.

In what follows we distinquish between factors influencing assessment and factors influencing the threshold for action. Additionally, we will structure the description of in terms of client, professionals', situational and interactional factors.

Note that the largest part of the literature included in this review is American. In the United States child protection services refer to a governmental agency that responds to reports of child abuse or neglect. We focus on the determinants in the decision-making process regarding child abuse. For a systematic overview of the risk factors or factors associated with child abuse we refer to Desair, K and Hermans, K. (2011)[71].

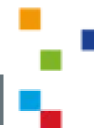
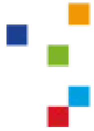


Table 8 — Examples of determinants of professionals' decision-making regarding child abuse

Stages in the decision-making process	Detection/recognition/becoming suspicious	Decision whether or not the injury is likely to be caused by abuse	Decision to report
Warner and Hansen[67] terminology	Assessment and evaluation	Identification and diagnosis	Reporting
Client/case characteristics	• Medical shopping • Visibility of the abuse	• Provided explanation for the injury • Delay in care seeking • Pattern of injuries	• Type and severity of the injury • Abuse as response to children's misbehaviour • Demographic variables (age, gender, ethnicity and income) • Objectification of harm • Child's disclosure of maltreatment
Professionals' characteristics	• (Insufficient) knowledge and skills • Field of expertise	• (Un)familiarity with the family/child • Knowledge about previous CPS involvement • Use of available resources	• Time pressure • Fear of legal proceedings • (Lack of) knowledge and skills • (Un)certainty about the diagnosis • (Un)clarity of child abuse definitions • • (Adverse) experiences with reporting • (Lack of) confidence in child protection services • Professionals' belief that they can do better • Anticipation of adverse outcomes • Type/profession of reporter • Clinical experience • Training • Attitudes towards child discipline • Personal history of family violence • Demographic characteristics (age, gender)
Situational characteristics			• Institutional protocols and hierarchy • Insurance restrictions • Type of practice • Size of the community
Interactional characteristics			• Relationship with/loyalty to the child/family • Consultation of colleagues and experts • Collaboration with child protection services



The distinction between barriers and facilitators is not always useful: firstly because the facilitators are often simply the reverse of the barriers; secondly because they represent a static non-system approach. Therefore we decided to list the elements influencing professionals' decision-making regarding child abuse, without differentiating barriers and facilitators. Note also that we use the term professionals if the finding applies to more than one professional group. If not, we refer to the specific professional group to which the finding refers (e.g. nurses, dentists, physicians).

5.3.1 Methodological note

Two types of methods are used in research on reporting behaviour/intention. The first is the case method, which involves the reviewing of medical records or asking professionals to retrospectively provide data on their actual reporting behaviour[67]. Most research however is based on another method, the so called analog method, in which professionals are asked to respond to vignettes[67]. Vignettes are descriptions of hypothetical cases. Hence, professionals are given analog cases of child injuries and are then asked to indicate whether the injury could have been the result of maltreatment and whether they would report the case, or more indirectly, whether the case should have been reported. By using vignettes certain variables can be systematically manipulated, for example age and gender of the child, severity of the injury. Subsequent effects on identification and reporting intention can be studied. The main shortcoming of this method is that responses to vignettes may not translate into actual behaviour in reality[67]. In fact, what is measured is not reporting behaviour, but reporting intention. However, throughout the literature, researchers use reporting behaviour, while in fact they measured only a proxy of that behaviour.

5.3.2 Factors influencing the detection/recognition/becoming suspicious

5.3.2.1 *Client/case characteristics*

Medical shopping

Abusive families often change from care providers or hospitals to prevent suspicion and conceal their difficult family situation. Steenackers[72] emphasised the importance of registration of patient information to double-cross this strategy. The suspicion of child abuse is mostly the result of putting together several pieces of information providing an idea of the families (dys)functioning[72]. Hence, it is seldom the result of one encounter.

Visibility of the abuse

Absence of (visible) physical injuries, such as in case of neglect or sexual abuse makes the evaluation more uncertain[73].

Provided explanation for the injury

Professionals became suspicious if the explanation provided was not consistent with the injury[73, 74], or if no explanation was given for the injury[74], and/or if there was a considerable delay in seeking care. Also the pattern of injuries or the history of previous injuries may cause suspicion[74].

5.3.2.2 *Professionals' characteristics*

Insufficient knowledge and skills

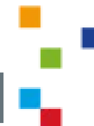
Expertise about clinical signs and symptoms are necessary to discriminate between the abusive or accidental nature of an injury. Insufficient training and preparation for handling situations of child abuse impedes this discrimination process[72].

Field of expertise

Particular risk factors may be more obvious to certain reporters[75]. For example: dentists are better placed to notice neglect, while general practitioners or emergency doctors are more sensitive to physical abuse. Teachers might detect still other types of abuse.

Knowledge about previous CPS involvement[74] facilitates suspicion.

Use of available resources, such as consultants (colleagues, experts, specialists, etc.), radiographic findings[74] may facilitate the diagnosis of child abuse.



Key points

The detection of child abuse is more difficult in the absence of visible physical injuries and/or if families switch between care providers often. Also insufficient knowledge and skills of professional hamper detection.

Furthermore, the decision whether or not the injury is likely to be caused by child abuse is influenced by

- **explanations that are inconsistent with the injury , unlikely or absent**
- **delay in care seeking**
- **use of available resources such as medical imaging techniques**
- **previous experiences with reporting child abuse**

5.3.3 Determinants of the decision to take action

5.3.3.1 Client/case characteristics

Type and severity of injury

Authors from empirical studies (e.g. Zellman, 1990) concluded that the perceived seriousness of cases, increases the likelihood of a report being made, especially when sexual abuse is being suspected. Also Beck and Oglof f[76] found that suspected sexual and physical abuse was more likely to be reported than suspected emotional abuse or neglect.

The relative contributions of professionals' judgements, such as seriousness, the benefit of a report for the child, to the likelihood of reporting varies by type of abuse. In other words, the decision-making process differs by type of maltreatment. Suspected sexual abuse was more likely to be reported than physical abuse or neglect[11].

Demographic variables

- **Age** of the child and age of the parents

  Younger parents and younger children seem to be more at risk of abusing or being abused. Young children are overrepresented in statistics of reported cases, but it may be that younger receive more severe or life-threatening injuries and are therefore more likely to come to the attention of reporters[77].

- **Sex** of the child and sex of the parent

  Female children are more likely to be abused[77]. Vignettes involving physical abuse by a father were rated significantly more abusive than those involving mothers[78].

- **Race** of the child

  Coloured children more likely to be reported than white children[77].

- **Income** of the family

  Lower income families have a higher probability of being reported than families with higher incomes. Effects of severity of the case impacted the discrimination between reported and unreported cases only after the income variable was eliminated from the analyses[77].

Objectification of harm

The decision to report child maltreatment increased in complexity when the signs and symptoms were less overt or included only subjective evaluation[68].

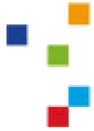
Child's disclosure of maltreatment

Of particular interest is the finding in the study of Eisback and Driessnack[68] that nurses often consider a child's disclosure of maltreatment to be adequate evidence. Some nurses felt the need to assess the veracity of the child's disclosure prior to making the report to CPS[68].

Key points

The decision to take action (e.g. report child abuse) depends on client or case characteristics such as:

- **the type and severity of the injury**
- **children's misbehaviour**
- **demographic variables, such as age of the child and age of the parents, sex of the child and sex of the parent, race of the child and income of the family**
- **the objectification of harm**
- **the child's disclosure of maltreatment**



5.3.3.2 *Professionals' characteristics*

Time pressure

Time related arguments are often mentioned throughout the literature on reporting child abuse. Time is a barrier in many ways. In the first place, the decision-making process, the reporting and follow-up (e.g. making reports and court attendance) of child abuse take extra time[79, 80]. Moreover, activities such as CPS, questioning the parents, consulting colleagues or experts, providing emergency hospitalisation if necessary and court attendance may not be financially reimbursed[67]. The time used for these activities can then not be used for other activities or patients/clients. For physicians this implies that reporting may result in a loss of opportunities to see other patients for which a physician would be financially reimbursed[67].

Fear of the legal proceedings

Physicians do not want to get involved in legal proceedings, they fear going to court. They estimate that this would be very time consuming (e.g. going to court, producing legal reports)[67].

Lack of knowledge and skills causing feelings of uncertainty and incompetence

Lack of training and experience in child abuse has been found to be a major obstacle in reporting child abuse[81]. This barrier is raised in almost every journal article addressing the reporting of child abuse (e.g. Flaherty, et al., 2004[79]; Vulliamy and Sullivan, 2000[80]; Alvarez et al., 2005[82], Delaronde, et al., 2000[83]; Eisbach and Driessnack, 2010[68]; Flaherty et al., 2008, in Pietrantonio et al., 2013[84]; Donohue et al., 2002[81]) and applies to all professions concerned with child abuse, both in countries with and countries without mandatory reporting. In addition, lack of knowledge and skills applies to every stage in the decision-making process: lack of knowledge about child abuse in general[79], lack of knowledge in function of identification and management of child abuse[79], unfamiliarity with the reporting procedures, knowledge about the legal system[70, 82], lack of tools to engage families in discussions about their child's injuries[79].

Professionals need both knowledge and skills. Physicians who had received formal education in child maltreatment following their residency program, were 10 times more likely to report concerns to CPS than providers who had not received any formal training[73]. Cited content areas to be included in training programs are types and definition of abuse, reporting procedures and legal issues, skills to involve the client in the reporting procedure, and knowledge refuting misbeliefs about reporting and the consequences of reporting[85].

Uncertainty about the diagnosis – Lack of evidence

Uncertainty about the diagnosis[79, 83] and the fear of making false accusations[68, 86] are mostly mentioned as consequences of the lack of knowledge and skills in identifying and managing child abuse, but not necessarily. In addition, they may have an impact on the decision to report or refrain from reporting independent of knowledge or experience. Therefore we mention them as a factor in its own right. Although diagnostic accuracy in not required for reporting (in countries with mandatory reporting, physicians indicate that their estimate of their diagnostic accuracy influences their decision to report maltreatment[67]. Also Beck and Ogloff[76] found that lack of evidence in detecting maltreatment was indicated as a significant barrier against the reporting of suspected child abuse among psychologists.

Confusion by vagueness of child abuse definitions

Reasons for failing to report were also definitional or evidentiary confusion[68, 80].

Consultation of colleagues and experts

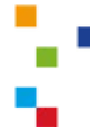
Professionals found it very helpful to discuss suspicions with colleagues or to consult child abuse experts. Also emergency departments with paediatric expertise were a valued resource[79].

Collaboration with child protection services

A higher degree of comfort in reporting a case to CPS was associated with the ease of the reporting procedures and being treated in a professional manner[80].

Adverse experiences with child abuse reporting or CPS

Physicians' adverse experiences with child abuse reporting may make them less likely to file subsequent reports to CPS[79]. Strozier et al.[87] concluded from their research that family therapists perceived CPS to be underfunded,



understaffed and inadequately trained. Also family therapists believed that CPS was not likely to do its job wel, and that their interventions often worsened family situations.

Reported adverse experiences relate to the reporting process, as well as the outcome.

- Professionals feel discouraged and disappointed that they did not receive more support from CPS during the reporting process[68, 79];
- Professionals not always receive feedback from CPS after they made a report[74, 79, 88];
- When CPS did not follow-up on the physician's concerns, the physician felt "exposed" [68, 79], findings among psychologists were comparable[76];
- CPS-reporting hotline may defer taking a report for hours, even though the patient and family are in the office waiting room[79];
- Anticipated outcome of CPS intervention[74]

Critique to CPS (dys)functioning is mainly based on American literature. It is unclear to which extend they apply to other countries. The lack of response from CPS at several stages in the reporting process is mainly caused by the understaffing and underfinancing of CPS. Critics refer to the dysfunction of CPS to argue against mandatory reporting. In their view, mandatory reporting leads to a work overload for CPS[87].

Previous experiences with CPS guided the expectation of negative outcomes and **set a level of suspicion** at which to report. In other words, from previous experiences with reporting, professionals learn from which point, the suspicion is strong enough for CPS not to dismiss the report without investigation[68, 74]. Hence, professionals tend to filter their reports and report only those cases for which they think CPS will take action (Flaherty, 2008). By means of a national survey among mandated reporters Zellman[11] already in 1990 found that some would-be reporters decided not to report cases when they were reasonably confident that a report would not be accepted or acted upon, because then, no benefit to child or family could be expected.

However, Flaherty[73] warns that "*this approach may impede access to CPS services for chronically abused children with repeated minor injuries, which are often accompanied by emotional abuse and consequent long-lasting psychological and developmental harm. Lack of referral for such services may result in missed opportunities to prevent escalation of the severity of the abuse, which may result in serious or fatal harm*" (p. 616).

Lack of confidence in CPS, unrealistic expectations, lack of awareness of CPS roles

Vulliamy and Sullivan[80] point out that professionals will not begin to adequately report until they have confidence in CPS and feel they are receiving a fair exchange. Research[89] demonstrated that reporters are most satisfied when the action taken by CPS was what they expected it could be[89]. Also Beck and Ogloff[76] identified a lack of confidence in child protection services as an important reason for past failure to report child maltreatment.

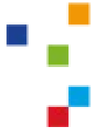
The lack of confidence among physicians might originate in hierarchical differences between reporters and CPS collaborators: CPS social workers commonly have less status and earn lower salaries than those who are expected to report to them, physicians not motivated to collaborate, perhaps to avoid social workers' domination by the doctors[80].

Professionals' belief that they can reach better outcomes than CPS

Lack of confidence in CPS build throughout negative experiences with CPS (e.g. no action taken following a report) comes together with the professionals' belief that they could work with the family outside intervention[79, 90]. Reporting to CPS is perceived to be the last option, when all the other attempts to help the family failed[68].

Anticipation of adverse outcomes of reporting

Part of decision-making process on reporting suspicions of child abuse is the balancing of costs and benefits of reporting for the professional, the child, the family and the interaction between the professional and the child/family. In the United States, anticipation of negative patient outcomes of reporting seems to outweigh often the legal mandate to report injuries from suspected child abuse to CPS (Jones et al., 2008). Also the belief that reporting may produce more harm than good for the child[83] is a strong barrier. In a study of Kvist et al.[86] dentists prioritised providing (dental) treatment over reporting, because reporting might disrupt the treatment plan and harm the relationship with the family.



Also adverse outcomes for the reporters themselves are mentioned in the literature, for example concerns about own safety, fear of the family's retaliation[68].

Type of reporter/profession of the reporter

McDaniel[75] came to the striking conclusion that all reporters, professional and non-professional, reported different families, and there was little overlap in the risk factors[75]. The figure below (reproduced from McDaniel, 2006) illustrates this complementarity.

Figure 1 — Determinants of reporting for several types of reporters

Table 5
Summary of mandated and non-mandated reporting patterns*

	Non-mandated reporters	Teachers and child care	Law and social service	Medical professionals
Family risk factor				
Lower household income	+			
Younger children	+		+	
More children	+	+		
Harsh discipline		+		
Mental illness (caregiver)		+		
Frequent alcohol/drug use		–		
Homeless			+	
Learning disability (caregiver)			+	
Live in Chicago				+
Parenting stress				+

*+ = increased risk at $p<.05$ level.
– = decreased risk at $p<.05$ level.

(Reproduced from McDaniel, 2006[75])

In addition, based on a national study of professional reporting practices, Zellman[91] grouped mandated reporters into four categories, based on their past reporting behaviour:

- Consistent reporters who always reported
- Consistent non-reporters who never reported
- The uninvolved, who had never encountered suspected child abuse
- Discretionary reporters who sometimes reported and sometimes did not.

The latter group was the second largest group after consistent reporters, accounting for four-fifths of all those who admitted having ever failed to report.

Interestingly, Zellman's data suggest that this group of reporters was well-trained and committed. What most distinguished discretionary reporters from other groups, was their negative views of the professionalism and capabilities of the child protection services. Also, they believed that reports often had negative consequences for the children involved. These findings suggest that non-reporting may not be solved simply by education and enforcement by law[91].

Zellman's study also revealed a small group (6%) of consistent non-reporters. These professionals were mostly employed in private practice settings and pointed mainly to personal consequences and costs to them, such as the loss of time and patients.

Clinical experience

Renninger[92] reports inconsistent findings from the literature regarding the impact of clinical experience on reporting behaviour. Hansen et al. (1997) found an increase in reporting with increasing number of years of clinical experience, while Crenshaw et al.[93] found no significant association.

Training

Findings mixed with respect to reporter training, degree type, and profession[92].

Attitudes towards child discipline

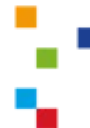
Professionals with a higher acceptability level for physical discipline, were less likely to report abuse[67, 94, 95].

Personal history of family violence

Clinicians who have a personal history of family violence are more likely to report suspected abuse or neglect[92, 96].

Demographic characteristics of reporters

The findings regarding the impact of professionals' gender and age on their reporting intention are rather inconsistent.



With regard to **gender**, Hansen and Warner[67] found that female undergraduates were more likely than male undergraduates to rate behaviour described in vignettes as abusive and were more likely to indicate they would report the cases. Note that students were interrogated and that vignettes were used (see 5.3.1 Methodological note).

The professionals' **age** may be correlated with the number of years since the physician was formally trained, and may therefore be confounded with both content of medical training and years of clinical experience[67]. Morris and colleagues (1985; in Warner and Hansen, 1994)[67] found that younger physicians were more likely to indicate they would report suspicions of child abuse, compared to their older colleagues.

Key points

Health care professionals are less likely to report (suspicions of) child abuse if:

- **They experience a lot of time pressure**
- **They fear legal proceedings**
- **They lack knowledge and skills, causing feelings of uncertainty and incompetence**
- **They have adverse experiences with child abuse reporting, lack confidence in child protection services, have unrealistic expectations, believe they can do better than child protection services**
- **They anticipate adverse outcomes of reporting**

Furthermore reporting behaviour is also influenced by:

- **The type of reporter or the reporters' profession**
- **Clinical experience**
- **Training**
- **Attitudes towards child discipline**
- **Personal history of family violence**
- **Demographic characteristics of reporters**

5.3.3.3 *Situational characteristics*

Institutional protocols and hierarchy

Institutional protocols often instruct professionals to channel reports of abuse to their supervisors before making a report to CPS. Many professionals complain that they are unsure of what course of action to pursue when there is disagreement with a supervisor concerning the decision to report[85].

Insurance

Some insurance carriers may not allow professionals to refer a child to an institution recognized to provide the quality diagnostic studies or expert opinion needed to make the diagnosis[79].

Type of practice

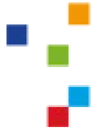
Warner and Hansen[67] mention in their review that only a small number of reported cases were reported by private practice physicians (Ten Bensel and Wilcox, 1986, in Warner and Hansen, 1994)[67]. Explanations offered are compositional effects (private practice physicians may not see as many abused children) and the fact that negative consequences may be more salient if restricted to one or two physicians. In group practices or hospital settings, negative consequences could be more diffused across individuals. In the latter settings, physicians also have more opportunities of consulting colleagues.

Size of community

The findings on the community effects go in the same direction: physicians practicing in small towns (population < 20,000) were less likely to report cases of physical abuse, compared to physicians in urban settings (Badger, 1989, in Warner and Hansen, 1994)[67].

Key points

Reporting is also hampered by situational characteristics, such as institutional protocols and hierarchy (e.g. in hospitals) and a small community size. Also physicians working in a group practice are more likely to report than those in solo practices.



5.3.3.4 *Interactional characteristics*

Relationship with/loyalty to the child/family

A recurrent finding throughout the literature on reporting behaviour is physicians' fear of losing contact with the child or family. This fear relates to possible negative consequences for the child/family (they become more reluctant to seek help or shop between health care professionals) on the one hand, and personal financial loss because of losing patients (both directly and indirectly by means of negative publicity) on the other hand.

The relationship with families works as both barrier and facilitator[74, 79]. On the one hand, physicians feared offending families. Close relationship with the family makes it harder to consider abuse, they were more likely to accept the family's explanation for an injury[79], or find it difficult to believe the family would abuse or neglect their child[67]. On the other hand, their knowledge about certain problems within a family caused them to be more suspicious that an injury was caused by abuse[79].

Professionals are concerned that their own ability to continue to monitor the child would be compromised if the child was reported[74]. More generally, maintaining good relationships with their patients/clients is mentioned in several studies as a reason to refrain from reporting (e.g. Delaronde, et al., 2000)[83].

Also professionals point to the difficulties they experience in talking to parents, explaining their suspicion of maltreatment and consequent actions such as sending a child to the hospital for a body scan[79].

Key point

Finally, interactional or relational characteristics may discourage reporting behaviour:

The relationship with families works as both barrier and facilitator. On the one hand, close relationship with the family makes it harder to consider abuse, on the other hand, their knowledge about certain problems within a family may cause them to be more suspicious that an injury was caused by abuse.

5.3.4 *Empirical models explaining reporting behaviour*

5.3.4.1 *Test of the theory of planned behaviour*

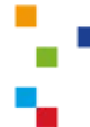
Feng et al. [97] applied the theory of planned behaviour[98] to explain reporting behaviour among Taiwanese kindergarten teachers. This theory has been used to explain a large array of health behaviours, for example the participation in screening programs. In the theory of planned behaviour, behaviour is determined by the intention to behave in a certain way, which is in turn determined by attitudes towards the behaviour, subjective norms and perceived behavioural control. Feng et al.[97] found that with exception of subjective norms (also perceived societal expectations), their findings support the theory of planned behaviour. This means that kindergarten teachers' attitudes and the control they had over their reporting behaviour, seemed to be more important predictors than societal expectations regarding the intention to report child abuse. However, note that it is unclear to what extent these findings apply to other professions and other national contexts, and that the attitudes measured do not directly relate to reporting behaviour. They were attitudes towards child discipline, abusive parents and professional responsibility.

5.3.4.2 *Zellman's model of judgements contributing to the decision to report*

Zellman's data[11] indicates that five judgements capture much of the variance in ratings of likelihood of reporting (R^2=.71):

- The seriousness of the incident
- The likelihood that the injury is caused by abusive behaviour
- The reportability of the incident (does the law require a report?)
- The overall impact of reporting on the child
- The overall impact of reporting on the rest of the family

Across all types of abuse, the judgement whether the law required a report contributed the most to the decision-making (Figure 2). Since the respondents to study where all mandated reporters, social desirability could have played in the scoring of this judgement. Mandated reporters do also weigh potential benefit to child and family in making decisions about reporting. Since in the United States the law requires professionals to report



suspected abuse and neglect, they often report, while in fact they believe that their report will not be helpful to anyone, and could in fact be harmful11. In addition, the judgements relate somewhat differently to the decision to report as a function of the type of abuse (Figure 2).

Figure 2 — The likelihood of reporting as function of abuse-relevant judgements by type of abuse

Table 5. Likelihood of Reporting as a Function of Abuse-Relevant Judgments by Type of Abuse

	Vignette		
Judgment	Neglect ($N = 4$)	Physical Abuse ($N = 3$)	Sexual Abu ($N = 4$)[b]
Seriousness	.23[a]**	.14**	.14**
Abuse?	.27**	.17**	.10**
Law requires a report?	.74**	.93**	.96**
Report benefit to child	.19**	.12**	.13**
Report benefit to rest of family	.07*	.10**	.03**
R^2	.71	.74	.71

[a] Cell entries are coefficients from a regression of question 6 on questions 1–5. The variables used in this regressic are adjusted responses based on standardized residual from regressions that account for the factors varied in ea vignette.
[b] Madden vignette is excluded because of its unique metric.
* Significant at $p < .01$. **Significant at $p < .001$.

(Source: reproduced from Zellman, 1990[11])

5.3.4.3 *Moderators in the decision-making process among nurses*

Based on a qualitative study with individual interviews, Eisbach and Driessnack[68] identified three steps in nurses' decision-making (Figure 3) regarding reporting child abuse:

- Becoming aware of potential child maltreatment
- Intervening on behalf of the child and/or family themselves
- Reporting to CPS

In addition, factors were identified that moderated the rate at which the nurses moved from one step to the other:

- The nurse's **knowledge and professional comfort level** identifying the signs and symptoms of child maltreatment, influenced the identification step in the decision-making process. Cases are not always clear cut. Especially when suspicions were based solely on subjective evaluation in the absence of any objective signs of maltreatment, they felt that they did not have enough evidence to report.
- Nurses **contextualised their assessment** of child maltreatment by assessing the family's social situation before they proceeded. Nurses took time to understand the child's family situation, parenting skills and role models, levels of stress, and /or resources. Nurses also questioned parental intentionality. They hesitated to report until they had a grasp of the bigger picture
- Nurses **reflected on available services**, weighing the pros and cons of providing services themselves with referring or handing off the case to CPS. Sometimes they decided to delay their decision in function of:
    - Safety of the child.
    - Fear that the stress of a CPS report would stress an already-stressed family.
    - Concern that the family would cease contact with healthcare providers.
    - Own safety

Interestingly the authors found that if nurses were comfortable with their knowledge and skills at the first moderating point, they appeared to pass through the second and third points with little moderation or delay in the reporting process. However, if nurses hesitated at the first moderating point, decision-making became increasingly complex and the influence of the second and third moderating points expanded and delayed the process. This finding would point to the importance of knowledge and training of health care professionals, not only in function of detection, but of the whole decision-making process.

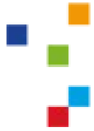
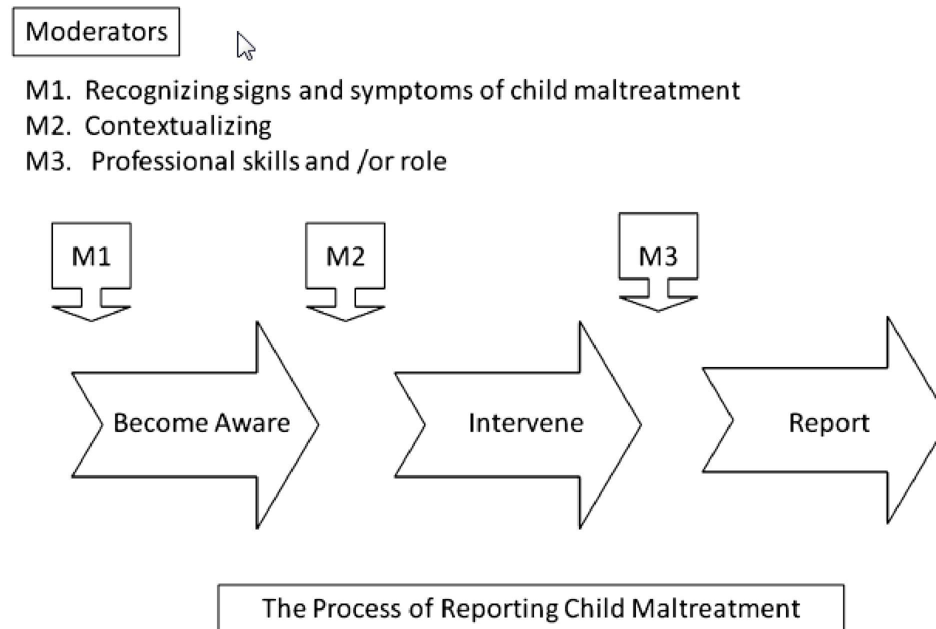


Figure 3 — Decision-making process of nurses in the study of Eisbach and Driessnack[68]

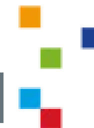


(Reproduced from Eisbach and Driessnack, 2010[68])

5.3.4.4 *Multistep process of identifying and reporting child abuse among physicians*

Warner and Hansen[67] describe in a review article the identification and reporting of child abuse as a four-step process, in which each stage in the process is related to responses in the preceding stages . Physicians go from assessment and evaluation of injuries to validation of the abuse, via diagnosis and reporting.

Stage 1 involves the assessment of the injury and the explanation for its cause. At this stage the physician must differentiate between abusive and accidental injuries. When the physician decides that the child might have been abused, stage 2 in the process has been reached. In stage 2 the possibility that the child was abused was identified. The identification of abuse or the physician’s judgement that a child may have been abused does not have to be definitive. Also, in countries which mandatory reporting, diagnostic precision is not required to report a case. A reasonable cause to



suspect that a child was abused is sufficient. In stage 3 the physician decides to report the possibility of abuse to child protection services. However, not all suspicions are reported. Therefore between identification and reporting, physicians take several considerations into account. These have been described in the preceding paragraphs. The decision-making between identification (stage 2) and reporting (stage 3) is not further detailed by Warner and Hansen[67]. Stage 4 involves follow-up of the report. At this stage the physician is no longer in control, CPS took over to investigate and validate the report.

5.3.5 Conclusion

Deterrents in reporting child abuse are both structural and cultural. In other words, they relate to the structural context in which professionals work (e.g. private practice versus hospital setting), but even so cultural variables such as professionals' attitudes and values (Feng and Levine, 2005, in Feng et al., 2010b[17]) play are role. Jankowski and Martin[23] conclude from the literature that "*the decision-making process of reporting maltreatment is a complex matter comprised of therapist, client, and situational factors. The complexity is also evident in the multiple layers of decision-making that occur when a decision to make a report of child maltreatment is considered."(p. 315).*

6 KEYS TO IMPROVE THE DETECTION AND REPORTING OF CHILD ABUSE

6.1 Solution strategies from the literature

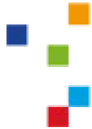
From the narrative literature review on the determinants of the decision-making in child abuse cases, we also paid attention to the solutions for underreporting. Additionally we searched the grey literature. Hence, we did not run a separate literature search on solutions or ways to improve dealing with child abuse and thuis do not claim to be exhaustive.The main solution elements to improve the reporting of child abuse mentioned in the sources resulting from the narrative literature search are:

- prevention and structural changes to limit risk factors (e.g. poverty),
- mandatory reporting,
- training to improve knowledge and skills,
- collaboration and involvement,
- counselling and feedback.

We will build this chapter mainly on these five entry points.

6.1.1 Prevention

The European report on preventing child maltreatment[1] provides a clear statement: child maltreatment can be prevented through a public health approach. Moreover, prevention is more cost-effective than dealing with the consequences. Traditional responses focusing on protecting children from harm fail to reduce child abuse. This insight brought policy makers, practitioners and activists to focus more on and invest more in prevention[1]. In addition, prevention is the only way to break the cycle of violence (transmission of violence between generations). Only by investing in prevention programs can the long term consequences of child abuse be countered.
Protection of children within a holistic context focusses on prevention and early detection of risks and subsequently the provision of specialist services for vulnerable children and their families[1].



Numerous interventions are now being implemented, and some are tested on effectiveness, although the evidence base on the effectiveness is still scarce[1].

In this chapter we explore in a rather concise way a range of types of interventions to prevent child maltreatment and if available the evidence base behind them. We refer to the European report on preventing child maltreatment[1] for further reading.

Two broad categories of prevention programs can be distinguished: first, universal interventions targeting whole populations through for example educational programs or media campaigns, second, selective interventions addressed to populations and individuals at increased risk.

Universal approaches

- School-based violence prevention programs

  These interventions aim to educate children about abuse, recognise harmful situations, teach them strategies for saying "no" and encouraging disclosure to trusted adults. Although some studies report a positive impact on children's knowledge, several also reported negative effects such as increased child anxiety and wariness of touch. An example from the Belgian and Dutch context are the so called "weerbaarheidsboekjes" (resilience booklets) of 'Kaatje Cactusbloem'. Although these booklets had an enormous success and have been translated in other languages, they are subject to critique (e.g. http://www.tegenwicht.org/07_rechten/kind_in_nood.htm): they might frighten children and create confusion: children are not expected to say 'no' in daily life, but in harmful situations they should. Children are made responsible for what happens, and they blame themselves for not being able to avoid adverse events. There are other, more effective ways to build resilience.

- Media-based public awareness programs

  Media campaigns are meant to build awareness among the general public using channels such as television, radio, printed materials and the internet. Findings on the effectiveness of mass media programs are mixed. They are frequently used and can be effective in raising awareness about the existence of child maltreatment (Wellings, K. and Macdowal, W., 2000; in Sethi, 2010[1]). Studies have also reported improvements in parenting practices and competences (Sanders et al., 2000; in Sethi, 2010[1]).

- Interventions to prevent abusive head trauma (Shaken baby syndrome)

  Educating new parents about the dangers of shaking their child and inform them about alternative strategies for dealing with persistent crying, was found to reduce the incidence of abusive head trauma injuries (Dias, et al., 2005; in Sethi, 2010[1]).

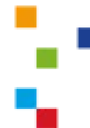
- Reducing the availability of alcohol

  Drinking alcohol is associated with increased child maltreatment. Reducing the availability of alcohol by for example increasing prices, the purchase age, or banning alcohol in public places resulted in violence-prevention benefits (e.g. Nemtsov, 1998, Rossow and Norstrom, 2012; in Sethi, 2010[1]).

Selective approaches

- Home-visiting programs

  "Home-visiting programmes provide parenting, health and social support to new mothers in their own homes, typically via specially trained nurses"[1] (p. 65). Home visiting programs, sometimes specifically targeted at vulnerable families, have been implemented in several European countries (e.g., UK, Denmark, Germany, the Netherlands). Often the program starts antenatally and continues for several years after birth. Mostly the focus is on promoting healthy behaviours, child development, coping with stress, parenting skills and parental self-sufficiency. Evaluations showed that they can be effective in reducing risk factors for child abuse, but their impacts specifically on child abuse are less clear.



Box 1 — VoorZorg, pilots in the Nederlands and Buddy near the crib, pilots in Belgium

The **VoorZorg program** is based on the Nurse-Family Partnership (NFP) in the United States[99] and specifically aims at preventing child maltreatment by addressing risk factors among high risk pregnant women. The VoorZorg programme consists of approximately 10 home visits during pregnancy and 20 per year during the first two years of life. The visits are conducted by trained VoorZorg nurses. The duration of a visit is between one hour and one and a half hour. The aims of the visits are "*structured behavioural changes, health education, discussing questions of the expectant mother, setting and maintaining realistic and achievable goals, increasing the mother's self-efficacy and involving the social network of the mother into the program*". The Voorzorg programme is effective on preventing child maltreatment, but also intimate partner violence and cigarette smoking in the presence of the baby. Since January 2015 the VoorZorg programme is available for high risk pregnancy mothers everywhere in the Netherlands[100].

The aims parallel the **Buddy near the crib** initiative in Belgium, which consists of perinatal coaching for underprivileged families by midwifery and social care students. Students take on the role of a buddy and assist an underprivileged family during a period of 18 months. They offer "*basic emotional support and assist the family in obtaining health and social care, empower the family's sense of self-sufficiency and strengthen the family's social network"*. The buddy visits the family every two weeks, in addition to a weekly phone call. Although the primary aim of the program is to improve health outcomes of mother and child, the prevention of child maltreatment could be a beneficial "side-effect". The support to vulnerable families during a crucial life transition, can reduce risk-factors or strengthen resources, hence prevent the use of violence[101].

- Parenting programs

  In contrast to home-visiting programs, parenting programs are often delivered through group sessions, both universally and to high-risk groups. These programs generally aim to improve parent's knowledge of child development, increase their parenting skills and strengthen parent-child relationships. Similar to the effectiveness of home-visiting programs, parenting programs have shown their effectiveness in reducing risk factors for child maltreatment, but evidence for the reduction of actual maltreatment remains limited[1]. Triple-P is one of the most well-known parenting programs, developed in Australia. One American study reported preventive effects on child maltreatment injuries, substantiated child maltreatment and out-of-home placements for nine counties providing Triple-P services, compared to counties with standard care (Prinz et al., 2009; in Sethi, 2010[1]).

- Multi-component preschool programmes

  Multi-component preschool programmes provide both preschool education for young children and family support, including parenting support. Some positive effects have been reported, such as lower lifetime rates of child maltreatment[1].

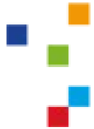
- Support and mutual aid groups for parents

  Support and mutual aid groups bring parents or parent-to be together to strengthen informal support networks and meet with peers in the community. They can provide peer support and strengthen parenting and coping skills. Examples of such groups before and after birth are respectively Centering Pregnancy and Centering Parenting. These examples are not organised in function of preventing child abuse or family violence, but rather to improve antenatal and postnatal follow-up and strengthen parents' self-reliance.

- Few studies have examined the impact of support groups in preventing child maltreatment. Some nevertheless reported benefits[1].

Universal prevention programs do not offer structural solutions or support, but aim at increasing knowledge, and changing attitudes and cultural norms and values.

The WHO emphasised in their 2010-report that early childhood child maltreatment programs clearly have the potential to produce benefits that



offset their costs. The programmes they listed, as well as meta-analyses, returned benefit-cost ratios greater than one, with benefits ranging from US$ 2 to US$ 17 for each US$ 1 invested. In addition, the cost-benefit ratio is likely to be higher for programs targeting higher risk groups. Still, most European countries invest in child protection services, rather than prevention.

In addition to prevention programs addressed to (large) groups of people, prevention can also be part of doctor-patient interactions and is as such physicians' responsibility. McCarthy[102] pointed out that "*Paediatricians could be empowered to identify risk factors and intervene earlier, before there is abuse that needs reporting*".

6.1.2 Mandatory reporting?

Mandatory reporting means that health professionals are required by law to report any reasonable suspicion of child abuse and/or neglect to governmental authorities. Mandatory reporting of child abuse and neglect has its origins in the USA, where it was enacted in the 1960s. It is now in place in all USA states, but also in for example Australia, Canada and Sweden[84].

Mainly in the American literature on identification and reporting of child abuse, the pros and cons of reporting laws are heavily debated. Even in countries where reporting is mandatory, health care professionals acknowledge that they do not report all cases of suspected child abuse to child protection services (Flaherty et al., 2008). Also in these countries health professionals account for only a small number of reports to CPS[84]. The Child Abuse Recognition and Evaluation Study (CARES), a large national US prospective study, found that 27% of primary health care providers did not report injuries to child protection services, despite suspecting that they were likely or very likely caused by child abuse[73].

Non-compliance of health care professionals is often explained by the overloaded and understaffed, hence dysfunctioning child protection services. Hence, physicians often believe that reporting will do the child more harm than good[84]. Finkelhor and Zellman[91] argue that increased training of professionals combined with mandatory reporting, does not bring down the high rate of non-compliance. Zellman's data[91] suggest that most noncompliance occurs among well-trained and committed professionals, "*whose failures to report are often good faith attempts to protect children in the context of overloaded child protective systems*" (p. 336). Only a small group (6%) of consistent non-reporters, mentioned personal consequences and costs, such as lost time and patients, as reasons for not reporting. Most of them worked in private practice settings and had little child abuse training.

Mandatory reporting leads to overwhelmed child protection services which investigate only a minority of all reports due to underfinancing and understaffing. Reporters are aware of this and therefore only report the cases for which they expect CPS to take action.

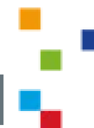
Ainsworth[103] criticizes mandatory reporting by arguing that it drains resources away from services to children and their families to forensic and investigative activities. "*Mandatory reporting systems are overburdened with notifications, many of which prove to be not substantiated, but which are time consuming and costly. As a result it is more than likely that mandatory reporting overwhelms services that are supposed to be targeted at the most at-risk children and families who then receive less attention than is required to prevent neglect or abuse*" [103].

For a more detailed critical evaluation of the US child protection system, we refer to Melton[104] who argues that "*the evidence is overwhelming that many of the catastrophic problems in contemporary child protection work in the United States are a direct product of the system's design. Analogous problems have appeared in other jurisdictions with mandated reporting*" (p. 10)[104].

6.1.3 Supportive tools

Frontline workers are in need of supportive tools in the child abuse detection and reporting process.[105]

In the Netherlands for instance, the national child abuse reporting guideline (meldcode voor huiselijk geweld en kindermishandeling) is effective as of July 1, 2013.[106] The guidelines comprise 'rules' regarding conduct and instructions for citizens and professionals when they suspect or identify a case of child abuse. The guidelines distinguish five steps; gathering and documenting signs of abuse, consulting a colleague, talking to the parents, judging the severity of the situation, and acting upon the suspicions of abuse (e.g., arranging help, filing a report). The mandatory use of the guideline for professionals does not imply that reporting regarding child abuse is mandatory. The guidelines primarily serves to 'guide' professionals in their



decision-making. Moreover, child abuse reporting guidelines could not only be helpful in providing direction, but they can also provide support, for example, reducing professionals' feelings of guilt in situations where the child is placed out of the home due to a report[105].

6.1.4 Training to improve knowledge and skills

A wrongful diagnosis of injuries can imply the lack of protection of children in need. On the other hand, an inaccurate diagnosis can falsely accuse parents or other relatives. Therefore, sufficient forensic expertise for primary care providers is primordial. Studies in other countries point out that only 5% of the general practitioners is able to correctly interpret the injury as caused by a trauma or abuse related. Knowledge of urgency specialists also deemed to be insufficient. A study in the Netherlands, where the participants needed to evaluate situations based on photographs and including surveys, shows that there is a lack of sound expert training for general practitioners[107].

More education and training is the most cited way to improve identification, management and reporting of child abuse by professionals of all kind. Both knowledge and skills need to be improved. The need for knowledge about child abuse, the legal system, reporting procedures and outcomes, as well as the need to train skills to determine the cause of the injuries and to talk to children and parents are mentioned in the literature[79, 92].

More training could improve reporting behaviour in many ways. For example the little amount of time spent in medical school studying child abuse and neglect could install the notion that child abuse is of marginal importance. In another way training in the misapprehension of effects of reporting suspected abuse on children and their family, could eliminate misbeliefs mentioned by professionals to legitimate their decision not to report.

In addition to training for reporters, also expert qualifications of all child protection staff are essential to improve reporting by professionals. Vulliamy and Sullivan[80] argued that the lack of confidence among physicians might originate in hierarchical differences between reporters and CPS collaborators. Physicians might not be motivated to collaborate with CPS social workers to avoid social workers', who commonly have less status, domination. Reduction of the traditional hierarchy separating physicians and social workers could therefore improve reporting behaviour[80].

Also more professional education for social workers could eliminate social workers' misapprehension of the limits on confidentiality. It must be clear that reporting back to an allied professional concerned with the outcome of a report of suspected child abuse is not a violation of client confidentiality when that professional may be in a position to provide continuing treatment and monitor the progress of a child at risk[80].

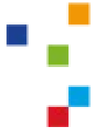
However, some studies also question the impact of training and point out that problems with reporting child abuse will not be solved simply by education and training. For example, Beck and Ogloff[76] found that knowledge of the reporting law did not influence the reporting behaviour of psychologists. However, degree of certainty that abuse was occurring accounted for a substantial amount of the variance in reporting intention. Hence, knowledge supporting the identification competences seemed nevertheless important, be it indirectly. Also Finkelhor and Zellman[91] question the use of education to solve the problem of noncompliance with reporting laws.

6.1.5 Collaboration, communication and involvement

Improve collaboration and communication between health care professionals and child protection services

A large part of the literature on child abuse reporting by physicians addresses the dysfunctional interaction between physicians and child protection services (e.g. Compaan et al., 1997, in Vulliamy and Sullivan, 2000[80]). Health care providers and child protection services should interact more and collaborate well[102]. Information should be shared between health care professionals and social workers in child protection services. One of the reasons physicians quote for non-reporting is the lack of feedback from child protection services. Social service agencies could ensure that physicians are informed about the progress of their report through the various agencies and the status of the child and the family[67]. If CPS is to gain trust from reporters and encourage reporting, they must provide follow-up information to the reporters. CPS social workers need to become involved in the practice of reciprocal exchange by providing feedback to those who report suspected child abuse[80].

One model encouraging collaboration is **discretionary reporting** (developed by Finkelhor and Zellman, 1991[91]): "*qualified professionals*



would be allowed to defer reporting a suspected case of maltreatment if they believed that they needed more time to work with the family and or gather more evidence of abuse. The policy would allow reporters to provide a first-order level of screening, reduce the CPS caseload, and would make reporters rather than CPS responsible for working directly with families to prevent further episodes of maltreatment"[83].

Encourage multidisciplinary collaboration

McCarthy[102] proposed to establish "*multidisciplinary centers of excellence to which cases of abuse could be referred; not only would these centers give those children more complete and better assessments, but they would be places where students and doctors could learn. Such centers, by offering educational opportunities and role models, might also encourage more paediatricians to pursue the certificate in special qualification in Child Abuse Pediatrics, which is another step toward keeping all children safe*".

Multidisciplinary collaboration[17] could also reduce anxiety, the burden of caring, the risk of becoming a target of angry family members, and improve quality of care and communication.

However, multidisciplinary collaboration is not self-evident. Although health care, social service and education disciplines each play important roles in the process of child protection, each discipline has different knowledge and competences in child abuse, which makes them respond differently to child abuse. For example, health care providers may emphasize physical symptoms and laboratory results, while school teachers may stress behavioural indicators[17]. In addition, McDaniel (2006) showed that professionals consider different risk factors: "*Health care professionals were likely to report families with more parenting stress, while police officers and social workers were likely to report families with domestic violence, homelessness and caregiver learning disabilities. Teachers were likely to report families with mental illness and parents who applies harsh disciplines.*"[75]. Also multidisciplinary collaboration could induce confusion about responsibilities, role expectations and team leadership. Power inequality is often at the core of the failure of collaboration. Feng et al. [17] concluded that "*Despite the growing awareness of the ability of interdisciplinary collaboration to detect, report, and treat child abuse, the dynamic nature and interaction among disciplines has not been examined and is poorly understood.*" Doyle (2008, in Feng et al., 2010[17]) reviewed the barriers and facilitators of multidisciplinary team work and noted that co-location, team meetings and communication systems, were necessary but not sufficient for effectiveness.

In conclusion, the process of multidisciplinary collaboration brings potential benefits as well as tensions, conflicts, and dilemmas across disciplines. Barriers to effective collaboration include issues of confidentiality, accountability, communication problems, and power struggles (Flaherty et al., 2006, Goad, 2008, in Feng et al., 2010[17]).

Multidisciplinary training

Multidisciplinary training could be one way of resolving the difficulties of and barriers to effective collaboration. It provides professionals the opportunity to exchange ideas, understand efforts of teammates, begin collaboration, establish trust, and develop shared languages[80](Horwath and Morrison, 2007, in Feng et al. 2010[17]. An example is the EPIC-SCAN Program (Educating Physicians in Their Communities on Suspected Child Abuse and Neglect)[102].

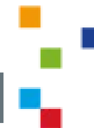
Case management models and a single-entry point services

Case management models and a single-entry point service could help to simplify the process and procedures and better coordinate professionals from different disciplines. In addition, the designation of an institution or a team rather than an individual as reporter would reduce the risk of retribution for reporting child abuse and may improve reporting compliance[17].

6.1.6 Counselling and feedback

In the literature we found several suggestions regarding counselling and feedback:

- Flaherty et al.[79] proposed a clearinghouse that functions like the poison control hotline. If health care professionals have a question, they could call and discuss their concerns or findings immediately with a child abuse expert. The same proposition was done by Warner and Hansen[67]. In addition, Flaherty et al.[79] thought of an office-detailing format similar to that used by pharmaceutical representatives[79].
- Vulliamy and Sullivan (2000) suggested that CPS social workers could be consulted by physicians for consultation on difficult child abuse cases[80]. Consultation with a CPS staff member regarding a



"hypothetical" situation to determine if a report is necessary may also be helpful[92].

- Renninger et al.[92] emphasised that given the complexity of most situations, practitioners should consult with colleagues.

Key points

The international literature presents the following solution elements to improve the detection and reporting of child abuse and protect children more effectively:

- **Prevention en structural changes**
- **Mandatory reporting**
- **Supportive tools**
- **Training to improve knowledge and skills**
- **Collaboration, communication and involvement**
- **Counseling and feedback**

7 QUALITATIVE PART

The qualitative research permits to confront results stemming from literature with the perception of Belgian respondents and allows to transpose the information into the Belgian context.

7.1 Research design and technique

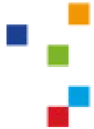
Qualitative research was performed with a descriptive phenomenological methodology from the perspective of the health care providers, social and legal workers. We chose to conduct individual interviews instead of focus groups. The use of focus groups would be very interesting (especially the collaboration/articulation with different organizations) but would have been challenging to organize as the professionals we wanted to deal with often have a very tight agenda. The research design detailed below was submitted to the Ethics Committee of the Antwerp University and was validated by this Committee.

7.1.1 Interviews

The interviews were semi-structured with a topic list, but in a non-directive way. An interview is considered to be semi-structured if it is flexible as the interviewer does not follow a formalized list of questions. Instead, he has a list of general topics; called an interview guide.

The interviews were

- conducted as face-to-face conversations;
- conducted in French or in Dutch, depending on the language used by the organizations or individuals contacted;
- taking place at the respondents' office or in another quiet environment chosen by the respondent;
- lasting for one hour to one hour and a half;
- recorded with the respondents' written consent.



7.1.2 Interview guide

7.1.2.1 The structure

The interview guide analysed the whole process of child abuse and subsequently addressed solutions adapted to Belgium. It was structured by themes:

- Prevention
- Attitude-detection/reporting/management/follow-up of cases of child abuse: vision of the problem and its consequences;
- Organisational aspect- detection/reporting/management/follow-up of child abuse;
- Barriers with the detection/reporting/management/follow-up of child abuse;
- Possibilities to improve the detection/reporting/management/follow-up procedure

Each theme was introduced through an open question. At the beginning/end of the interview, a number of questions were asked in order to define some basic socio-demographic data concerning the respondent and to summarize his profile.

The interview guide started as a framework and was adjusted according to the exchanges with the respondents and the researchers.

7.1.2.2 The script

We presented only the main topics, the sub-questions are in the Dutch and French version.

The interviewer introduces himself and explains the research project and its purposes to the respondent. He stresses the importance of the respondent's opinion and his experience but also the view that the respondent has on his colleagues and institutions involved. He also discusses the practical arrangements (audio-recording, anonymity, validation by Ethics Committee, access to research results, possibility to withdraw from the research) and requests the signature of an informed consent form.

1. ICE BREAKER
Q1. In your daily practice you have probably been confronted with a suspicion of child abuse. Could you remember this case and tell me more about it? What did you do? What happened?
2. ATTITUDE
First of all we would like to talk about the role of GPs in the whole process of child abuse. **Q2. What is your role in detection, reporting, follow up of child abuse?** **Q3. What is your vision about the role of other organisations:VK/SOS enfants, justice and preventive services (CLB, B)? What do you expect from them?** Secondly, we would like to ask you something about your vision on consequences. **Q4. What consequences do you see in general regarding reporting child abuse/child maltreatment?** **Q5. What consequences do you see in general when you do not report? (first in general, afterwards zoom into the other topics)**
3. SELF EFFICACY
Q6. How self-confident do you feel to handle these problems? Physicians in general? Can you explain this further?
4. SOCIAL NORMS
Child abuse is a sensitive topic in society. **Q7. What influence does the opinion of society have on your attitude? (of physicians in general)**
5. ORGANISATIONAL ASPECTS
Q8. What is your opinion about the organisation of detecting, reporting, follow up of child abuse? **Q9. What factors have an influence on this process?**

6. BARRIERS

We already talked about (a lot of) difficulties concerning detecting, reporting and the follow up of child abuse.

Q10. Are there other difficulties or barriers you want to add? Which one(s)?

7. FOLLOW UP AND COLLABORATION

This topic is optional if respondents didn't talk enough on it before.

Please go back to your remembrance of your experience with child abuse

Q11. What is your opinion about the follow-up and collaboration?

8. POSSIBLE IMPROVEMENTS/SOLUTIONS

We are very interested in possible solutions coming from the workplace. This is an important issue in the interview. Concluding that there are only a few reports from GPs and knowing they are confronted with a lot of obstacles:

Q12. What are, in your opinion, possible solutions to detect child abuse earlier/ in an earlier stage, to report, to follow up, to manage and to collaborate?

Are there issues we didn't discuss until now?

7.1.2.3 *Various specificities*

We took into account Belgian cultural specificities. Consequently, the ice breaker for the French-speaking part was modified:

When one talks about child abuse, in your daily practice, in general, what would you have to tell me? And concerning the report to SOS-Enfants and legal authorities, do you consider that the current practice is appropriate?

This script was adapted for the specialized and legal services which only deal with the management and the follow-up of these situations. The adaptation is stated below:

ICE BREAKER

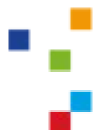
In your daily work, what is your involvement concerning child abuse? Could you tell me more about this? What do you do? What happens?

ATTITUDE

- How is your vision on your role as VK in the process of management of child abuse?
- How is your vision on the role of the GP, paediatricians and other physicians in detecting and reporting child abuse?
- What do you expect from GP, paediatricians and other physicians after reporting? What's your experience in case of collaboration?

SELF-EFFICACY

How self-confident do you think GP, paediatricians and other physicians are to handle these problems? What's your experience in practice?



7.1.3 Pretesting

The interview guide was pretested. The external team conducted one interview in both languages with professionals who have nearly similar profiles as those targeted in this project (1 GP in a solo practice and 1 GP in a capitation system). The interview guide has been adapted according to the analysis drawn from the pilot interviews. The results of these interviews have been integrated in the data analysis.

7.1.4 Realisation of the interview

The interviews will be realised by members of the external teams (2 French speaking and 2 Dutch speaking). A supervision, which includes role-play simulations, was organised before the pretesting.

7.2 Sampling and recruitment of the respondents

7.2.1 Sampling

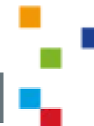
We used a purposeful sampling strategy with critical cases for each of the organizations to include. With critical cases, we mean respondents who adhere to following criteria:

- experience in this field;
- representative of their respective organization;
- work in an urban or semi-urban area;
- not always belong to a Child Abuse (CA) Commission

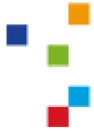
The sample was elaborated with in mind the chronology of the detection and the seriousness of a child abuse case. It concerns the sectors of prevention, involved in the detection (school, general practitioners…) as well as intervention sectors (no matter if a judicial management would follow or not). The number of scheduled interviews is 29 (14 in French and 15 in Dutch) and their distribution is detailed below (Table 9). This sample allowed the collection of rich data.

Table 9 — Overview of respondents

	INSTITUTION	NUMBER	OTHER PROPERTIES
PREVENTION, SERVICES		**6**	
	Promotion de la santé à l’école (PSE)	1	Réseau libre
	Centrum voor Leelingenbegeleiding (CLB)	1	Vrij CLB
	Centres psycho-médico-sociaux (CPMS)	1	Réseau official
	Centrum voor leerlingenbegeleiding (CLB)	1	CLB GO
	Office de la Naissance et de l’Enfance (ONE)	1	
	Kind en Gezin	1	



	INSTITUTION	NUMBER	OTHER PROPERTIES
HEALTH CARE		**9**	
General Practitioner	Société Scientifique de Médecine Générale (SSMG) Domus Medica	1 2	2 private practice 1 GP Orde van Geneesheren
Paediatricians	Vlaamse Vereniging voor kinderartsen Belgische vereniging voor kindergeneeskunde	1 1	
Emergency doctors	Belgian college of emergency physicians	1	
Nurses	Association Francophone des Infirmier(e)s d'Urgence (AFIU)	1	
Mental Health Service	Ligue de Service de Santé Mentale Centra voor Geestelijke Gezondheidzorg (CGG)	1 1	
Specialized services		**9**	
	SOS-Enfants Cellule Maltraitance (Paediatrician) Vertrouwenscentrum Kindermishandeling (VK)	2 1 3	2 based in a hospital (Fr) 3 based outside a hospital environment 1 based in a school
	Direction Générale de l'Aide à la Jeunesse (SAJ) Ondersteuningscentrum Jeugdzorg (OCJ)	2 1	
JUSTICE/POLICE		**5**	
Policeman	Commission Permanente de la Police Locale Jeugdbrigade	1 1	
Services for Judiciary Protection	Service de Protection Judiciaire	1	
Magistrates	Tribunal de la Jeunesse de Bruxelles Familierechtbank	1 1	



7.2.2 Recruitment strategy

The recruitment strategy consists of two phases

- Contact with the institution involved

The research teams have contacted the selected organizations by phone to explain the objectives of the research and to ask them to nominate the representative(s) the most suitable to be interviewed. The contacted person of the organization has received in addition an email for further information. Moreover, the institutions have also been asked to explain in a short motivation text the reasons for their choice.

- Contact with the respondent selected

The respondent designated by his/her organization was informed by e-mail. Arrangements were made by telephone in order to fix an appointment for the interview which took place at the respondent's workplace or in another quiet environment. The time required will be at least one hour to one hour and a half.

7.2.3 Recruitment

The recruitment was conducted during the month of March. The organizations accepted to collaborate and mostly proposed two respondents. They also informed the potential participants of the project. The research teams contacted the selected respondents in order to fix appointments during the months April and May.

7.3 Ethical approval

The Ethical Committee of the University hospital of Antwerp (UZA) gave a positive advice on the 16th of March 2015.

7.4 Data analysis

All interviews were audiotaped and transcribed verbatim. A thematic analysis was performed starting with an open coding procedure. In the process of coding, text fragments were identified and labelled. In a second step these open codes were grouped into concepts (themes). These themes imply some degree of repetition. An issue that just raised once is not kept as a theme, but still played part in the analysis. We looked at patterns of themes over the whole dataset, to highlight what respondents had in common as well as how they differed.

In the first stage of descriptive coding both research teams independently read through respectively three Dutch and French interviews. They highlighted relevant material and attached memos. They defined descriptive codes and refined the codes after a collaborated team meeting. Most codes were common although some were specific for each research team because of the specific context in the two parts of the country. In a second stage these descriptive codes were clustered into interpretative codes. The clustering was done by the whole research team and in function of the research questions. Each research team applied the interpretative codes to full data set. Additional codes emerging from those interviews were agreed upon in consensus. From these dataset the team derived the overall themes and constructed a diagram to represent relationships between levels of coding.

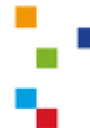
Because of the heterogeneity of the sample, it was important to look at the themes both within cases and between cases.

From the different chapters and parts of the chapters written by both teams, KCE made an integrated version which also served as cross validation.

7.5 Findings

Below we present the difficulties professionals encounter in assessing (potentially abusive) situations, the decision to take action and barriers towards interprofessional collaboration. These difficulties and barriers are not experienced by all professionals in the same way. This variation is illustrated in the presentation of a five-stagetypology of professionals' involvement when confronted with the suspicion of child abuse (7.5.6). Subsequentlywe address macro-level challenges indirectly impacting professionals' assessment and decision-making.

Generally, it appears that the barriers professionals encounter in decision-making when confronted with the suspicion of child abuse are similar to those described in the the international literature. However, we did encounter some specificities resulting from the organisation of , the complex Belgian state structure and the presence of several national languages. The prevention and detection of domestic violence as well as care for the victims is the competence of the Communities, i.e. Flanders, the French Community



and the German speaking Community (See 3.1). Some problems stem from a different organisation of the services in both parts of the country. These are described in 7.5.7 Regional specifities in dealing with child abuse.

Finally, we conclude the chapter by moving towards a system approach in order to uncover underlying dynamics and leverage points. The identified leverage points can serve a positive transformation of the system and are the guiding principles for our recommendations (see synthesis).

Quotes are included to illustrate and support the conclusions. The quotes are written in italic. Between brackets the profession of the respondent is mentioned in order for the reader to be able to situate the quote. The quotes are presented in the language of the respondent to stay as close as possible to the original.

This chapter reflects the beliefs and worries of the interviewees. Occasionally it contains misbeliefs or false preconceptions stemming from a lack of knowledge about the field. For example some respondents suggested to create a booklet to guide health care professionals through the system, while this already exists. Nevertheless we have chosen to include the misbeliefs in the text to stay as close as possible to the experiences of the respondents.

7.5.1 Aversion to see

Some professionals are persuaded that abusive situations are irrelevant for their clientele.

Il y a un truc en maltraitance qui s'appelle l'aversion de voir. Ça c'est dans n'importe quel colloque consacré à la maltraitance. Et il y a toujours bien quelqu'un qui va nous parler de ça. Et alors c'est vrai que c'est en gros: « c'est tout plutôt que ce diagnostic-là ». (Specialized service, Paediatrician)

The reasons are multiple, for instance the therapeutic alliance or sympathy for the parents. One of its consequences is that especially health professionals search for causes of problems or complaints only at the child's level. The aversion to see sometimes results in completely odd diagnoses.

On va s'accrocher à « c'est l'enfant qui ne va pas bien, c'est un problème psychique chez l'enfant à lui tout seul ». C'est tellement difficile même à penser déjà, pour soi-même, quoi. C'est tellement de l'ordre de l'impensable qu'on met de côté, qu'on nie soi-même. (GP)

Also a range of misconceptions concerning child abuse combines with the aversion to see, for example preconceptions about disadvantaged social classes. Therefore, some professionals will only pay attention to disadvantaged social groups.

Pas que je suis persuadée qu'on ne maltraite pas forcément plus dans le monde ouvrier que dans les beaux quartiers d'Uccle. Uccle, c'est le quartier huppé de Bruxelles. Après c'est peut-être plus caché chez les uns que chez les autres. Ce qui est d'autant plus difficile pour nous. Malgré tout oui, c'est vrai que je vais le dire platement, il y a un délit de sale gueule quelque part quoi et ça c'est dommage. Il y a des parents qui présentent bien, qui savent parler et qui vont être suffisamment manipulateurs peut-être qu'on va passer à côté ; tandis que ceux qui arrivent brut de coffre, en rudoyant l'enfant et en lui criant dessus, on va tout de suite dire: « on va voir, s'il n'est pas maltraité ». Cela peut être aussi bien les uns que les autres. (Emergency, Nurse)

Others focus on another aspect of the family context, for example partner violence and are blind for child abuse.

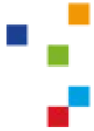
Op het moment van de melding was het vijfde kind al 12 jaar. Dat wil toch zeggen dat wij vrij lang met de praktijk dingen hebben getolereerd. Wij hadden het toen vooral moeilijk met de manier waarop die man zijn vrouw behandelde. Daar lag de focus wat meer op: we gingen die vrouw vooral versterken. Maar uiteindelijk bleek ook dat die kinderen in de klappen deelden en dat hebben we dan eigenlijk niet gezien. (GP)

7.5.2 Barriers in assessing the situation

If professionals are open to the suspicion of child abuse, they encounter several barriers in assessing the situation.

7.5.2.1 *The relationship with the professional and with the family/the minor*

Being in a long term trusting relationship with the family and/or the minor facilitates and hampers detection at the same time. Preventive services emphasized the importance of a long term trusting relationship to notice irregularities or problems within a family. According to the interviewed general practitioners however, a trusting relationship has limits too:



- The general practitioners acknowledge that a (too) close relationship with patients can bring about aversion to see child abuse.
- It is difficult for general practitioners to arrange a consultation with the child alone or send parents away. Even the question itself raises suspicion from the parents, hence hurts the trusting relationship with the parents. The general practitioners thus runs the risk of losing the family, as they might consider seeing another physician next time. Other settings such as schools or hospitals are more suited for private conversations with children, as parents are more distanced.

Demander pour faire sortir les parents, c'est pas toujours bien vu. Ils commencent à se dire: « mais qu'est-ce qu'elle me veut celle-là ? ». Donc voir l'enfant seul en consultation en médecine général, c'est quasi impossible. Que peut-être à l'école, ils n'ont pas les parents, ils ont le PMS, ils ont encore plus facile pour parler. Tout comme tout quand ils sont à l'hôpital, ils ont des moments où ils n'ont pas les parents sur le dos. (GP)

7.5.2.2 *Constraints in time and resources*

Most health care providers feel stressed because of a lack of time and resources. Initiatives to free up time and education may improve alertness and interest in child maltreatment.

Spontaan zou je kunnen zeggen: vorming, maar ik weet niet of dat daar iets aan gebonden is, want je kan veel vormingen doen, maar dan moet je daar nog wel iets mee doen, ik denk een nieuw obstakel is: voortdurend aandacht blijven hebben daarvoor en als huisartsen de tijd daar niet voor hebben, gaan ze dat niet doen. Dan gaan ze wegtrekken, denk ik. Dus ik denk, alles wat de huisartsgeneeskunde ondersteunt om niet te veel patiënten achtereen te moeten zien, gaat daarin helpen, denk ik. (GP)

Saving costs at the hospital level may impact indirectly on prevention and early detection of child abuse. Shorter hospital stay after delivery may have major consequences for mothers who have little support once they are home.

Respondent: A la maternité même, en plus maintenant les sorties sont de plus en plus précoces, ça c'est encore pire, je pense.

Interviewer: Ce serait un facteur aggravant ?

Respondent: Au niveau de la maltraitance potentielle, oui. (Specialized services, SOS-Enfants)

7.5.2.3 *Difficulties in sharing concerns with parents*

Health care providers and specialized services pointed out that inviting parents to share worries is a good first approach. However, it is experienced as extremely difficult. The difficulty relates to:

- Fear of damaging the (patient) relationship with the child's parents and family

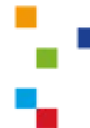
Ik heb het gevoel dat we momenteel, dat er eigenlijk van ons te veel wordt verlangd. Dat het té specifiek is en dat we er te weinig in ondersteund worden. Het aankaarten met ouders. Die kinderen blijven wel in hun scholen zitten en die vertrouwensband met dat kind en die ouders en die school is heel belangrijk. En als je vanuit onze dienst dat gaat bespreken dan ben je dat eigenlijk kwijt. Eigenlijk vind ik dat dat stuk bespreken met de ouders beter bij die externe dienst zou zitten, beter bij de VK. (Prevention and health promotion, CLB)

- Fear of losing the family
- Risk for wrongly accusing people

Je pense que l'on pourrait être mal à l'aise peut-être parce qu'on l'exprime pas correctement, d'accuser injustement des gens. Voilà, on n'a pas envie d'avoir le mauvais rôle, donc je ne suis pas très courageuse, on va dire. (Emergency, Nurse)

Yet, several respondents also stated that authentic and non-judging open communication can help.

On a déjà eu des médecins généralistes qui clairement se sont mouillés parce que leur position était de dire: «bon face à votre situation familiale pour moi celui qui et le plus en danger aujourd'hui c'est votre enfant et donc je dois protéger votre enfant ». Ce qui ne veut pas dire que... Alors que peut-être eux-mêmes ils connaissent les parents depuis qu'eux-mêmes sont petits: « Aujourd'hui l'adulte, c'est toi et moi aujourd'hui je suis inquiet pour ton bébé. Comme j'ai pu m'inquiéter pour toi avant, aujourd'hui je m'inquiète pour lui ». Alors de nouveau c'est un peu théorique. Mais dans les faits, ça



marche. Enfin ça marche, c'est pas une recette miracle. (Specialized services, Paediatrician)

In that scope, professionals feel the need for training in communication skills.

Ik denk dat er heel veel vanaf hangt van: hoe het gezegd wordt, wat er gezegd wordt en op welke manier en met welke bedoeling? Als mensen de boodschap krijgen een stuk van: ik ga ervan uit dat jij ook wel het beste wil voor jouw kind, ik zie dat het nu niet lukt en ik wil samen met u gaan kijken wat goed gaat en wat niet goed gaat. Dat je een opening krijgt en dat je gerust moogt zeggen van: kijk, ik kan me best voorstellen, allee, je bent nu kwaad, ik zou dat ook misschien zijn, maar ik wil dat samen met u bekijken. Laat ons die weg ten minste gaan. Dat je meer bereikt dan dat je zwijgt. Maar ik dat daar heel wat vorming en ondersteuning en opleiding belangrijk is. (Prevention and health promotion, K&G)

Even after losing contact with the family, healthcare professionals notice a real effect of having addressed the issue. Also the representatives of specialized services pointed out that reporting is considered an expression of concern for the safety of the child and not a denunciation of the parents.

Wij van onze kant uit gaan dan zeggen van ja, maar howla, ja maar nee, wij gaan niet zomaar aan de slag gaan. Wij verwachten wel degelijk dat u toch nog mensen aanspreekt, opbelt, uw best doet om die uit te nodigen om te laten horen dat u naar ons gebeld hebt, dat wij hen gaan uitnodigen. (Specialized services, VK)

7.5.3 Difficulties in the decision to take action

According to the respondents, taking action in general and reporting in particular is stressful for the professionals. They hope that others will have the same suspicion and will act. The fears and concerns that professionals face may impede contacting the appropriate services.

Mais il y a quand même plein d'intervenants qui ont été tous inquiets. Et finalement, voilà tout le monde est resté avec ses inquiétudes et tout le monde s'est dit que l'autre allait probablement signaler. Je pense que les gens ont peur de signaler. (Specialized services, Paediatrician)

Underlying motives to refrain from reporting are:

- **Fear of breaking or changing the therapeutic relationship with the family**

A recurring barrier quoted in the interviews is the professionals' wariness to lose the relationship established with the child's family if they decide to report the situation. Reporting will inevitably bring changes to the relationship with the family, working with the family will be more difficult or at least different.

Als er nu overduidelijk KM is, dan moet het, dan denk ik dat iedere arts wel zijn verantwoordelijkheid opneemt, maar de gevolgen zijn zeer groot, uw vertrouwensrelatie met het gezin is helemaal weg. Daar kunnen ook bedreigingen naar de arts zelf ook geuit worden, dus het vraagt wel, allee, het is traumatisch voor iedereen, een melding. (GP)

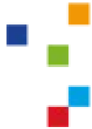
Since the therapeutic relationship is at stake, taking care of the suspected perpetrator (by prescribing drugs for instance) is an alternative way for especially general practitioners to support the family. In the same way school workers may also hesitate to report as they are afraid of losing pupils. Emergency workers do not express this kind of fear when reporting as they benefit from a greater distance to the family.

- **Fear of being the informer**

Professionals hesitate to interfere with families' private business and to assume the role of the 'informer' or 'betrayer', hence to be perceived as the 'bad one'.

Les soignants deviennent les mauvais, ils risquent fort d'être les dénonciateurs bien qu'ils ont travaillé d'une manière constructive jusque là. (Jugde)

Vaak hebben hulpverleners schrik van 'ik ga dat gezin kwijt zijn'. We weten dat het risico om het gezin kwijt te raken is veel groter als het gezin achteraf van ons gaat horen: die hulpverlener waarvan u dacht dat u daarmee een vertrouwensrelatie had, heeft hier een melding gedaan zonder dat met u besproken te hebben - dat dat tot een breuk komt, die kans is veel groter dan wanneer een hulpverlener hen in alle openheid zegt van: 'dat dat niet prettig is voor u, wat ik u hier zeg, maar ik moet mijn verantwoordelijkheid opnemen. (Specialized services, VK)



- **Fear of being blamed by authorities and the media**

Professionals are afraid of being blamed by authorities or the media for not reporting fast enough.

Je crois que chez le professionnel, on sent la leur d'être remis en cause, d'être interpellé par la justice, pointé du doigt, montré comme défaillant. Ça je trouve, quelque que chose qui est compliqué, c'est la question d'évaluation: donc effectivement est-ce que j'ai signalé assez vite ou pas assez vite ? (GP)

- **Fear of worsening the situation for the family**

When the danger is obvious, the respondents are less reluctant to report. However, usually the decision is very complex and the consequences of reporting are not straightforward. Reporting is perceived as having a dramatic impact anyway. Professionals observe feelings of shame and anger, an increase of violence or the breakdown of the family. Everybody seems to be punished: the parents (a judicial intervention is perceived by them as brutal) and the child (sent away to a foster facility or feeling extremely guilty).

Ja, ik denk dat wel, he. ik denk dat dat het voor een stuk moeilijk maakt he. Je ziet ouders soms heel hard hun best doen en dat het dan maanden goed gaat, en als het dan ineens een grens overgaat waardoor het ineens slecht gaat en dat je moet ingrijpen, ja dan, je weet ook welk effect dat dat gaat hebben op die mensen ook. Vaak spreken ze die vrees ook uit: dat dat maar nooit gebeurt! Dat ze maar nooit mijn kinderen afnemen! En dan weet je ook dat de gevolgen zullen zijn, de psychische gevolgen voor de ouders, als er dan een beslissing wordt genomen waar ze niet mee akkoord zijn, dan weet je ook, hoe je nadien, dat er een heleboel andere problemen, dat daar meer problemen, er is één stukje opgelost, maar... (GP)

The collaboration with the perpetrator is in jeopardy: he(she) can refuse all help proposed later..

Mais en général l'abuseur qui sait quand même bon, être confronté à la loi pour lui, toute sa vie c'est une lutte contre ça. Donc c'est souvent très, très compliqué. Alors soit il se referme tout à fait ou c'est pire, enfin voilà… C'est compliqué. (GP)

7.5.3.1 *Limitations of voluntary participation*

Managing abuse cases is easier when a family's internal resources can be mobilized in a broader sense. This allows for monitoring the situation and facilitates the introduction of external help. For example, GPs often intervene by addressing general health issues.

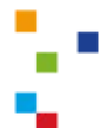
J'ai des retours et de fil en aiguille je sais que les choses évoluent et parce que je soigne la grand-mère, que je sais que la grand-mère a les enfants. Donc voilà, quand je dis que c'est vraiment de la médecine familiale mais c'est qu'on peut faire intervenir, quand on soigne plusieurs personnes de la même famille, on peut plus facilement peut-être faire intervenir des personnes qu'on connaît, qui sont bien et qui sont de confiance pour aider justement. (GP)

Although care providers and services acknowledge the limits of the voluntary character of a families' participation. One of the most important threats/obstacles of this first-line help is that it is based on participation and that parents can choose to walk away any time they want. Therefore, respondents note they have little control and tend to develop a series of strategies to handle these situations, for instance redirecting cases to other networks. To allow a better continuation of first line care, care providers suggest facilitating more regular contacts, for instance by lowering the fees and invoicing third-party payers or, using various indirect methods, proposing relational solutions that allow better contacts.

7.5.3.2 *The difficulty of risk assessment and case-management*

Health care professionals find risk assessment difficult to decide where non-mandatory care stops. This often entails a balance between trusting and supporting the parents and protecting the minor. This process is characterised by a high level of uncertainty which makes the first line responders genuinely uncomfortable.

Ja en ook, dan denk ik, jongere kinderen zijn gewoon veel kwetsbaarder en veel afhankelijker en daar ga je dan rapper het gevoel hebben dat je iets moet voor, dat er iets ja.. Als wij het niet kunnen of het kind kan niet voor zich spreken, dat je meer in actie misschien moet schieten. Maar is dat 16-jarigen of 17-jarigen vind ik wel iets moeilijker. Omdat je soms ook heel hard naar hun een signaal wilt geven van dit is niet oke, maar dat je hierin ook



wel echt voelt: die zijn ook voor een stuk hun eigen leven aan het opbouwen waar dat ze ook al wel heel veel vaardigheden wel voor hebben en waar je op wilt inzetten en waar ze ook soms aan hun context niet meer zoveel aan kunnen veranderen. En doe je daar dan altijd goed aan om te melden? (Health care providers, CGG)

Evaluating the situation from the perspective of the actual danger to the child is the main criterion even if protective measures can also be driven by the fear to “loose” the victim or family, as already mentioned in previous stages

C’est dans l’intérêt de l’enfant donc, moi je trouve que ce sont des gros moyens mais c’est que si on les laisse partir dans la nature et qu’on ne sait pas ce qui se passe là, on n’a jamais aucune certitude qu’ils vont aller ailleurs. Ça c’est le problème, les parents disent alors on va aller ailleurs, on va plus près de nous etc… Mais quand ils sont dans cette optique-là, avec des parfois des raisons d’éloignement géographique ou pour un autre problème etc… alors on organise le transfert. On ne le laisse pas partir dans la nature. (Emergency, Nurse)

Respondents find it difficult to manage the case: evaluating the abuse (especially psychological abuse which is sometimes impossible to witness directly) and finding the adequate solution to each case are equally tricky.

Au cas par cas. Et si on a l’impression que c’est plus travaillable, que l’enfant présente beaucoup de symptômes qui nous font penser qu’il est en souffrance dans le quotidien etc. On va passer la main, avec des suggestions. Parfois du côté d’un éloignement ou… pour apaiser un peu tout le monde. (Health care providers, SSM)

7.5.3.3 *Professionals try to balance assistance to people in danger and professional secrecy*

Professionals try to balance assistance to people in danger and professional secrecy. The Belgian non-judiciary approach leaves to professionals the choice to report or not.

C'est vraiment une clinique du risque dans laquelle en permanence on doit se positionner. Ce n'est pas facile car dans le modèle belge, il est laissé à notre libre appréciation le degré de danger, de risque, la nécessité ou pas de signaler. (Specialized services, SOS-Enfants)

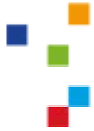
De moeilijkste taak die er is. Ik zeg het, iedereen zegt altijd, de jeugdrechter is een moeilijke taak. Maar ik denk de mensen die dagdagelijks op het terrein werken, dat die de moeilijkste taak hebben omdat ze constant die afweging moeten doen van: we moeten de jongere beschermen, we moeten met die ouders nog kunnen samenwerken, we moeten ons houden aan de wettelijke regels, we moeten... Zij hebben zoveel dingen waarmee ze rekening moeten houden, zodat ze constant op een slap koord aan het lopen zijn van: Wat mogen we wel? Wat mogen we niet? En vooral, ze moeten denken vanuit een vertrouwenssituatie. Dat is bij mij niet nodig. Ik heb dat liefst ook, dat een jongere mij kan vertrouwen en dat ik die jongere kan vertrouwen, of dat ik ouders heb die ik na een tijd kan vertrouwen. Maar ik heb dat niet nodig, want ik kan uiteindelijk zeggen: het is zo en niet anders. Ik heb een gezagssituatie. Een gezagsfiguur ben ik. (Judge)

However, this approach allows voluntary collaboration with the families. The criteria professionals use to report relate to the child’s safety and the type of abuse. Focussing on the child’s safety is particularly important, it removes the fear of reporting and enables the professional to act in the child’s best interest.

Ayez toujours comme point de mire l’intérêt supérieur de l’enfant. Parce que du coup ça dégage de plein de choses, ça dégage de la peur, ça dégage de: « oui mais j’ai peur de me faire engueuler ou j’ai peur d’être mal par rapport à mon collègue ». Si on se dit: « Non, je fais ça parce que c’est l’intérêt supérieur de l’enfant ». En tout cas, moi je trouve ça aidant. (Specialized services, Paediatrician)

The professional secret is perceived to be very rigid and physicians are afraid of violating it.

Dat is heel moeilijk hé, als arts en hulpverleners, dus in eerste instantie moet ge hulpverlener zijn. Dat is het allereerste en dus in samenwerking met het vertrouwensartscentrum en zo voort is hulpverlening het eerste, en het is pas, behave in een acute situatie natuurlijk, als je voelt of ziet dat dat niet lukt, dan pas denk ik dat ge… In alle geval, ge kunt het doen en in bepaalde situaties moet ge het eigenlijk doen. Je moet dat kind beschermen, ik denk dat dat heel belangrijk is dat dat kind beschermd wordt. Zeker, mishandeling en dat soort dingen, ja dat moet stoppen, punt, en dan moet er ingegrepen worden en eigenlijk is daar op het ogenblik als een vorm van meldingsplicht in, want als ge dat niet doet dan riskeert ge toch wel een klacht op



verschuldigd verzuim, artikel 422, ja, of 422 bis ik weet het niet juist, in elk geval, het schuldig verzuim, ik denk dat de rechters daar niet mee lachen als ge daar niet, als ge daar niet iets doet. (GP)

7.5.4 Barriers to collaboration in dealing with child abuse

From the analysis of the interview data we found a number of barriers hampering collaboration between actors in the field of youth welfare and health care. They are summerised in Figure 7 and described in the following pages.

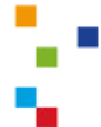


Figure 4 — Overview of reported barriers to collaboration in dealing with child abuse

LACK OF RESOURCES
- Time
- Peer and institutional support
- Skills and knowledge

EMOTIONAL TOLL

EXCESSIVE WORKLOAD

INDIVIDUAL PROFESSIONALS (e.g. GP, teachers, nurses in childcare facilities)

SPECIALISED SERVICES (VK / SOS enfants & SAJ)

SERVICES WITH HIGH ACCESSIBILITY (e.g. medical prevention services in schools (CLB/PMS))

Collaboration

POLICE

JUSTICE

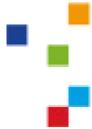
Policy

LACK OF MUTUAL TRUST
- Lack of knowledge and high expectations
- Negative experiences

POOR INFORMATION EXCHANGE
- Professional secrecy

SATURATED NETWORK
- Insufficient prevention efforts
- Insufficient number of residential places

LACK OF COORDINATION AND CONTINUÏTY OF CARE
- Lack of data registration



7.5.4.1 *Barriers reported by first line professionals confronted with suspicions of child abuse*

Individual first line professionals lack resources

Individual first-line care providers (including GPs, teachers, social workers in prevention services in schools etc.) experience a high workload in combination with a lack of resources. Therefore they often feel unable to intervene in case of suspicion or follow families regularly over time.

Je ne sais pas si il y a une prise en charge régulière des PMS parce que je crois qu'ils ont quand même pas mal de boulot. (Prevention and health promotion, PSE)

Dat heeft te maken met de visie op die aanpak denk ik, omdat als je start als een soort ik noem dat soms voor detective in het gezin, is het stukken moeilijker denk ik om dan samenwerkingsrelatie te krijgen. Terwijl je juist die samenwerkingsrelatie nodig hebt om aan hulpverlening te kunnen oden. En ik denk dat daar het probleem zit voor onze mensen. En eenmaal je start binnen die hulpverlening, waar ik op zich wel in geloof en waar het decreet ook op aanstuurt, maar daar heb je weer tijd voor nodig. En dan botsen we op de ja, al de andere taken voor de CLB medewerker op dit moment, de complexiteit van alles, waardoor onze mensen eigenlijk dreigen te verzuipen. En dit is eigenlijk weer iets nieuws wat erbij komt voor onze mensen, een nieuw soort taak waar zij, ja toch zeggen, dat ik ben 30 jaar bezig, waar taken toch helemaal anders lagen. Dus vandaar een beetje de nood aan ondersteuning zeker. (Prevention and health promotion, CLB)

- Taking time is essential

Health care providers identify with the responsibility to take care of the children. This is particularly the case for the GPs who find it a privilege to work with families. However, they perceive taking care of high-risk families as **very time- and energy consuming**. Handling the issue involves multiple complex tasks and requires a lot of the professional's attention. The capacity to deal with this aspect also depends on the working environment and the remuneration system. Working in a solo practice and a fee for service remuneration system can hamper investment in time consuming trajectories.

Ja, ik vind dat absoluut een taak van huisartsen, omdat dat over de gezinnen en gezinsstructuren en het functioneren en optimaal functioneren van alle gezinsleden in dat gezin, kunt ge niet anders dan dat als een taak zien, een belangrijke taak, zien. En naarmate dat je inderdaad die gezinnen ziet opgroeien, ga je daar meer en meer belangtelling voor hebben en dan vind ik persoonlijk ook dat naarmate dat je gezinsstructuur... dus zeker als ik zie naar mijn 25-jarige carrière nu, dan merk ik dat in bepaalde gezinsstructuren of gezinnen dat dat ook een voorrecht is dat je daarin mee kunt steunen of structureren of melden of ... en ben je wellicht ook op tijd en preventief ook vaak bezig om dingen te gaan inschalen en op tijd hulp bijhalen. (GP)

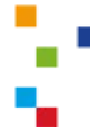
Ca va me prendre beaucoup de temps, beaucoup d'énergie et ça va être très compliqué. Beaucoup de démarches, beaucoup de coups de téléphone et …faire intervenir à différent niveaux que ce soit hôpital, psychologue, des contacts et donc quand j'ai un cas je sais que ça va me prendre beaucoup de temps et que ça va m'occuper l'esprit. (GP)

Yet, health care professionals and services agree that taking time is essential, also because it takes time for a child to reveal the situation. Commitment to the child's welfare goes hand in hand with accepting the time-consuming aspect. Health care providers feel a personal commitment when dealing with alarm signals and suspicion. Also they evaluate their impact as positive, e.g. better interpersonal/social contacts, the possibility to see the child alone in consultation or an improvement in school performance.

Et on sait aussi que quand on a un cas de maltraitance qui arrive-t-il va falloir du temps et il va falloir y consacrer du temps et de l'énergie et les heures vont couler quoi. Mais je pense que c'est en se disant ça d'emblée qu'on sait qu'on aura du résultat parce que on va y mettre du temps et qu'on va être opiniâtre. Et je crois qu'il faut être opiniâtre. Parce que je pense qu'il faut déjà parfois beaucoup de temps avant que l'enfant vienne révéler des choses et donc c'est logique aussi d'y accorder un crédit supplémentaire. Combien de temps cet enfant a déjà mis pour arriver à oser le faire cette démarche. (Prevention and health promotion, PMS)

- Peer and institutional support are empowering

Teamwork, active collaboration and support of a network are empowering. Handling suspicion in a (multidisciplinary) team facilitates multidisciplinary decision making. Working in solo practice is a major obstacle for an



adequate handling of suspicion. GPs report difficulties to maintain a clear vision and adequate therapeutic distance.

Etre toute seule dans ces cas-là, c'est impossible. Là on perd la boule, quoi, ou on se met dans le déni ou dans la confusion « incestuelle» presque quand c'est des abus. Je vais peut-être utiliser un mot particulier… « maltraituelle » ?. (GP)

Respondents agree that these problems demand a multidisciplinary approach. Multiple converging insights contribute to a better and more efficient dealing with suspicion. Health care providers working in group practices together with psychologists or with mental health centres in their professional network see more opportunities to involve colleagues (nurses and social workers…), to coach the families, to evaluate the risks for the child, the necessity of reporting and to do the follow up in a non-mandatory pathway.

Dus wij hebben onze multidisciplinaire teams waarin dat er toch enkele disciplines samen zitten, en dit soort casussen verwachten wij dat mensen zeker op een team brengen. Ze kunnen niet meer alles brengen tegenwoordig, het zijn teveel zaken, maar dit wel. En vooral ook als het gaat om die morele dilemma's van: gaan we hier parket inschakelen of niet, gaan we hier toch naar het OCJ gaan of niet, gaan we het VK inschakelen of niet? (Prevention and Health Promotion, CLB)

Several collaborative initiatives have already been implemented and several suggestions for the future were made by respondents:

- GPs proposed to work in pairs with social workers or psychologists from SAJ who manage the burden of suspicion. Doing so, the trust bond with the doctor stays intact.

J'entends souvent des généralistes démunis au niveau d'adresses, de lieux où on peut faire appel, disponibles. Solution, oui, peut-être travailler avec des assistantes sociales, un espèce de service qui viendrait comme j'ai déjà eu la chance d'avoir, qui viendrait, on reçoit la famille avec un tiers qui vient ici dans notre cabinet et qui aide. Et toute l'agressivité, toute la suspicion, la peur de la famille peut alors se déplacer sur l'autre (sourire) mais qui l'assume et ça peut aider justement à ne pas rompre le lien. Parce que le gros danger c'est quand même ça, c'est la rupture du lien avec la famille qui ne nous fait plus confiance. Parce que nous-mêmes on a créé…on a mis un regard de méfiance. (GP)

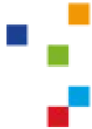
- Respondents mentioned that it would be useful to work with independent social workers. These workers would not only take care of suspicion but also of other issues (e.g. housing, family finances) They would ensure adequate logistics, back up the health care professional and thereby improve efficiency.

Des assistantes sociales indépendantes pff je ne pense pas que ça existe, ce ne serait pas mal en attendant. Ça ce serait une solution. Tiens j'y ai jamais pensé. Assistante sociale indépendante oui qui pourrait fonctionner pour, oui … et qui s'occuperai de tout ce qui est… mais pas que dans la maltraitance infantile. Elle pourrait s'occuper pas mal des gens qui n'ont pas de logement, des gens de nos patients qui sont en difficulté financière, les demandes allocations handicapées même pour des enfants aussi, il y a des enfants qui ont des handicaps qui doivent faire des bilans de santé ou des avis ORL pour des rééducations langage, les demandes de QI pour bénéficier d'aide psychologique, tout ça. Tout ça, si ça pouvait déjà être fait par une assistante sociale ce serait aussi un gain de temps. (GP)

- Respondents also plead in favour of implementing or increasing case intervisions and supervisions (by psychiatrists for instance). They provide the opportunity to share the difficulties inherent to dealing with suspicion.

D'ailleurs on envisage avec quelques-uns de mettre quelque chose en place aussi quitte à avoir des réunions avec un psychiatre tous les mois pour déposer ces cas-là pour avoir des espaces pour penser parce que ces familles font tout pour ne pas qu'on voit, pour ne pas qu'on pense, pour nous berner. Et c'est pas évident à ne pas se laisser berner, quoi. (GP)

Supervisions may also help health care professionals to cope emotionally with child abuse situations. According to respondents, supervisions and training groups also help them deal with these emotionally difficult situations. Especially first line health care providers experience child abuse cases as demanding. Being confronted with pain, violence and one's own social responsibility creates a significant emotional load. During the interviews, all health care providers expressed a variety of emotions, such as sadness, anger, irritation, powerlessness. This emotional burden makes work more



difficult and may have a long-term impact on the professional's health, in particular when they try to deal with abusive families on their own.

Er zijn heel wat vormingen die we gevolgd hebben of we werken of een opleiding gevolgd rond 'science of safety' en partnering rond safety. Om dingen in kaart te brengen, maar het blijft elke keer zoeken, naar emotionele ondersteuning van de mensen die het moeten doen, net omwille van die handelingsverlegenheid ook en wat betekent het ook van met deze problematiek geconfronteerd te worden. Als je te horen krijgt dat een kind de kamer rond gezwierd is, dat heeft een impact. En dat is niet altijd even eenvoudig om daar ook voldoende stil bij te staan van: en wat doet dat met u, als je dat meegemaakt hebt? (Prevention and health promotion, CLB)

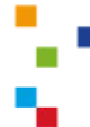
- Respondents suggest to involve forensic doctors earlier in the process (currently they can only intervene on request from the public prosecutor) so that they could assist paediatricians and GPs in the examination of the child and collect data in order to prepare a judicial file. There seems to be a lack of specialized forensic physicians. Specialized services (VK) report that they need more paediatricians specialised in forensic problems. Well-trained physicians would save resources on the long term, because centres would work more efficiently.

Sinon parce que le légiste est un médecin un peu particulier qui ne vient pas tout seul. Et ils le déplorent eux-mêmes. Les médecins légistes sont les premiers à déplorer de ne pouvoir se mobiliser que sur… Voilà ça aussi je crois que la relation entre pédiatrie, médecine générale et médecine légale devrait pouvoir être beaucoup plus fluide. Nous on a la chance ici de nouveau de beaucoup collaborer avec eux. Parce qu'au fil du temps, on se connaît. Et qu'il y a une confiance mutuelle qui s'installe. Mais effectivement j'imagine que le pédiatre qui travaille à trois ou qui est solo même dans un milieu hospitalier rural avec un cas de maltraitance qui arrive peut-être une fois tous les six mois mais ils doivent être bien perdus. (Specialized services, Paediatrician)

Ik heb de indruk dat forensisch arts in België niet of weinig bestaat. Als ik dan kijk naar, ik heb ooit de lezing van Rob Bilo gevolgd, die dat in Nl wel is, die effectief ook wel wat onderzoek doet van: wat is nu: klopt dat verhaal, klopt dat verhaal niet? Die alertheid daarvoor, bijvoorbeeld in ziekenhuizen, dat is, omdat je soms kinderen doorstuurt met algemene bezorgdheden, bijvoorbeeld ook met een gestegen hoofdomtrek, dat je daar soms ook nog zo van: ja, maar ja. Gezien de omstandigheden, bekijk het ten minste. We kunnen ernaast zitten, maar Ok, misschien is er niets aan de hand, dan is er niets aan de hand, maar doe tenminste de moeite om te kijken. Maar dan denk ik van: dat is een referentie-arts of een referentiepersoon binnen de organisatie die dat dat kan, die kan passen in dat stappenplan, he. Zorg ervoor in elke organisatie dat je een aanspreekpunt hebt, dat je invenstariseert van wat zijn stappen die we volgen? Hoe spreek je ouders aan? Maar ik kan me voorstellen dat er binnen de artsenkringen dat er daar ook iemand kan zijn die dat opneemt en voor een stuk van de collega's opvolgt. (Prevention and health promotion K&G)

- Collaboration within a network of specialists is perceived as essential to ensure continuity of care. The workload can be shared and a network can compensate for the absence of some of its members. Health care providers evaluate collaboration with preventive services such as K&G/ONE and CLB/PMS positively, especially if they take time to explore suspicion and contact GPs or other health care providers.

Ook dat is een vorm, weliswaar niet zo zwaar, maar het ook een vorm van kindermishandeling: kinderverwaarlozing. En daarvoor zijn de situatie en dat merken wij dan. En dan wil ik niet zeggen, want zij had al eerder, zij was gekend bij ons, dus die kinderen staan onder toezicht. Dan is voor ons de signaalfunctie. Dan kunnen wij gaan bellen met de thuisbegeleiding en zeggen: ze is weer serieus aan het ontsporen. Hoe moet het nu verder? Geven we ze nog eens een kans? Hoe moet het verder? En dan wordt het wel tijd dat we eens rond de tafel gaan zitten. Want je kunt mensen een kans geven, en iedereen verdient een tweede of een derde of een vierde kans, maar ergens moeten we wel een grens trekken. En dat is dan onze taak. Om aan die bel te blijven trekken en om te signaleren: het loopt hier mis. Want dat weet de hulpverlening niet altijd. En daarom moet er eigenlijk een wisselwerking zijn. Gewoon om, als er een nieuw probleem is of een bijkomend probleem of het gaat terug naar beneden, om dan op tijd te zeggen: mannen, wakker worden, het loopt hier eigenlijk fout en het moet terug in de goede richting. Dat denk ik dat onze rol moet zijn. (Police)



Health care providers note that personal contacts within other organisations are important as well as a good understanding of their mission and services. It saves time, generates more trust and facilitates collaboration.

Travailler en étroite collaboration avec des gens, ça nous fait gagner du temps. Connaître ses partenaires, ça fait gagner du temps. Ça ne semble peut-être pas grand-chose comme ça et ça n'est peut-être pas très quantifiable mais ça met le travailleur dans une situation plus à l'aise pour travailler, de savoir qu'il n'est pas seul, qu'il a tout de suite les informations dont il a besoin, qu'il peut en parler en équipe, qu'il connaît les partenaires extérieurs. Tout ça fait gagner du temps, fait prendre de la confiance. Et j'oserais espérer fait gagner en efficacité. (Prevention and health promotion PMS)

- "Multidisciplinary decision making" does not (necessarily) imply that all the team members are in direct contact with the family. Involving too many professionals with the family may, somewhat paradoxically, lead to increased tensions (and abuse) of the child.

Trop d'encadrement, je sais bien qu'on est dans l'ère du réseau depuis des années, peut parfois être nuisible pour les familles qui sont très tendues avec ça. Il y a certaines familles, je pense qu'elles savent qu'elles sont tout à fait quadrillées comme ça au niveau …et puis que le réseau va aussi se perfectionner pour être plus performant. Je pense que ça va parfois à l'encontre du bien-être des enfants. (Health care providers, SSM)

Moreover, health care professionals and services complain about too many organisational structures that detriment effective care.

De ideale visie.. Ik merk in het algemeen in de hulpverlening dat er meer mensen bezig zijn met de hulpverlening te organiseren en door te geven dan met de effectieve hulpverlening. Dat is een beetje mijn algemene bedenking. Dat heeft voor gevolgen dat men eigenlijk van ons ook wel verwacht van oke, als wij een tijdje bezig zijn, dan kunnen we dat doorgeven, maar dan zie je die volgende diensten die weer doorgeven en soms missen we voldoende mensen die echt effectief met het gezin op stap kunnen gaan. En ik denk naar beveiliging van kinderen toe, dat dat de enige weg is. (Prevention and health promotion, CLB)

The respondents considered that the aim is to generate a network starting from the family unit (and not from the professionals).

Ça sert à rien de gonfler encore de 50.000 intervenants. Je pense pas que c'est une question de quantité, je pense que c'est une question de qualité. Et que la qualité de penser le réseau au départ des familles et pas de penser le réseau entre nous pour se rassurer que toi tu fais ça, toi tu fais ça OK. Il n'y a personne qui s'est demandé quel sens ça avait pour la famille, quoi. Donc c'est important de penser le réseau au départ de la famille. Et je pense que si on pouvait plus faire ça, probablement qu'on aurait des interventions qui seraient plus justes et donc plus adéquates. Et sans compter qu'un réseau qui se coordonne dans une bien-traitance autour de la famille, rien que ça a déjà un effet. Et je parle même pas du contenu de ce qui est réalisé. Le réseau devient aidant en soi. Et donc on a tout à gagner de fonctionner comme ça. (Prevention and health promotion, ONE)

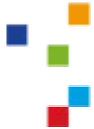
- Respondents perceive their personal network of (health care) professionals as an alternative to the official system dealing with child abuse (e.g. specialised services such as VKs and SOS enfant and justice). Paediatricians sometimes report patients to general practitioners for follow-up when they suspect child abuse. Sometimes they consult colleagues or report their suspicion to the department head. The same applies to GPs who report cases to guidance centres or to their supervisors.

Mais alors c'est vrai que les autres instances comme les centres de guidance ou les lieux de supervision, je les vis un peu comme des lieux de signalement aussi. Parce que voilà, ils prennent aussi la famille en charge avec moi. Donc de nouveau je suis pas seule, il y a le regard tiers. (GP)

Respondents emphasize the importance of being supported by their institutions. These could for instance cover the cost of training sessions on dealing with child abuse.

Oui donc dans le cadre des centres PMS, on a des formations régulières de différents organismes qui organisent donc les formations dans lesquelles on peut suivre des formations… Des formations à l'écoute active, voilà. Et alors bon j'ai ma collègue qui a la formation de thérapie brève. Et on se forme, on a une imposition de formation ah oui ça de toute façon. (Prevention and health promotion, PMS)

Preventive services such as ONE/K&G employ specialists who can assist field workers. In line with this initiative, respondents propose to create a position for a child abuse referent in institutions, schools, hospitals,…



Specialized services recognize that health care providers are less reticent to contact a person within their organisation who has a similar professional background.

C'est utile que dans les services PMS il y ait un référent par exemple « maltraitant » quelqu'un qui puisse écouter ses collègues dans une situation X et peut-être éveiller leur vigilance à aller vers tel ou tel service. (Prevention and health promotion, PMS)

Maar goed, we zien tussen vertrouwensartsen dat zij die kinderarts zijn meer meldingen krijgen verhoudingsgewijs van kinderartsen en ik krijg van kinderpsychiaters uit heel Vlaanderen telefoon. En ik denk, dat is misschien wat mensen kunnen bekritiseren, maar eigenlijk is dat een realiteit. En misschien moeten wij op een andere manier de piramide maken. En moeten wij binnen beroepsgroepen, moet de overheid een mandaat creëren voor een collega die binnen die beroepsgroep een aanspreekpunt is. Zit je met een vermoeden kindermishandeling? Ben je bang voor de casus? Vraag je je af, wat mag ik hier doen, wat moet ik hier doen? Bel met.. en dat die persoon, dat daar een vertrouwenscentrum een preferentiële relatie mee ontwikkelt, zodat als die persoon contact opneemt en zegt: ja, ik meld jullie een dossier of er gaat een collega bellen. Maar dat die als intermediair de toeleiding faciliteert. (Specialized services, VK)

According to respondents, institutional procedures facilitate dealing with abuse. For instance, emergency services dispose of working procedures to deal with abused children at night or over the weekend, when other services are less available. CLB/PMS have rather informal procedures based on tight collaboration between the concerned parties (PMS/PSE/educators).

Neen, ik denk dat ons stappenplan vrij uitgebreid is, en het geheel omvat. Omdat het is, het is niet echt een strikte procedure van als-dan. Dat hadden we vroeger dat was echt een plan van aanpak. Nu hebben we een stappenplan en de eerste stap is van: alertheid voor signalen, intercollegiaal overleg, gesprek met ouders, grondige analyse van de situatie met een expert en beslissen naar melding of hulpverlening. Dus, die 5 stappen, die zitten erin, maar het is geen rechtlijnig iets, omdat we sterk vertrekken van: elke situatie is anders, de bagage van mensen is anders. Heb je een acute situatie of een observatie, moet je direct met de ouders in gesprek. Heb je vage aanwijzingen, ga je misschien eerst intercollegiaal overleggen, dus het is niet iets dat heel vast staat, maar ik denk dat het, zoals het omschreven is, heel wat handvaten biedt, samen met de vorming en de intervisie, de casusbespreking enzo die wij hebben. (Prevention and health promotion, K&G).

- Skills and knowledge

Lack of training results in passing the buck to legal authorities or to specialized services.

Avec la formation qu'on a au départ, c'est dur parce que la réaction sera de réferer au judiciaire ou d'être dans le déni soi-même (GP)

Detection of child abuse is challenging. The task is made complicated mainly by the multiplicity of symptoms and/or the subtlety of the symptoms. In addition, families do anything to hide it. Professionals experience difficulties in distinguishing between a problematic parenting situation and child abuse. Especially in absence of physical symptoms there is a lot of doubt.

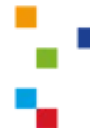
Training/awareness sessions with the aim to increase the vigilance for child abuse are already organized for teachers and health care providers, in particular for students. The further elaboration of adequate training sessions would be meaningful.

Respondents are also in favour of the creation of an accessible booklet containing symptoms of abuse and a list of specialists who can be contacted in case of suspicion. They stress the importance of knowing the available resources and who to refer to.

Oui peut-être d'essayer d'avoir une petite brochure un peu générale avec les signes d'appel. Mais je crois qu'au-delà de ça, c'est vraiment toujours le relais vers un professionnel spécialisé. En tout cas, c'est ce qui permettrait d'être le plus complet. Aussi parce que on a une bonne connaissance du réseau et que parfois ces médecins ou ces agents PMS, scolaires etc. ignorent peut-être les relais qu'il peut y avoir à gauche et à droite (Specialized services, SOS-Enfants)

Heavy emotional burden for individual first line professionals

Dealing with child abuse can be both emotionally challenging and frustrating because of various reasons related to the system as well as to the problem itself. Overall, professionals mention fatigue, lack of motivation, powerlessness and professional strain. Respondents observe that burn-outs occur, especially among younger collaborators.



- Often professionals feel powerless because of too little resources and saturated agenda's. They believe the quality of their work is at stake. Some organisations have time-out procedures, which implies no more new cases are accepted for a certain period of time, to protect the service from overload. This strategy shifts the burden to other actors in the field. Especially judges are confronted with this problem, resulting in long delays and potential risks for the child. Experienced health care providers may decide to leave the organisation out of frustration, hence valuable expertise is lost.
- Immediately after reporting health care providers and judicial employees often feel doubts and confusion. They reflect on their decisions and some of them feel frustrated by control loss.

We komen ze tegen, dat is gewoon zo, dat achteraf dan blijkt dat heel veel gerelativeerd moest worden en dat het misschien zo erg nog niet was. Maar op het moment van beslissen. Wij moeten binnen een bepaalde termijn beslissen. Wij kunnen niet zeggen van: we gaan wachten en wachten en wachten. Want het risico is soms te groot. En dan achteraf moeten we soms zeggen: misschien zijn we té ver gegaan. Maar dan is het enkel en alleen omdat we denken van, de veiligheid van het kind staat hier nu centraal. Zijn we verkeerd? Liever extremer tussenkomen dan achteraf te moeten merken van, we zijn niet ver genoeg gegaan en er zijn nog meer slachtoffers gevallen. (Juridical services)

- Health care providers mention that the backlog of cases is demotivating and frustrating especially after a long trajectory of non-mandatory care. This does not encourage services to report.

Ja, ik heb daar eigenlijk niet echt een opmerking in. Ik denk enkel met het Comité dat is soms wel een heel stug en zeer sterk afgrenzend bij voorbaat van; wij gaan dat zeker niet opnemen. En dat is, dat hoor ik ook bij collega's, op het moment dat je dan zelf belt, als je al verschillende stappen gezet hebt om een team te verzamelen, dan ben je al heel intens met zo'n gezin bezig geweest en het is al moeilijk om dan die beslissing te nemen. Als je dan die beslissing neemt en je krijgt dan te horen van: nee, dat is niets voor ons. Dat is zeer moeilijk. Dus ik denk de contacten met het Comité zijn wel erg moeilijk, ik denk dat dat wel, dat dat vooral te maken heeft met personeel en overbelasting van het personeel of misschien krijgen die de boodschap van: we moeten zoveel mogelijk afhouden, maar dat is zeer frustrerend. Dus eigenlijk bij ons is nu een beetje de teneur van: die bellen we toch niet, want die helpen ons toch niet. Maar wat we wel mee kunnen samenwerking is met de opvoedingsondersteuning die het CAW aanreikt, ja die zijn wel laagdrempelig. (GP)

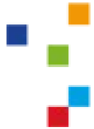
- Professionals face complicated and sometimes chronic situations. It is discouraging to see that some cases are resistant to any management or help, despite all the energy and time invested by professionals.
- Professionals get little recognition for their work.

C'est une clinique où il y a peu de reconnaissance aussi. Parce que les familles ne viennent pas de gaieté de cœur ici, rarement en tout cas. Et donc on sert souvent de lieu vraiment de crise ou d'autres vont prendre le relai plus dans le soutien thérapeutique et donc nous on reste un peu identifiés comme les mauvais. Donc je trouve que comme clinicien c'est rarement très, très gratifiant, valorisant. Et on est plutôt pointé aussi du doigt par la société quand ça ne fonctionne pas. Et donc peut-être pour 10 situations où on a bien géré, on a jaugé le risque voilà on l'a évalué à bon escient. Les situations qui dérapent sont celles dont on va parler et pour lesquelles on va être remis en question… Ou même dans le réseau parfois simplement. Heureusement, tout ne démarre pas toujours en première page de la presse, DH etc. Mais alors c'est les plus graves. (Specialized services, SOS)

- Professionals are exposed to the risk of verbal or physical assaults.
- Specialized services (SAJ/judges) have to deal with a form of institutional abuse.

Ce qui est très embêtant pour les professionnels de la maltraitance ça, ça va vraiment rentrer, je dirais dans votre sujet, c'est la maltraitance institutionnelle. Alors on est frappé de voir, sur des problématiques de maltraitance où il est question, je dirais de transgression, donc l'inceste ou que sais-je, abus sexuels, où il est question de cadres, de rappels à la loi etc. combien les professionnels entre eux sont peu respectueux voire maltraitants. Et donc les professionnels sont très, très, je dirais dans le miroir ou fonctionnent de manière extrêmement symétrique par rapport je dirais à la problématique qu'ils ont à connaître. Et ça c'est qui m'épuise le plus en fait. C'est ça qui est le plus épuisant. (Specialized services, SAJ)

Respondents confirm that some institutions have installed measures to support their workers: training sessions, psychological assistance (including



debriefing and relaxation methods), logistic units, institutional supervision and additional staff in crisis situations.

Le débriefing sur tous les intervenants en tout cas, toutes les personnes qui sont intervenues. Et là on vide le sac éventuellement. Ça nous aide énormément. Maintenant Monsieur X était déjà venu nous voir et nous donner des principes… des méthodes pas de relaxation mais entre guillemets oui, de relaxation, qui nous permettent préalablement à une intervention d'être prêts pour une intervention. (Policeman)

7.5.4.2 *Challenges encountered by specialized services*

According to specialized services strengthening first-line services is crucial to cover the needs and to decrease the number of referrals.

Les PSE, les PMS qui sont quand même les premiers à faire des constats. Parce que au niveau des écoles, même dans les écoles maternelles, les enseignants peuvent s'adresser au PMS ou au PSE. C'est leur premier interlocuteur. Et le médecin, je pense qu'il doit aussi pouvoir avoir accès. Et la médecine scolaire, c'est quand même pas n'importe quoi. C'est vraiment: « est-ce qu'elle est suffisamment développée ? » Mais en tout cas pour nous ce partenariat-là, il est important. Et que je trouve que si on développe mieux ou plus ces services de terrain de première ligne, je pense qu'alors ça désengorgera, ça évitera que des dossiers arrivent ici. Si on peut aider les gens tout de suite. (Specialized services, SPJ)

The following ideas were identified from the interviews :

- Create mobile teams intervening directly when front-line teams need assistance.

Equipes de référence ou des équipes mobiles qui seraient familiers et qui pourraient être appelées en référence. Enfin, en appel si jamais il y avait des situations qui pourraient soutenir les médecins de première ligne, ça je pense que ça serait utile. (Specialized services, Paediatrician)

- Increase the availability of specialised preventive, psychological and psychiatric services.

Wat daar … en dan vind ik dat ook, dan moet dat beginnen bij de kinderpsychiatrische diensten, die zeggen, van, wij vinden dat een goede oplossing, want ik kan daar niet zo goed over oordelen of dat dat nu voor hen een aanvulling is. ik weet alleen dat de toch wel nood, denk ik ook, is vanuit de kinderpsychiatrie dat er te weinig plekken zijn. Ik denk dat daar toch ook genoeg is over gesignaleerd dat daar toch wel wat meer mag zijn, he. En dat zal zo'n zaken van kindermishandeling toch ook wel ondersteunen, lijkt mij. (GP)

- Improve and extend acute and interventional services (at home).

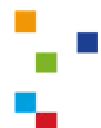
Acute dingen moeten we zeker wat betreft gedragsproblemen bij kinderen, daar moeten we eigenlijk meer jeugdpsychiatrische opvang hebben en niet met zo een centraal meldpunt waar er dan op de wachtlijst gestaan wordt. Zo'n mobiele K-teams aan huis, in crisisituaties, dit meer begeleiding van scheidende gezinnen, want daar komen veel problemen van. En dan vanaf het moment dat OCMW en de budgetbeheerder en die probleemgezinnen daar moet ook veel meer energie in gestoken worden. (Paediatrician)

- Within each organisation the performance on detecting, approaching and reporting the problem of child abuse could be improved by introducing a general 'action plan'.

Ik denk dat er daar serieus wat ruimte is voor verbetering, als ik kijk naar meldingen, dan blijf ik erbij dat een kind-check voor iedereen zou moeten verplicht worden of ten minste ook opgelegd worden aan organisaties dat men min of meer een stappenplan heeft, zodanig dat iedereen weet: dat zijn de stappen die moeten gezet worden en dan kom je van: moeten we melden of niet. (Prevention and health promotion, K&G)

- Furthermore organisations should take better care of their personnel, especially in psychological health care to avoid burn-out related problems and to increase job satisfaction.

Want als je hier nu ziet, er gaan 2 mensen op pensioen, ze gaan niet vervangen worden, er zijn geen middelen voor. Dat gaat over de experts in ons team. Dat zijn mensen met heel wat ervaring.. Dat zijn mensen die tot hun 65ste hebben gewerkt. En dan moet dat ingezet worden en dat moet dat, krijg je daar een halftijdse voor terug en dat moet dat dan iemand zijn onder de 25 jaar. Wat ook belangrijk is dat we op jonge mensen inzetten, maar ik denk dat daar 190 euro, komaan jongen, welke studiedag kost er allez. Wat, hoeveel kun je er doen met 190 euro? 2 ofzo als je goed uitkijkt? Dat zijn echt, dat vind ik echt schandalige dingen. En ze geraken overwerkt, in burn-out, mensen die binnen de geestelijke gezondheidszorg werken



worden zelf… ik vind dat hier eigenlijk niet, daarop kunnen ze inzetten denk ik, op veel meer personeelszorg. (Health care providers, CGG)

7.5.4.3 *Challenges affecting collaboration between first line professionals and specialized services dealing with child abuse*

Lack of mutual trust inhibiting collaboration

- High expectations and lack of knowledge about working procedures

Specialized services deplore that many family doctors and nearby hospital teams have not heard of SOS-Enfants and SAJ or ignore their working practice. Many professionals are not aware that specialized services can be consulted for advice or that they can intervene for example at the hospital.

According to respondents, often professionals perceive specialized services negatively. Misbeliefs may explain reticence towards reporting.

Maintenant on nous (SAJ) fait une image diabolisée de gens qui ne collaborent pas. (Specialized services, SAJ)

Other professionals sometimes treat specialised services as coercive authorities. They threaten parents with reporting. Specialized services are aware of this type of argument. They remind us of the focus on the support (instead of coercion) to safeguard future collaboration with the family.

L'idéal, c'est de présenter le SAJ comme un service d'aide et pas comme une punition, de venir avec eux parce qu'ils sont conscients qu'il y a un problème et qu'il faut être aidé. Et de pouvoir présenter… soutenir les personnes. (Specialized services, SAJ)

The same negative perceptions apply to legal authorities: the professionals see them as horrible and inadequate institutions.

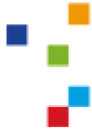
Specialized services are committed to information provision and preventive work, which they consider to be as important as case management. They inform professionals about their working methods, goals and constraints. They set up training and prevention programmes (brochures, DVDs, training sessions etc.) for teachers and preventive services. This helps professionals to refer in appropriate ways to other services.

J'ai envie de dire que un, le fait de faire un travail de prévention... La prévention pour moi c'est de faire connaître les services, de pouvoir établir des collaborations. Enfin, c'est un petit peu tout ce que je vous ai expliqué avant. C'est pas de traiter préventivement les situations. Mais le fait de faire connaître et c'est là que je vois l'importance de tous les pans du travail. C'est de faire en sorte non pas qu'il y ait moins de situations, parce qu'on croit toujours s'il y a la prévention, il va y avoir moins de situations, ON EN A PLUS. On en a plus parce que les personnes savent ce qu'elles peuvent faire si ça ne va pas. Et se dénoncent et viennent demander à ce qu'on intervienne. Voilà. Donc, c'est ça qu'il faut faire, c'est essayer d'avoir le plus de communications, de publicités. De pouvoir faire savoir qu'il y a des services qui sont là et deuxièmement qui ne sont pas là pour vous envoyer au casse pipe ou vous enlevez vos enfants. Mais qui sont là pour essayer de vous aider à trouver des solutions à vos problèmes. (Specialized services, SOS-Enfants)

Reports registered by the prosecutor's office (parquet) frequently rely on vague concerns and should therefore not have arrived there. Furthermore, based on past experiences respondents observed a negative impact for the child.

Specialized services provide case-tailored advice, therefore the process is perceived as 'variable'. The respondents denounce a lack of 'long term' follow up and mention that specialized services narrowed their scope and limited their interventions to advising professionals. Professionals feel disappointed if expectations of immediate help are not realized and they are left on their own to take care of a case. Consequently they are less inclined to report in the future or they contact legal authorities instead of specialised services.

En ik denk dat het nog heel erg blijft hangen in de vrijwilligheid. Ehm, dus ik denk dat er een soort van ja, deels verplicht traject moet komen, lopen de mensen daar sneller doorheen, wat bijvoorbeeld moet uitgespreid over een jaar, anderhalf jaar, lopen ze daar sneller doorheen, als blijkt dat er toch geen sprake is van KMH, dat die ouders versterkt worden en dat er eigenlijk vanuit een positieve manier mee wordt omgegaan, dan kan dat snel afronden. Maar het is ook zo variabel: je weet niet, als je een melding doet, wat gebeurt er nu? Bij de een gebeurt het zo en de ander.. en er is niet een gevoel van 'je wordt au serieux genomen'. Hetgeen dat ik nu ervaar met mijn fragmentarische casussen, want uiteindelijk is het allemaal heel verschillend. (GP)



Les expériences, les mauvaises expériences ? R: Bien sûr, on a des médecins avec lesquels le premier signalement s'est très mal passé par exemple et l'enfant s'est retrouvé après, je sais pas, aux urgences, vraiment dans un état grave. C'est évident que ce médecin-là n'a plus envie de tergiverser et que dès qu'il a des doutes il aimerait autant une réponse assez énergique avec placement. (Specialized services, SOS-Enfants)

- Poor information exchange

According to respondents the information flow within the network regarding the follow up of abusive situations is sometimes problematic.

Le suivi faut pleurer pour avoir les rapports hospitaliers, des fois il faut même crier, gueuler un bon coup, ce qui est déjà arrivé à deux, trois reprises. Ça dépend, j'ai, par exemple deux pédiatres à l'Hôpital X avec qui je m'entends très très bien et là je sais si je les adresse, j'aurai un retour. J'ai le courrier, même si ce sont des cas ONE, le courrier m'est toujours bien doublé pour que je sois informée de l'évolution et de ce que je dois faire dans le cadre de l'ONE. Par contre pff il y a des pédiatres, des neuropédiatres qui renvoient tellement bien la balle aux médecins généralistes que c'est aux médecins généralistes à aller dépatouiller sur le terrain et colloquer si nécessaire, gérer la situation sur place. (GP)

The same difficulties are reported in relation to mental health centres and social services. According to our respondents, this is due to the division between psycho-social services and general medicine, which excludes the GP from handling abuse.

Preventive services (PMS) note a disruption of the information flow when children start school. ONE does not inform them about past abusive situations. This is a regrettable interruption of the therapeutic process and affects adequate handling of child abuse situations in the long run.

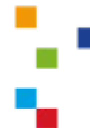
Parce que on a JAMAIS d'informations qui viennent de l'ONE. Ça c'est un réel handicap par contre. C'est que quand une TMS, travailleur du terrain de l'ONE, suit une situation, suit une fratrie, il y a au moment de la scolarité de l'enfant une cassure qui se fait dans la communication et dans la transmission des informations. On a eu ici sur Tournai une fois par an une réunion de l'ONE qui venait donc chercher les informations et proposer un petit peu je dirais comment dire ça, proposer leurs services, dire quelles étaient leurs difficultés. Et à plusieurs reprises on a dit: « Mais finalement, vous avez connaissance de certaines informations, l'enfant quitte quelque part votre maison, vos missions, votre sphère d'actions, il va ailleurs et on recommence à zéro (Prevention and health promotion, PMS).

- Professional secrecy

The shared professional secrecy can be considered helpful to prevent misuse of information. However, the various professionals involved interpret the legislation differently and have different ethical codes. Strict application of professional secrecy can be an important barrier for sharing valuable information. If parents do not agree about informing other services follow-up becomes difficult. Services have to start all over again which is a waste of time. Professional secrecy sometimes counteracts child protection.

Je pense que donc on se doit de respecter le secret professionnel. Quand on contacte par exemple un intervenant, on dit: « Je contacte avec l'accord des parents et dans le respect du secret professionnel partagé ». Je ne pense pas que c'est une barrière. Je pense que la déontologie et le respect du secret professionnel, c'est justement quelque chose d'aidant, c'est ce qui permet aussi de pouvoir dire aux gens: « On est tenu au secret ». Ah non, non, je ne dirais jamais que la déontologie est une barrière, ah non. (Specialized services, Paediatrician)

Alle juristen hameren heel sterk op het beroepsgeheim. Ik wil dat niet minimaliseren en ik wil dat ook niet van de tafel vegen want dat moet er zijn. Maar je moet de grenzen aftasten in het belang van het kind. En daar merk je dat daar wij emotioneler op reageren dan de juristen, die eigenlijk niet in het werkveld staan. En dat is mijn eeuwige frustratie. Dat klinkt nu zo zwaar, maar dat is eigenlijk de frustratie van heel veel mensen op het terrein. En dat gaat zowel naar de mensen van Kind & Gezin als bij ons politiemensen als ons maatschappelijk assistent, noem maar op. Alle mensen die op het terrein staan willen maar één ding, en dat dat stopt voor dat kind. En dat willen de kinderen zelf. En dan is het makkelijk om vanuit de academische wereld te gaan zeggen: ja, het beroepsgeheim is heilig en dit en dat. Je hebt wel spreekrecht, maar ja, dat is dan ook weer zo afgelijnd terwijl dat wij allemaal, als je daar ter plekke in een gezin komt, in een huis, dan kun je zeggen van: doe maar, het zit hier echt niet goed. Maar je moet er wel mee voort doen. Je moet de volgende dag wel in de spiegel kunnen kijken van: shit, zou dat kind wel goed terecht komen? En dat is hetgene dat wringt en dat is hetgene dat je volgens mij niet kunt dicht schrijven. En toch moeten



we daar een mogelijkheid toe bieden dat we die mensen op het terrein kunnen ontlasten van die druk. Want het is echt niet evident. Als je zulke dingen merkt en je kunt er niet mee weg. (Juridical services)

Respondents suggested that the legal framework should be reviewed to allow for better exchange of information between services. Since patients can consult their electronical medical file, professional secrecy has become even more problematic.

Ca bloque maintenant les histoires que maintenant le patient est propriétaire de son dossier, la communication entre justement psychologue, pédiatre, neuropédiatre dans des situations de maltraitance, aller mettre maltraitance dans un rapport médical qui va être envoyé au médecin traitant et que le médecin traitant peut donner le dossier au patient. Ça c'est un gros blocage. (GP)

7.5.4.4 Challenges situated at the policy level influencing professionals' assessment and decision-making

7.5.4.5 Saturated services

According to respondents, specialised health care teams, e.g. crisis intervention, lack time and are overburdened. Hence they are not sufficiently available nor accessible, have long waiting lists and select narrowly the cases in which they intervene.

On a vraiment une saturation des services. Donc centres de santé mentale, SAJ, évidemment tous les centres d'accueil d'urgence, tous les centres, centres de violence conjugale, alors tout ce qui est accueil de l'enfant. Les pouponnières. Tout ça est complètement surchargé. (Prevention and health promotion,ONE)

Facing a general overload of the system, professionals feel let down. As reaction they try to manage on their own with alternative and sometimes counterproductive solutions.

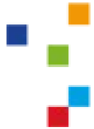
Maar wachtlijsten, ja, ik hoor hier in onze regio bepaalde mensen, centrum geestelijke gezondheidszorg zegt van ah, wij kunnen pas opnemen ten vroegste binnen een paar maanden. Het centrum algemeen welzijnswerk zegt hetzelfde en daar zitten wij dan. Crisismelding is ook soms iets gelijkaardig. Dat is een enorme frustratie van onze mensen. Er zijn hier collega's die ja, de vrijdagavond dan om 3 uur crisis op school, kind belt en durft niet naar huis om allerlei redenen, alle hulpverlening sluit en ja, je staat er dan voor, de school staat in paniek en dan doen wij toch en ik heb hier collega's die tot halverwege de nacht soms bezig geweest zijn. En die in nood dan zelfs met de eigen wagen moeten rijden om een kind daar ergens te gaan brengen omdat andere diensten dit niet doen. Maar het voordeel bij andere diensten hebben het volgens ons ook soms een beetje makkelijk, die zeggen gewoon van: aha we hebben wachtlijsten, geen nieuwe aanmeldingen, en die zien die jongeren dan ook niet. Ze kunnen de deur sluiten, maar ook hun ogen sluiten, wij kunnen dat niet. Wij kunnen zeggen allez die, wij zien, wij blijven op die scholen komen en die leerkracht die kan ook zijn ogen niet sluiten, want die blijft met dat kind geconfronteerd en dat maakt denk ik het grote verschil voor ons, wij kunnen niet zeggen wij pakken dat niet op of wij doen daar niets aan want die alarmbel blijft luiden en we horen ze ook nog alle tijd, dat is ook het probleem. Een andere dienst die niet op school zit, ja die zegt gewoon neen en daar blijft het bij. En wij kunnen, wij proberen ook tegen de scholen nee te zeggen, maar de week daarop krijg je dan opnieuw de vraag en dat is. verklaart voor een stuk ook onze overbelasting, denk ik. (Prevention and health promotion, CLB)

- No continuity of care

When the intervention is discontinued, the family is left on its own. In case of relapse the process has to start all over again, which is frustrating for all parties involved. The short term perspective and associated discontinuity of care is one of the main frustrations in the field and is a major barrier for good clinical practice.

Et puis après on voit que les mises en place, elles tombent petit à petit pour finalement se retrouver un an plus tard dans la même situation. Et on se rend compte que ben non, après deux mois finalement la psy dit: « on a trouvé que ça allait pas trop mal donc on l'a laissé » hop et puis après ça finalement ça allait bien alors on a laissé tomber. Et puis finalement la logopède elle a dit qu'il y avait pas trop de truc et tout, tout, part. Et puis après on se retrouve que un an plus tard dans le même bazar quoi parce que à long terme il y a rien qui a été maintenu. I: Et c'est dû à quoi, tu penses ? R: Le temps… overbooké, surchargé… et donc on met tout dans l'aigu et dans le long terme après c'est bof. (GP)

Some services have sixty days to six months to examine a case and to gather all the information before taking any decisions. From the perspective



of specialized services it takes too much time. Because of lack of places for children, professionals have to turn to alternative strategies. They turn to default choices in order to help the child and the family, well aware of the inadequacy of the solutions.

Effectivement c'est parfois assez lourd ce qui est demandé de mettre en place. Mais parce qu'aussi de nouveau je pense qu'on est amené à proposer un peu des roues de secours. Et donc on se dit, l'idéal ce serait un travail par une équipe qui irait à domicile, qui rencontrerait de temps en temps madame, de temps en temps monsieur, de temps en temps etc. Mais on en a pour six mois ou sept mois avant d'avoir une place. Donc en attendant on ne peut pas laisser la situation comme ça. Donc est-ce que madame pourrait pas être soutenue là et monsieur pourrait pas être soutenu là et l'enfant soutenu là. (Specialized services, SOS-Enfants)

- Long waiting lists

The long waiting lists for therapy are a real barrier. While waiting the situation often deteriorates. When the support finally arrives the program is no longer adapted to the new situation.

Wat dat natuurlijk wel een probleem is op dit moment, en dat is iets dat je misschien heel vaak gaat horen, is dat er een heel groot gebrek is aan middelen binnen alles wat dat jeugdbescherming betreft. Ik heb het dan over plaatsingen, pleeggezinnen. Ik heb het over thuisbegeleiding, over welke begeleiding dan ook, is er overal plaatsgebrek. Dus je kan wel zeggen van kijk, we zijn ervan overtuigd dat die maatregel het beste zou zijn. Maar het kan gewoon nog niet gerealiseerd worden. En dan gaat er soms wat meer tijd over, waar dat je eigenlijk al lang weet: dat is de juiste maatregel en die is ook dringend nodig. Maar als ik die niet kan doen, dan moet ik wachten. Of ik moet een andere maatregel gaan zoeken die misschien minder gepast is, maar die dan nog beter is dan niets doen. Dus dat is een constante afweging die je doet, waardoor je ook maakt dat het heel moeilijk is om die termijnen een stuk te gaan respecteren. (Juridical services)

- Need for coordination or supervision of the care trajectory

The respondents note that some preventive services are overburdened that it becomes impossible to coordinate all the support services and interventions running or even that their core mission is under pressure. Some claim that there is an urgent need for a case manager for each family. Someone who follows the family over a long period of time from detection onwards.

Dans le décret de l'aide à la jeunesse le SAJ normalement une des missions c'est d'articuler le réseau. Mais vous pensez bien que le SAJ, enfin ça c'est de nouveau, je veux pas dire que c'est partout comme ça, mais je pense que c'est une mission dans laquelle ils sont de plus en plus mis à mal. Pourquoi ? Parce qu'ils ont déjà pas le temps de répondre à toutes les demandes qui leur sont amenées tous les jours. ((Prevention and health promotion, ONE)

Persoonlijk geloof ik daar ook heel erg in dat dat voor gezinnen heel erg zinvol is en voor kinderen heel erg zinvol is dat er een vaste trajectbegeleider is. Nu heeft men trajectbegeleiding meer georganiseerd in doorstroom in verschillende hulpverleningsvormen, bepaalde organisaties kiezen er dan voor om binnen de organisatie een soort van trajectbegeleider samen te stellen, maar ik vind inderdaad, er gaat veel waardevols verloren op het moment dat een gezin weer van hulpverlener A naar hulpverlener B moet gaan. Dus ik geloof wel in trajectbegeleiding, maar anderzijds heeft iedere organisatie zijn beperkte opdracht en lukt het op dit moment voor geen enkele organisatie om te zeggen van: kijk, ik ga dat wel doen. maar dat dat op zich zeer waardevol is absoluut. (Specialized services, VK)

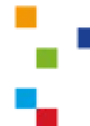
- Services do the work of others

Specialized services (SOS) mention that they end up managing cases that were not assigned to them, until the other services are ready to step in. On contrary they have no time left to take up cases assigned to them. Respondents agree on the need to strengthen existing teams both ambulatory and residential services.

Et quand on arrive en équipe que chacun ne sait déjà plus mettre un rendez-vous sur l'agenda et qu'on se dit il y a six signalements et c'est six pour nous, c'est difficile ça. Mais parfois on ne sait pas prendre, on réoriente alors que c'est bien pour nous. (Specialized services, SOS-Enfants)

7.5.4.6 *Insufficient prevention and early detection efforts*

Although a lot of initiatives are already in place regarding the direct or indirect prevention of child maltreatment (e.g. soutien à la parentalité yapaka.be; ouderschapsondersteuning K&G), respondents believe



prevention merits more efforts and should be prioritized, especially because it is an important way to stop the intergenerational transmission of abusive situations. Preventive approaches are less stigmatising and result in less social problems such as delinquency, additions and psychiatric illness.

Figure 5 — Four layers of prevention and early detection efforts appearing from the interviews

From the interviews we identified preventive activities at several levels, as visualised in **Figure 5**. The levels refer to the target groups: from vulnerable families to the general public.

- Identification of vulnerable families

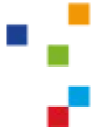
Although risk factors for child abuse are well known, identification of and access to vulnerable families remains challenging. Professionals at specialized services (VK/SOS Enfants) identified the perinatal period at large, and the pregnancy in particular as a window of opportunity in the identification of and first contact with vulnerable families. During pregnancy (future) parents are usually very open to information and suggestions. Pregnancy is also a time during which the large majority of families come into contact with care givers, which offers a unique opportunity to access them.

Donc en termes de prévention, c'est évidemment extrêmement intéressant de rentrer par ce biais-là dans les familles. Parce que on ne rentre pas parce qu'il y a un problème, on rentre parce qu'il y a un enfant qui est né, ce qui est complètement différent. (Prevention and health promotion, ONE)

Today, specialized services already collaborate with hospital staff during the perinatal period in order to support a future birth occurring in a potentially risky family situation. However, they point out that the current trend toward earlier discharge from the maternity ward may prevent hospital staff from identifying problems, as the time to get familiar with the family decreases. By shortening hospital stays staff has less time to pass on information on child care and parenting skills. The continuation of postnatal care at home by midwives can counter the disadvantages of a short maternity stay, but is often absent, especially in vulnerable families.

During the perinatal period information can be provided about the challenges associated with parenthood and where to find support. Awareness raising about parenting challenges and specific dangers such as the shaken baby syndrome (and its consequences) is appropriate.

Donc quand nous, on rencontre des infirmières ou des pédiatres dire: « mais il faut pas hésiter aux premières consultations à parler aux parents, à dire vous savez parfois c'est très dur les mauvaises nuits, on est très fatigué, ça arrive que de l'exaspération… Et si on est tout seul, qu'on n'a pas toujours un conjoint, dans nos familles monoparentales maintenant après quatre nuits où on ne dort pas c'est dur et on ne réalise pas et on a un geste d'énervement qui a des conséquences graves ». Et peut-être qu'il y a pas besoin de SOS Enfants dans ces cas-là vous voyez ? Parce qu'après, c'est des parents qui sont déjà très abîmés par le fait d'avoir secoué leur bébé d'exaspération. Donc là je pense que c'est toutes des petites choses sur lesquelles il faut travailler. (Specialized services, SOS-Enfants)



In addition day care facilities and schools need to pay attention to children in vulnerable families, especially in places where these families are overrepresented. The offered services should support parents instead of causing extra stress to the child or the family.

Enfin que les lieux institutionnels d'accueil de la petite enfance soit des crèches ou des écoles, soient adaptées aux publics qu'ils rencontrent pour développer par le jeu la possibilité que l'enfant s'épanouisse. Parce que si on sera dans l'épanouissement, des enfants pourront se développer de mieux en mieux, il y aura moins de risques de débordements dans les familles. Parce que il y a parfois des débordements parce que les enfants ça ne va pas à l'école etc. Les parents sont anxieux. Donc c'est un cercle vicieux. Je ne sais pas si je me suis bien fait comprendre. En tout cas le secteur de la santé mentale, on a vraiment voulu souligner ça, même dans le cadre de la réforme. (Health care providers, SSM)

- Access and support to vulnerable families

Once vulnerable families are identified, continuous support should be provided. Respondents identified several ways to do this. Expansion of the family's resources is one way: e.g. informing them about allowances, building peer support networks, etc. Respondents also suggested support in organising leisure activities, help for learning disabilities or other educational services.

Maar ik denk dat dat vooral in het preventieve een groot stuk zit: het helpen bij vrijetijdsbesteding, het helpen bij leermoeilijkheden of het aanbieden van, op een laagdrempelige manier, van wat een goede opvoeding is. Als dat iets is waardat mensen gemakkelijk binnenstappen, gaat dat iets gemakkelijker zijn om van daaruit naar hulpverlening te gaan. Dan is dat niet zo een kloof van: we gaan enkel naar hulpverlening als het helemaal misloopt. Want dat is een spectrum natuurlijk, dat wordt niet ineens heel erg, dat gaat geleidelijk. Doordat daar te weinig draagkracht is, of allee, dat zou ideaal zijn. Natuurlijk als huisarts in de eerste lijn willen we heel sterk op preventie inzetten, he. Voor ons is dat de toekomst he. Want het duurt al een paar generaties om wat er is misgelopen weer te gaan rechtzetten, dus dan kunnen we maar beter voorkomen in plaats van genezen. Maar dat vraagt een omslag in het financieringsbeleid. (GP)

On travaille beaucoup avec toute une série de situations où au détour des suivis on se rend compte que les parents sont débordés, n'en peuvent plus parce que ils sont très souvent en panne du côté de comment soutenir, cadrer et prendre plaisir à être dans le jeu avec des enfants. (Health care providers, SSM)

Lack of families' social resources could be countered by building peer support networks. This could be done by proposing the participation in group activities or programmes for young parents, before difficulties arise, for example during pregnancy. Also support groups could be proposed to young parents facing parenting problems or difficulties with their children.

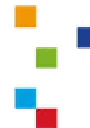
Si on pouvait tous les convoquer à un an, quand l'enfant a un an pour essayer d'avoir, ne fût-ce que des groupes de parole, je pense que ces gens sentent qu'ils vont passer la limite ou qu'ils sont énervés, le fait déjà de pouvoir le dire pourrait mettre en place certaines choses. (Emergency, Nurse)

- Family oriented approach to increase alertness for families needing help

All health care professionals, as well as professionals in education, child care and judicial services should be encouraged to develop an alertness for children/families needing help. Respondents representing these professions all emphasised the importance of awareness not being limited to health care professionals, but relevant to all personnel involved in health care in general and child care in particular. For example, professionals treating addictions or psychiatric disorders should by default gain information about the wellbeing of the children present in those families.

Specialized especially adult psychiatric care tends to be very client oriented instead of family oriented, and therefore neglect the risks for children present in the family.

Dat ze zelfs geen weet hebben van kinderen. De kloof is heel groot, vind ik, tussen de volwassen geestelijke gezondheidszorg en hoe mensen uit, met kinderen. Pas op, ik vind dat die, ik vind de laatste jaren wordt daar heel veel in geïnvesteerd, dat vind ik wel. Ik denk dat er ook heel veel met de volwassen dienst van heel veel rond samen gezeten is, gezamenlijke vormingsgesprekken, rond KOPP (kinderen of jongeren met ouders met psychische problemen); om die kinderen veel meer in het vizier te krijgen.



Ik denk dat daar wel veel rond gedaan wordt, maar ja, ik, je blijft wel elk op uw stoel wat zitten zo. En natuurlijk vanuit een kinderstoel, of werken met kinderen, ben je gewoon meer gealarmeerd dan dat je werkt met volwassenen. Volwassenen kun je ook een eigen tempo laten kiezen, maar een kind is afhankelijk van. (Health care providers, CGG)

Increasing awareness of the larger family context and seeking solutions for potential family problems may prevent abusive situations.

On organise un colloque dans quelques semaines là-dessus, je pense qu'aussi le monde de la psychiatrie adulte notamment s'inquiète souvent trop tard de la parentalité de leurs patients. Et c'est vrai que c'est un conflit entre le lien, leurs patients adultes. Et que s'ils devaient nommer: « Ah mais tiens comme je vous vois, je pense que vous avez du mal à être un bon parent ». Il y a le risque pour le lien. Mais en même temps parfois alors on laisse des situations et on se retrouve avec des enfants qui sont signalés à 8, 9 ans qui vont pas bien. Et on se rend compte qu'en fait depuis 9 ans ils vivent dans la paranoïa de leurs parents ou ils vivent avec toutes les particularités de leurs parents sans qu'il y ait rien qui ait été mis autour. (Specialized services, SOS-Enfants)

Patient-specific medical files may lack the link between different cases in one family. Respondents suggested to have a (medical) file for an entire family instead of for individual patients.

En wat dat ook zou, dat is ruimer ook he, maar op dit moment is het zo dat binnen jeugdhulpverlening, er een dossier is op naam van het kind, en niet op naam van het gezin. Dat heeft zijn voordelen, want soms verandert het, verandert de situatie en krijgen mensen een nieuwe kans, van 'zit er niet op'. Maar in sommige situaties is het echt wel een nadeel, want het kan zijn dat een gezin gekend is omwille van een aantal kinderen geplaatst. Een paar jaar later komt er een baby en hoewel die andere kinderen nog in hulpverlening zitten, wordt er niet gekeken naar: hoe gaat het nu met dat jongste kind? Dat wil zeggen dat opnieuw een organisatie, K&G of een ander, als er signalen zijn, soms de melding moet doen. Maar als het al een gezin is, dat zegt van: bij ons niet meer, het is een vrijwillige dienstverlening, wij hebben geen mandaat. Als ze ons voor de deur laten staan, wil dat zeggen dat er niemand is die ook de jongere kinderen, kijkt hoe het gaat. Soms kan het ook zijn van: kijk, het gaat goed he. Maar dan mensen ook niet het ding van: Ok, nu gaat het wel goed. Dus, er is geen gezinsdossier, dat is gerechtelijk, maar ook binnen de hulpverlening. Omdat men kiest voor een dossieropname per kind. (Prevention and health Promotion, K&G)

- Awareness raising and informing the public in general

By extension every citizen is involved. Large mass media campaigns provide relevant information by using high-impact messages alerting the public opinion and informing the public about who to contact when confronted with suspected child abuse.

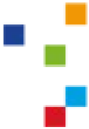
Signaler à la population qu'il y a des services compétents qui existent en cas de maltraitance. Et donc faire des campagnes de pub sur SOS ou sur …comme le fait YAPAKA. (Prevention and health promotion, PMS)

7.5.4.7 *Insufficient number of residential places*

Respondents complain about the lack of residential places for victims. There are particularly few available foster care structures adapted to young children. The participants deplore the closure of "mother-and-child" unities. In addition, there are too few institutions dedicated to minors suffering of psychiatric disorders.

Organisatorisch vind ik, is ook een moeilijkheid: het psychiatrisch aanbod in X. Eenmaal dat je de detectie hebt, of je hebt een kind met een gedragsproblematiek , dan de juiste hulpverlening op dat moment vinden, vind ik bijzonder moeilijk. Dat is echt het pijnpunt op dit moment. Ja, dan kunnen ze niet opgenomen worden of dan kunnen ze niet op dat moment uit dat gezin gehaald worden. En dan moet je die toch in dat gezin houden en dan moet dat daar in ambulante zorg liggen doen en dat vind ik soms ook, dat heb ik dan vooral over die moeder en kindzorg, als er dan vooral een problematiek is, waarbij je zegt dat kind moet eigenlijk uit dat gezin. Ehm, maar kan nog niet zonder die moeder. Dat, dat vind ik heel lastig. (GP)

Global familial support programs nurturing the bond with the child are lacking. Also the shortage in appropriate residential places in cases of emergency cause children to be sent to general paediatric wards where they sometimes stay for a long time without appropriate support. Professionals deplore long hospital stays as they are detrimental to children: they can be exposed to infectious disease, they are out of school without appropriate guidance and they need to retell their story over and over again. Professionals are aware that a hospital stay is not appropriate and even call these working practice institutional abuse.



Ze pakken dat kind mee en bij crisisopvang brengen ze die bij ons binnen, langs de spoedgevallen. Geen ouders mee, niets. Het wordt toegewezen aan het ziekenhuis. Het kind is drie weken bij ons gebleven totdat wij, nadat we anderhalve week geen ouders gezien hebben een keer informeerden: hoe komt dat nu? Waarom….? En toen bleek eigenlijk dat beide ouders in de psychiatrie in X te zitten. Het kind in Y. Dus iemand van X die belt: "waar is dat kind dat door de politie..?" Het kind had geen kleren, had geen schoenen, dat babbelde ook bijna niet. Het heeft drie weken bij ons gezeten nadat het naar het CKG gegaan is. Ja, dit is allemaal veel te traag he. Dit is ook kindermishandeling en verwaarlozing. Ja, dat zijn zo van die dingen dat we zeggen.. vroeger ging de politie meer initiatieven nemen en … via de jeugdrechtbank. (Paediatrician)

C'est vraiment pour moi le manque d'alternatives de placements…vraiment de possibilités de dire: « on met un enfant à l'abri quelques jours, quelques semaines ». Le réseau est plus que saturé. Et donc soit on trouve des alternatives mauvaises, on les place parce que on n'a pas le choix de les placer mais c'est chaotique. On rentre dans de la maltraitance institutionnelle où l'enfant est trois jours là, quatre jours là. Comme je vous disais il se retrouve trop longtemps à l'hôpital et donc est déscolarisé. Et donc on rajoute des tas de problèmes. Et alors finalement on s'étonne qu'au bout d'un certain temps l'enfant se rétracte en disant: « Vous savez, j'ai jamais rien vécu moi, surtout tout ce que je veux c'est rentrer à la maison ». Mais c'est une évidence. Donc je pense que là vraiment il y a un souci. Et qu'il faudrait des places. Certainement au niveau de l'hôpital je pense que ce serait pertinent, des possibilités de placement à l'hôpital, mais avec des places spécifiques, avec un encadrement spécifique et pas une concurrence avec des enfants malades somatiquement. Et puis des lieux d'accueil adéquats, vraiment des lieux de vie pour l'enfant. (Specialized services, SOS-Enfants)

Moreover, obtaining a hospital bed is not easy either. This is especially the case in hospitals without beds dedicated to non-medical paediatric problems, hence appropriate supervising staff. Respondents suggest extending hospital beds dedicated to the issues of child abuse and separated from the other paediatric beds. One should also consider increasing short and long-term residential places.

Et qu'il faudrait des places. Certainement au niveau de l'hôpital je pense que ce serait pertinent, des possibilités de placement à l'hôpital, mais avec des places spécifiques, avec un encadrement spécifique et pas une concurrence avec des enfants malades somatiquement. Et puis des lieux d'accueil adéquats, vraiment des lieux de vie pour l'enfant. *Avec différents modèles. Parce qu'il faut je pense des lieux de courte durée, longue durée. Tout ça, ça existe, mais c'est plein. (Specialized services, SOS)*

There is also a lack of specialized health care solutions for offenders. Increasing facilities for offenders (group therapy, residential places) appears to be particularly useful, since some perpetrators were themselves abused as children and reproduce similar behaviour.

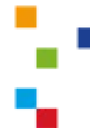
Mais l'intervention judiciaire oui. Nous ne sommes jamais que le bras armé entre guillemets. On fait le lien entre l'autorité judiciaire et les justiciables, on va dire. Donc oui. On voit une amélioration, on voit un changement de comportement et d'attitude dans le chef des maltraitants. Parce qu'il n'y a pas forcément que la sanction qui est donnée à ces personnes, il y a un accompagnement qui est mis en place. Un accompagnement qui est mis en place par l'autorité judiciaire pour justement amener ces personnes premièrement, à se rendre compte de ce qu'ils ont fait, qu'ils débriefent là-dessus. Et leur indiquer que ce comportement n'est pas acceptable. Voilà donc effectivement, on se rend compte qu'il y a une amélioration. Maintenant cette amélioration dépend du vécu de ces personnes également. Ce sont des personnes éventuellement qu'on a déjà reçu ici en tant que victimes quand ils étaient enfants. Et ils reproduisent le schéma qu'ils ont toujours vécu. (Policeman)

7.5.4.8 *Lack of coordination and continuity of care*

There is no general overview nor supervision on a national nor on a regional level. When children change schools, some specific problems are likely to occur. At present there is no registration of previous interventions and therefore also no continuity of care.

In order to prevent medical shopping enrolment in one primary care practice should be encouraged or imposed.

Ja, dat heeft zeker een invloed. ik denk dat er wel vaak met problemen naar andere artsen wordt gegaan, juist omdat, uit schaamte of om dingen niet te willen bespreken. Het feit dat we nu GMD-arts zijn, krijgen we wel sowieso



via Spoed meestal de verslagen binnen en kunnen we daar ook nadien op terugkomen, he. Wat is daar juist gebeurd? Maar ja, voor nog een hele reeks andere dingen ben ik sowieso voorstander voor een verplichte inschrijving bij één vaste arts en ook een verplichte echelonnering, dat je dan pas naar de tweede echelon gaat als je eerst de eerste gepasseerd zijt, dus ik denk dat dat er een van is, dat zou er wel baat bij hebben. (GP)

The respondents express the need for coordination of the care trajectory. Ideally, a tailored care trajectory starting from detection onwards should be followed by a case manager.

Wat wij ook al hebben gedacht, in de thuiszorg bij bejaarden, is een soort case-managers situatie, is dat een idee? Een case-manager, die dan het traject. Je meldt en dan wordt er een case-manager opgezet. Ik heb gehoord, omdat wij met een aantal zaken met radicalisering ook al eens gehoord hebben in X, wat kunnen wij doen? Stel dat je een casus of patiënt hebt die radicaliseert en die echt inderdaad ehm dat werkt nu ook via CAW met case-managers, dus misschien dat dat zinvol is? Ik weet het niet. Ik weet alleen dat dat veel geld kost en dat dat dikwijls in de plannen blijft zitten. Dus dat dat misschien niet opweegt tegen het probleem. (GP)

The respondents think that more time should be dedicated to listening to families in order to propose adequate interventions. Taking time to coordinate actions would result in more efficient interventions.

Les institutions et les structures et les personnes en place auraient plus de temps pour organiser et coordonner les choses différemment avec les services en place, je pense qu'on pourrait déjà travailler beaucoup mieux. (Prevention and health promotion, ONE)

Two major obstacles to the management of child abuse were identified by specialized services:

- The first one relates to the newly installed intersectoral access gate in the Flemish Community. Its purpose is to sort and dispatch all the requests for indirectly accessible. French-speaking specialized services are not granted access to this access gate and they have no longer the possibility to directly contact their Dutch-speaking counterpart. They have no guarantee whatsoever that those situations are taken care of and they are not able to evaluate the consequences for the families involved.

  Although the intersectoral access gate system was introduced to reduce congestion of specialised services, respondents experience it as introducing even more difficulties.

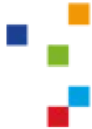
Alors deux problèmes. Donc vous ne savez pas l'atteindre sauf si vous êtes agréé portail quelque part. C'est-à-dire par exemple un service comme le nôtre on est le pendant de l'OCJ sur Bruxelles, ça pose un problème. Nous on n'a pas de portail. Moi directement si vous voulez je ne peux pas m'adresser et je ne peux pas m'assurer qu'une situation est prise en charge. Alors que les gens parlent le néerlandais, les enfants fréquentent… Ou alors c'est une situation qu'on a traité à un moment donné, les gens ont déménagé de la périphérie vers le centre etc. Ou toutes les situations qui viennent du parquet moi je leur écris: « Je ne peux plus directement etc, etc ». Bon donc on ne sait plus le faire. Portail aussi c'est… on ne sait pas. Tout ça a l'air un peu très amateur, manque de rigueur. On écrit, on n'a pas de réponse à nos courriers. (Specialized services, SAJ)

- Second according to the information available to specialized services, it is the location where the Brussels based minor goes to school that determines which Community (Flemish or French Community) will take care of him. Specialized services are confronted to situations where this rule raises questions.

  For instance if the child attends a Dutch-speaking school but his parents speak French. It is complicated to redirect the child and his family to Dutch-speaking services.

Mais ça pose plein de questions parce qu'on a des tas d'enfants scolarisés en flamand dont les parents ne parlent pratiquement pas flamand et dont la langue usuelle est le français. Donc c'est parfois compliqué de les réorienter vers l'autre système. D'autant que l'autre système c'est pas du copier coller. C'est une autre modalité de prise en charge. Tout ce qui est maltraitance passe d'office par les Vertrouwenscentrum et l'équivalent du SAJ ne coordonne pas ça. Leur équivalent du SAJ, il fait essentiellement de la coordination d'intervenants mais ne rencontre pas forcément les familles. Enfin donc pas toujours facile de s'y retrouver. (Specialized services, SOS)

Je ziet hele grote verschillen tussen vertrouwenscentra, niet als gaat over ouders en een kind, daar doet zich iets voor. Maar wel alle andere vormen van aanmelding. Wij hebben hier een fulltime apart staflid voor meldingen rond kinderen met mentale handicap en geweld. Wij hebben een aparte



werking rond vluchtingenkinderen, waar dat bijvoorbeeld heel vaak gezegd wordt: ja, maar die spreken geen Nederlands, die spreken onze taal niet. Wij werken met tolken, het gaat ons over het kind en eigenlijk interesseert het me niet of het kind Nederlands spreekt. In een land dat toenemend polariseert in die debatten en waarbij, we liggen dicht bij Wallonië, we hebben voortdurend dossiers waar bijvoorbeeld UCL, Saint Luc, Saint Pierre in het Brusselse die mensen verhuizen naar Vlaams Brabant. En ineens heb je allerlei overheden die niet meer mee willen. En dan hoop ik dat het kenniscentrum opnieuw het kind als enige centraal zal stellen en niet het paspoort van het kind. Het is schrijnend geworden dat je in dit land moet vragen: in welke provincie woont u? Welke taal spreekt u? Waar zijn uw ouders ingeschreven? (Specialized services, VK)

7.5.4.9 *Lack of data registration*

According to the respondents, a systematic registration and centralisation of all medical reports and data, allowing to track the patient's itinerary, may improve the detection and management of child abuse. However, the use of such tools raises ethical and legal questions. The interviewees raised for example the problem of the balance between patients' rights and assistance to people in danger.

Donc en tout cas le shopping médical ma foi c'est pas tant le shopping médical qui est un frein pour moi c'est l'impossibilité actuelle technique qu'on a d'avoir accès à tous les dossiers dans tous les hôpitaux. Pouvoir faire du recoupement….Le réseau santé wallon va nous aider. Ce qui manque c'est de pouvoir avoir accès par exemple, un enfant vient pour une fracture, imaginons. Et puis je me rends compte que dans l'hôpital dans lequel je travaille il est déjà venu quatre fois pour des accidents, des chutes, des brûlures, ça je sais le voir. Mais je sais pas voir si il a fait pareil avant. Ce qui manque je trouve, c'est la possibilité, ça commence avec le réseau de santé wallon mais de pouvoir avoir accès directement alors, peut-être selon certaines conditions de confidentialité, presque du secret professionnel. De voir si par exemple le même enfant a été vu dans d'autres hôpitaux de Belgique ou en tout cas de Wallonie pour des faits d'accident (Specialized services, Paediatrician)

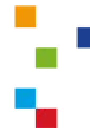
Without registration and central accessible data coordination and overview is extremely difficult to attain as families hop from school to school, GP to GP, use several emergency services, move often, do everything, to make sure nobody would become suspicious.

Ja, heel vaak nog voor we gemeld hebben. Dus wanneer dat ze voelen dat het warm wordt, veranderen ze heel vaak van school. Nu is het wel zo dat met de elektronische dossiers, dus de dossiers worden binnen de tien dagen overgegaan, dat we ook echt actief op zoek gaan naar waar die kinderen zijn. De nieuwe school moet ook melden aan de oude school dat ze ingeschreven zijn en dan nemen we wel contact op met het CLB. We proberen dat wel. Want anders beginnen die helemaal terug opnieuw. Eens dat die dan gezien hebben dat er iets aan de hand is, dus dat gebeurt niet meer. We nemen wel contact terug op. (Prevention and health promotion, CLB)

Registration and accessible data is also necessary in function of follow-up and continuity of care/support. Professionals should be able to consult a platform to check which interventions already took place in order not to start all over again. On the international level, tools such as trauma check lists exist to assess the risk but they are not translated and validated in the Belgian context.

Twee is dat testbatterijen die in het buitenland eigenlijk ruim toegepast worden, traumachecklists, er is er geen enkele die gevalideerd is door Vlaamse jeugd. We hebben er wel een paar die vertaald zijn, maar dat zijn Amerikaanse standaarden, want dat betekent dat de overheid een budget zou moeten geven dat men dat men dat kan standardiseren en daar een paar honderd Vlaamse jongeren in kan betrekken. Daar hebben we nog nooit de overheid toe gemotiveerd gekregen. Er bestaat geen onderzoeksfonds kindermishandeling in België. Ik heb er verschillende keren met Koning Boudewijnstiching over gesproken en die zeggen: wij krijgen daar geen mensen voor gemotiveerd. Men vindt dat een negatief thema. Het is niet zo fijn om mee in het publiek uit te komen. De pers, de media zeggen: kom op tegen kanker, kom op tegen kindermishandeling. Nee, dat is te negatief. Daar willen mensen niet naar kijken. Mensen willen die verhalen niet zo horen. Dus wij zijn ook wel erg afhankelijk van de steun van een overheid. (Specialised services, VK)

The respondents also pointed at the lack of aggegrate data on child abuse to gain further knowledge of the issue, particularly regarding the mechanisms and the ethical questions involved.



Je pense qu'il faut surtout vulgariser la pathologie, sensibiliser sur le fait que on a très peu d'études par exemple. On a très peu de chiffres parce que tout n'est pas signalé, on a très peu de chiffres parce qu'il y en a qui passent au bleu, on a très peu de chiffres parce que il faudrait pouvoir recouper les données…. D'ailleurs c'est assez parlant quand on voit les quelques études qui sortent en maltraitance et qu'il faudrait avoir des bases de données beaucoup plus larges avec des études beaucoup plus multicentriques. Mais alors ce qui est bloquant notamment dans les pathologies traumatiques style syndrome du bébé secoué c'est que particulièrement là le syndrome du bébé secoué il y a plein de situations où on ne connaît pas l'auteur au moment où nous on a l'enfant dans notre milieu hospitalier. C'est qu'il faudrait qu'on puisse plus collaborer avec le milieu judiciaire pour avoir quand même un peu accès au secret de l'instruction. En tout cas avoir accès à ces données-là. (Specialized services, Paediatrician)

7.5.5 Resistance of the target group hampering professionals' assessment and decision-making

Family members employ several strategies to hide the abuse and convince professionals that everything goes well:

- Denial or minimization by the parent: they stop talking about the issue; they try to get themselves out of the picture; they "manipulate" the person dealing with the case by trying to convince him/her that the situation is evolving positively.

Ca peut entraîner soit un déni, une minimisation en disant: « Oh j'étais juste un peu énervé, je t'ai téléphoné comme ça, mais c'est fini tu sais, je vais beaucoup mieux ». Et donc il faut vraiment à la fois la déculpabiliser et pouvoir la sortir de ce déni en disant: « Ecoute, je peux tout à fait comprendre, on a tous des moments où on jetterait bien notre enfant par la fenêtre ». C'est mieux que ça reste au niveau du fantasme. Et voilà il y a le déni, la honte qui peut faire en sorte qu'effectivement soit elles viennent plus soit elles en parlent plus, soit elles essaient de nous faire oublier la situation et de nous montrer de l'eau de rose, petite fleur bleue et « mon bébé va super bien et moi aussi », quoi…. parce que ces familles font tout pour ne pas qu'on voit, pour ne pas qu'on pense, pour nous berner. Et c'est pas évident à ne pas se laisser berner, quoi. (GP)

- Denial or minimization by the child: children try to protect their parent(s) or sometimes defend their parent(s) because they prefer to stay at home.

L'enfant aussi participe au déni en protégeant bien son parent et en nous montrant bien que papa ou maman est vraiment très gentil. Et que s'il sent qu'on est en train d'imaginer des choses ou s'il nous dessine pendant la consultation quelque chose qui nous ferait penser qu'il est en danger et puis après il va nier, donc c'est vraiment très compliqué. Alors est-ce qu'on va avec un petit indice ou une petite suspicion tout de suite contacter des instances ou ne fusse qu'un service de santé mentale ou pas ? C'est tellement souvent flou ces situations-là. Donc ça fait partie, oui, de l'obstacle en lui-même. (GP)

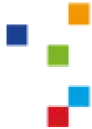
- The perpetrator or family have mixed feelings about the assistance they are being offered.

Et donc on est tout le temps en train de travailler avec ce double discours que les parents nous offrent très souvent dans ces situations. Donc c'est: « touchez-y mais ne touchez pas… Ils ont envie qu'on les aide, ils ont envie d'être soutenus. Enfin à certains moments plus que d'autres mais enfin voilà. Mais en même temps ça fait très peur. Ça fait très peur parce que: « est-ce qu'on va pas de nouveau me trahir, est-ce qu'on ne va pas de nouveau me lâcher ? (Prevention and health promotion, ONE)

- The perpetrators or families do not cooperate or refuse help.

Enfin force est de constater qu'il y a quand même pas mal de situations où il y a clairement pas de collaboration, il y a un refus de l'ensemble des services. (Prevention and health promotion, ONE)

These practices create confusion and necessitate a long term approach. According to respondents, getting the family to collaborate is a slow process. Its success depends on building confidence between the family and the professional.



- Medical shopping and school hopping

Respondents report also that the closer professionals come to the identification of abuse, the more these families engage in medical shopping and school hopping. They visit different health care providers and emergency services. Children from one family attend different schools. Families move from one city to another to avoid surveillance and confrontations. For other families this appears to be a way of living and essentially reflects unstable lives.

Oui, il y en a quelques-unes qui sont un peu spécialistes. Mais moi je ne sais même pas si c'est pour fuir le SAJ. Je crois que ce sont des gens qui sont instables et qui au fur et à mesure de ce qui leur arrive dans la vie vont à Liège, à Gingelom, dans les Ardennes et puis parfois partent, allez… Oui, oui, je crois que c'est plus dans le fonctionnement de la famille, des personnes, que vraiment de se dire… (Specialized Service, SAJ)

Ja, dat is een probleem. Ook het gemak waarmee ze het afschudden of van ziekenhuis veranderen. Maar het zijn wel de elementen, waarom kom je in een complexe situatie tot geweld? Daarin speelt die fragmentatie heel vaak mee een rol. Je ziet ook het schoolshoppen. Het proberen af te schudden van de bemoeienis van het CLB en zo. Het behoort eerder tot de symptomatologie. Zelfs mensen die zich ingeschreven hebben bij een huisarts durven veranderen en zo. Dus ik denk, wij zijn natuurlijk georganiseerd op de maximale gezondheid van mensen. Dus ik zie niet goed wat je daar structureel aan kan doen. (Specialized services, VK)

According to preventive services in schools their regular medical check-ups facilitate child abuse detection. However, their impact remains limited because of its low frequency and taking into account mainly physical aspects.

Les infirmières les voient quand même en slip et en chemisette… Donc tout le monde est quand même attentif… on n'est pas dans les écoles et qu'on ne voit pas les gosses, qu'on ne les voit qu'un an sur deux. Donc si on ne se base que sur nos constats de visites médicales, c'est qu'un an sur deux. Donc entre les coups, ils peuvent passer entre les mailles d'autant plus s'ils changent d'école et que le dossier il se perd… c'est aussi difficile de voir le changement de comportement. (Prevention and health promotion, PSE)

Moreover, the attendance rates of potentially abused children drop when medical examinations are announced to the parents, especially among young children.

Interviewer: Parce que programmé, il va pas le mettre de toute façon.

Respondent: Voilà de toute façon, ça c'est certain.

Interviewer: Alors « «non, tu n'iras pas à la visite médicale ».

Respondent: Déjà dans les maternelles quand on convoque 40 gosses, on en a 25. Les gens: « Ça ne sert à rien que tu vas à la visite aujourd'hui ». Et c'est généralement de nouveau dans les milieux qui en auraient le plus besoin. (Prevention and health promotion, PSE)

Preventive school services consider the possibility of organizing additional medical examinations for pupils suffering from abuse, with the school directors consent. They are aware however that not informing the parents may lead to legal action.

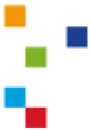
7.5.6 Typology of involvement in dealing with child abuse

Specialised centres confirmed the important role of primary care providers to be alert for and to detect child abuse, but not everyone is committed to the same degree.

Les généralistes disaient que « c'est pas de notre domaine, on n'est pas compétent là-dedans ». J'hallucinais, quoi. Mais peut-être plus dans l'ancienne génération. J'ose espérer que les nouveaux et les nouvelles médecins… (GP)

Professionals react differently to the suspicion of child abuse. In addition, professionals go through several stages of involvement. From the analysis of the qualitative data we distilled five stages of involvement in assessing the situation and the decision to take action. A professional might be in different stages regarding different cases. Also not every professional goes through all stages.

- The **uninvolved** do not identify abusive situations. They are convinced that it does not happen in the families they encounter.
- The **avoidant** do identify or detect situations that raise their suspicion, but they do not take any action to try to help.



- The **initiators** detect and attempt to share their worries with the child or family in order to mobilise resources or to help them.
- The **reporters** detect, do not approach the child or family, but report their suspicion directly to specialised services, the hotline, police or justice.
- The **persevering**, detect, try to help, and end up reporting.

These five stages are likely to be associated with different kinds of barriers in the process of identifying, approaching and/or reporting suspicion. Also the stage refers to kinds of resources available, such as access to a network, experiences, knowledge about who can be contacted for advice etc. In table 11 we link some examples of barriers to the typology. However, linking a barrier to a stage, does not completely exclude it for other stages, there is a certain overlap.

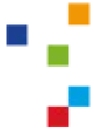


Table 10 — Stages in the responses to the suspicion of child abuse

Types of professionals	Uninvolved	Avoidant	Initiators	Reporters	Persevering
Identification/detection	no	yes	yes	yes	yes
First approach	no	no	yes	no	yes
Report	no	no	no	yes	yes
Typical barriers	• Aversion to see • Misconceptions about risk factors	• Feel unable to address the suspicion // lack of training • Fear of losing the family • Fear of doing more harm than good • Lack of time • Misconceptions about what to expect from specialised services • Negative experiences with specialised services	• Reporting is stressful and generates fear • Professionals try to balance assistance to people in danger and professional secrecy	• Feel unable to address the suspicion // lack of training • Fear of losing the family • Fear of doing more harm than good • Lack of time	• Limitations of voluntary participation • Difficulty of risk assessment and case management • Professionals try to balance assistance to people in danger and professional secrecy

7.5.7 Regional specificities in dealing with child abuse

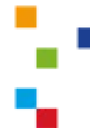
We deliberately chose regional accents instead of regional differences, because this chapter is a mix of organisation-related differences and issues which might coincidently be mentioned by respondents of one region and not by respondents of the other region.

7.5.7.1 *Specificities for the French Community*

Collaboration between specialised services and other institutions/professionals encounters many difficulties

Currently, collaboration between specialised services and other institutions or professionals is not always optimal and several barriers hampering collaboration were mentioned:

- **Difficulties to establish a partnership between specialised services and health care providers**



Even if specialized services mention good collaboration with some care units, it is difficult to build a joint intervention with the medical world.

Extrêmement difficile je veux dire de s'inscrire dans un partenariat avec le monde médical. Et je pense aux équipes SOS. Puisque un de nos grands pourvoyeurs, ce sera peut-être une question après, c'est quand même je dirais non pas les équipes SOS mais tout ce qui est milieu hospitalier évidemment. Il y a une explication à ça aussi d'ailleurs qui est plus structurelle. Et le parquet. Mais donc le pouvoir médical a extrêmement difficile de co-construire une intervention avec tout ce qui est socioéducatif. (Specialized services, SAJ)

Several reasons explain this situation:

- the difficulty to meet face-to-face with the medical community and establish a relationship.
- the lak of trust andc recognition of the socio-educative sector that is not granted legitimacy by the medical world. The medical community tends to consider it as an epiphenomenon of the judicial sector.

Le socioéducatif est un tiers pour le médical à la limite un espèce d'épiphénomène qui va un peu polluer je dirais le système…..Le monde médical ne fait pas confiance au socioéducatif. (Specialized services, SAJ)

- Professional secrecy is sometimes used as an excuse.
- Specialized services observe a shift in attitudes among professionals after reporting: when they have reported, they feel no longer responsible for the situation. They see specialised services as a general problem solver. This unrealistic expectation impairs collaboration of the frontline workers with specialised services.

Et ça parfois aussi je trouve dans les intervenants psychosociaux, il y a un peu ce fantasme de dire: «on leur a refilé la patate chaude, on n'est plus responsables». Donc eux sont un peu allégés et donc surtout que eux gèrent, éloignent, placent, punissent. On a un peu aussi cette idée que SOS va tout faire, tout résoudre, mettre tout le monde à l'abri. (Specialized services, SOS).

- Lack of clarity concerning the videotaped auditions' terms and delays

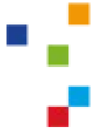
Specialized services reveal that they ignore the reason why the delays and the terms of videotapes auditions are so variable from one occasion to the next and from one prosecutor to another. As specialized services are obliged to wait for the child until he/she is auditioned before meeting him, the timing of their intervention depends on a timetable and procedures specific to each judicial district. As a result, the psychosocial approach is put on hold. Families feel that they have been left behind.

Parfois ça met du temps. Parfois on se rend bien compte que ce temps-là était nécessaire. Par exemple quand il y a plainte et qu'on ne peut pas nous rencontrer l'enfant directement. Il faut qu'il soit d'abord audio-filmé. C'est un accord tacite qu'on a avec les inspecteurs qui préfèrent qu'on ne voit pas l'enfant. Et donc parfois, il se passe du temps. Il peut se passer quelques mois où l'enfant a besoin d'aide et on peut pas le voir où on ne peut pas commencer à travailler donc oui. Ce qui est difficile, c'est qu'on ne sait pas d'une fois à l'autre, comment ça va aller. On se dit parfois, ça va pas aller vite, et puis le lendemain l'enfant est déjà là. Et puis d'une fois à l'autre un peu comme ça sans trop… Evidemment d'un parquet à l'autre, ça diffère aussi entre X et Y. Z, c'est pas les mêmes délais non plus. C'est un peu lent, quoi. Et pour les familles, c'est difficile parce que ils disent: « on ne nous aide pas ». (Specialized services, SOS-Enfants)

- **Lack of uniformity in the management policies of institutions**

Some SOS teams interviewed say that they work with several SAJ/SPJ, whose intervention policies can be different. Consequently, their workload increases. However, several initiatives have been taken to improve inter-institutional and inter-professional collaboration:

Oui, oui mais on a la difficulté de travailler avec trois SAJ-SPJ. Enfin il y a X, Y, Z. Donc c'est un petit peu plus compliqué. On ne dirait pas que c'est…il y a certains SAJ-SPJ qui font moins appel à nous que dans certaines régions que d'autres. Donc c'est pas toujours si facile que ça, nos relations… Donc ça nécessite (soupir) un travail de réseau plus important que si on avait qu'un SAJ et un SPJ, quoi c'est ça. (Specialized services, SOS-Enfants).



- **Cross-sectoral collaboration protocols**

In response to tragic events, various collaboration protocols were established (with ONE, SOS-Enfant teams, Preventive services PMS, doctors….). They have a protective effect because they allow for better interpersonal knowledge exchange, mutual understanding of everyone's role and continuity of care. They are also an opportunity to debate the shared professional secrecy, in order to be able to discuss cases in an efficient and law-abiding manner.

Ces protocoles, ils permettent aussi une espèce de compréhension mutuelle des rôles de chacun, ça facilite évidemment la collaboration. Je pense vraiment que, allez, cette politique actuelle de mettre en place des protocoles et de faire se connaître les intervenants entre eux a quand même un effet de protection par rapport aux enfants. (Services for Judiciary Protection, SPJ)

SAJ insists that these protocols should not decrease accountability but should nurture trusting relationships.

Vous pouvez faire les plus beaux protocoles, les plus beaux décrets. Tout ça ne s'impose pas aux gens. Il faut les nourrir. Et nourrir je dirais ce cadre plus formel, ça ne se fait qu'au travers des relations de confiance, d'accord ? (Specialized services, SAJ)

Specialized services insist on the necessity to develop protocols, especially in hospital situations or when facing different intervention policies (SAJ/SPJ)

- **Coordination commissions for child victims of maltreatment**

Known as "Commissions Coordination Maltraitance", these organs facilitate the collaboration between services engaged in child abuse management. The respondents highlight their role in providing support, information and doing interventions to solve conflicts between departments. The commissions bring together all the actors who, in the end, know each other better.

La Commission Coordination Maltraitance qui a été… suite à ma réunion explosive où j'ai été vraiment très maltraitée par l'hôpital ainsi que l'équipe SOS, je trouvais ça scandaleux… moi j'en ai parlé à la commission. Et du coup la commission est allée trouver le directeur de l'hôpital qui a accepté qu'on ait une réunion et voilà. Et on en a discuté avec l'ensemble des personnes de la commission. (Specialized services, SAJ)

- **Efficient collaboration with forensic doctors**

The good collaboration with the forensic doctors is valued: it helps to prepare a more complete legal file.

On a une bonne collaboration avec certains médecins légistes de la région liégeoise où, quand on peut le faire, on essaie d'examiner les enfants ensemble. On se tient au courant des informations médicales. Et si par exemple il y a une IRM prévue après le passage du légiste, on est en lien et donc on donne les informations au légiste pour que lui, sur le versant judiciaire, puisse alimenter son dossier. (Specialized services, Pediatrician)

Insufficient information exchange

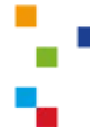
- **Information exchange is not optimal**

For SOS-Enfant teams, networking and the exchange of sensitive information between professionals is completely justified in situations when a child is in danger. This is generally well accepted by parents and medical professionals. However, SAJ finds it difficult to obtain the information needed for risk assessment, even if the doctor is the reporter.

Les médecins puissent peut-être aller un petit peu plus au-delà dans leur secret médical. Parce que ce n'est pas le secret professionnel, hein, c'est le secret médical. Mais qu'ils puissent se permettre de dévoiler certaines situations où ils estiment que l'enfant ne va pas bien… Mais que parfois ils signalent des situations aussi, hein. Ou qu'ils acceptent de nous dire un petit peu de renseignements sur la situation quand on la reçoit et que il y a un problème médical ou un problème …voilà, qu'on puisse parfois avoir un petit peu plus de renseignements qui nous permettent de déterminer le danger dans lequel se trouve l'enfant. (Specialized services, SAJ)

- **Lack of feedback to the reporter**

Front line workers complain about the lack of feedback from specialized services. From the moment health care providers report a case, they are no longer involved in the procedure. With this feedback missing, they cannot validate their reporting work nor assess the appropriate level of vigilance.



Si la thérapie ou si les mesures s'arrêtent ça peut nous aider de savoir qu'elles se sont arrêtées. De un, on le sait voilà et donc on peut déjà peut-être déjà se dire « ben ça a marché ». Il ne faut peut-être pas toujours se dire que ça va recommencer. Et être attentif dès que quelque chose recommencerait. Or si on ne sait pas, on ne sait pas être attentif. (Prevention and health promotion, PMS)

Police also deplore poor feedback which creates tensions and misunderstandings with families during home visits carried out to ensure the follow-up of legal cases. Specialised services are aware of this problem and of the resulting perceived inaction by reporters. They remind us that in this matter, they comply with the conditions of the law on shared professional secrecy (agreement of the family, best interests of the child).

D'abord il y a la difficulté que de nouveau le respect du secret professionnel fait qu' on peut prendre en charge la situation familiale et on n'est pas obligé de faire un retour à l'envoyeur. Donc ça c'est souvent difficile. Parfois l'envoyeur se dit: « Ils n'ont rien fait ». Mais simplement la famille nous dit: « Mais vous savez, j'ai perdu confiance dans l'école ou quoi, d'ailleurs mes enfants changeront en septembre. Je ne veux pas qu'il y ait un retour à ces professionnels ». Or le secret professionnel partagé, c'est seulement dans l'intérêt de l'enfant. Si cet enfant n'est plus scolarisé et n'a plus le même PMS, c'est de la pure CURIOSITÉ que d'informer le PMS. (Specialized services, SOS)

They insist on the importance of trust when one refers to specialised services and when contacting them again in case of new suspicions. However, they recognize flaws and suggest that an initial courtesy contact (only to communicate that the case is being cared for, without any details) could foster a constructive future collaboration.

En arrivant à SOS Enfants, j'ai fait une étude sur justement les retours des différents intervenants et leur vécu par rapport à ce que nous on faisait. Donc ce qui est ressorti de cette étude, c'était important d'au moins appeler pour dire qu'on n'a rien à dire. Donc essayer quand même de maintenir. Donc rappeler le PMS. « Vous savez on a pris cette famille en charge, voilà je ne peux rien vous en dire parce que c'est le secret professionnel et que je suis pas dans les conditions pour vous en dire. Mais sachez qu'on est intervenu». On s'est rendu compte que déjà rien que ça, ça aidait déjà énormément. Mais c'est vrai que c'est pas toujours possible, que on est parfois pris par notre ligne…Qu'il y ait des défaillances, je veux tout à fait bien le reconnaître. (Specialized services, SOS)

Lack of resources and residential places disarm judges

Judges and specialised services feel disarmed because several factors restrain their interventions. Lack of resources and residential places, de need for informed consent and lack of information transfer were mentioned in the interviews. Judges claim being unable to fulfil their mission because of a lack of resources.

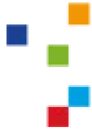
Mais je pense qu'on est tous conscients de pourquoi on fait ce travail-là. Je pense que personne dans l'équipe ne s'est dit un jour je vais travailler en maltraitance sans s'interroger au minimum sur ce qui fait que… on est bien au clair avec le fait que on n'est pas justicier, on n'est pas la police. « La cellule maltraitance, ni Zorro ni Don Quichotte ». C'est pour vous dire. Donc je pense qu'on est bien au clair avec ça. Ce qui ne veut pas dire que comme toute équipe on ne peut pas être mis à mal par certaines situations. Parce que les situations sont multiples et peuvent avoir de multiples facettes. Donc forcément on peut être mis en difficulté. Mais voilà globalement l'équipe est assez au clair par rapport à quel est notre rôle par rapport à la situation. (Specialized services, Paediatrician)

C'est épouvantable. Pour le moment on doit vraiment faire ce qu'on peut de brique, de broque et de bouts de ficelles. (Specialized services, SAJ)

Judges claim to be powerless to apply mandatory help to teenagers. Two major reasons contribute to this situation:

- Currently teenagers agreement is sought before placement.

Mais j'ai pas les moyens parce que quand il y en a il y a une difficulté de travailler dans le cadre de la contrainte. Si vous parlez d'une institution de placement, disons, une institution d'aide à la jeunesse, donc on est tout à fait hors secteur délinquance là, la philosophie est plutôt de travailler avec des jeunes qui sont en demande, ou un peu en demande, avec des parents qui le sont aussi. Bon et très peu de travailler avec des jeunes à qui on impose une mesure de placement. Je ne dis pas que c'est impossible, mais c'est très difficile. Et donc nous nous trouvons dans la situation paradoxale, nous, juges de la jeunesse, d'essayer d'avoir l'accord du jeune. Bon, parfois en bluffant: « Bon écoute, t'as pas le choix ». Mais on sait très bien que si



il dit: « clette », bon… Et donc de bluffer avec lui en disant: « Tu vois, cette procédure d'admission… ». Et puis bon, en espérant aussi que l'institution va à ce moment-là créer le lien. Bon mais c'est pas toujours le cas. (Judges)

- Medical services and childcare facilities tend to refuse them and send them to other institutions because of:
  - an actual lack of means
  - a lack of information about the means of the judge
  - a lack of knowledge about the field (over/under estimation of their own management capacity)

Et que l'unité machin brol à côté de chez eux est mieux outillée qu'eux. Ça c'est classique ça. Mais l'unité machin brol pense exactement l'inverse évidemment. Parce que personne n'a envie de prendre ça. C'est toute cette frange de population qu'on ne parvient plus à gérer et à traiter et à aider. Parce que personne n'en veut. (Judges)

  - excessive specialization of the support

Judges end up closing the case. They denounce this type of institutional abuse and are concerned about children and adolescents sent back home despite the judge's decision, without any follow-up.

Et donc en tout cas j'ai fait une proposition de clôture du dossier au Parquet même si je suis conscient que cette fille est en grand danger donc, pour moi en tous les cas. Enfin non, je suis sûr que vous partageriez mon avis si vous lisiez le dossier, c'est sûr. On arrive dans une impasse totale, alors qu'on est dans l'aide contrainte où le système légal, théorique, veut que je ne devrais pas arriver dans cette impasse puisque moi je devrais pouvoir imposer ma mesure qui par ailleurs devrait être miraculeuse, hein… C'est toute cette frange de population qu'on ne parvient plus à gérer et à traiter et à aider. Parce que personne n'en veut. Personne n'en veut. (Judges)

Criminalisation equals slow procedures and emotional burden

According to specialised services, criminalization of child abuse requires an additional reflection and may not be the best solution for the following reasons:

- **Criminalization implies a heavy and slow procedure.**

Once the complaint has been made, the child must be questioned during a videorecorded interview before any contact with support services can take place in order to avoid any "contamination" of the child's testimony. Specialized services complain that the system is slow and delays urgent help to the child. The waiting time for the interview is variable and depends on the prosecution bureau; sometimes the procedure is expedited, sometimes it takes more time. This has an impact on psychosocial support which is suspended by the judicial procedures.

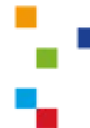
- **Judicial procedures are emotionally heavy and may not have the result the family or the child is hoping for.**

Est-ce que ça fait du bien à un enfant, à une famille de faire une démarche assez lourde vers la police…pour voir la plainte classée sans suite, voire un non-lieu parfois ? ». Bon, donc c'est pas sans conséquence. On croit parfois que simplement le fait d'aller porter plainte, on va être entendu, on va nous donner raison etc. (Specialized services, SOS-Enfants)

Involving the police may have a beneficial symbolical effect on the child. The severity of the abuse the child has endured is thereby recognised but children are ambivalent towards these institutions, especially when the perpetrator is a parent. The victim may not necessarily wish to have his parent(s) punished, but only for the abuse to stop.

Specialised services highlight inconsistencies between protection services and the judicial system. A good example is sexual abuse of a child by the father. When the child has been interviewed, the magistrate in charge of the investigation wishes that elements from the child's interview remain undisclosed to the perpetrator prior to his interrogation. However the child's father, even if he is the perpetrator, has access to his child's case file.

Moi j'ai déjà eu des cas aussi parfois où le système se mord la queue parce que on a un dossier protectionnel pour l'enfant. Où on évalue une question d'abus sexuel par le père. Mais le père avec son avocat a accès au dossier chez la juge de la jeunesse protectionnelle. Mais en attendant il y a une instruction. Et il va être auditionné. Or on sait bien que les magistrats aiment bien qu'à l'audition l'auteur présumé en sache le moins possible sur les allégations. Mais notre coco, il est allé avec son avocat, il est allé lire tout notre rapport sur les allégations de son enfant. Il a le droit, il est le père. Et



la procédure est en cours au niveau de la plainte. Ben voilà, ça pose questions. Mais en même temps c'est son statut de papa qui lui donne droit à avoir accès. Juridiquement tout est respecté mais voilà ça rend le cas du (Specialized services, SOS-Enfants)

Respondents voice similar concerns when they deal with siblings from different fathers or with siblings born after a judicial decision. In these scenarios the perpetrator may collaborate for only some of the children.

On a aussi des systèmes, pour vous montrer là où ça coince, on a des fratries où deux de la fratrie dépendent du juge et un dépend du SAJ. Parce que c'est par exemple pas le même papa. Alors le papa est collaborant dans un cas donc le SAJ doit garder. Mais dans les autres cas, non. Ou l'enfant est né après la judiciarisation des premiers. Donc comme c'est né après, le juge ne peut pas s'autosaisir d'un dossier d'enfant pas né ou à naître. Et donc il faut d'abord ouvrir au SAJ. Donc on a des parents avec lesquels on estime qu'on peut négocier, collaborer au SAJ pour un enfant et pour le reste de la fratrie pas. C'est complètement aberrant, hein. Donc le système est très complexe en soi et je pense qu'on ne sait pas éviter des espèces de quiproquos, d'incohérences. (Specialized services, SOS-Enfants)

Double reporting strategy in reaction to slow procedures

Preventive services usually pass cases to specialised services (SAJ), not directly to the Judge. In acute situations, too much time is lost and too many persons intervene.

Et donc on leur dit: « Ben, on va aller au SAJ ». Enfin ils nous disent très clairement qu'ils n'en veulent pas depuis le début. Donc on est obligé de passer par là. Et donc ça dans les situations où il y a de l'urgence, où il y a des enfants en souffrance ça fait de nouveau beaucoup de temps et beaucoup d'intervenants sollicités pour plein de situations on le sait déjà, qu'on aurait été au Parquet, qu'on pouvait encore aller au Parquet. Et que maintenant on ne peut plus aller au Parquet. On est obligé de passer par le SAJ. (Prevention and health promotion, ONE)

To speed up the process health care professionals often do a double reporting**.** This means they report simultaneously to the judge and specialised services. They believe it gives more weight to their action and hope it will be taken serious both by the authorities and the family. Specialized services (SAJ) however claim that double reporting undermines the efficiency of the procedures even further. Moreover it disrespects the procedures as established by legal authorities, reflecting a lack of trust between the parties involved. Non-compliance with working procedures is considered detrimental for many reasons. It is a waste of time because currently all cases are referred back to specialised services (SAJ). This leads to congestion and complaints at the judicial level.

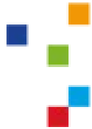
This strategy of bypassing social authorities creates confusion for the family and the risk that their basic rights are ignored.

I: Vous m'avez parlé de double signalement où il y a un manque de confiance. R: Oui des stratégies de contournement et donc créer des confusions dans les systèmes, je veux dire où les gens s'y reperdent aussi. Il y a un problème de lisibilité alors évidemment aussi. Je vous parle d'une mécanique, il y a des trajectoires à suivre mais ça c'est pas fait pour les chiens, les trajectoires. Ce sont des procédures. Et les procédures ça veut dire aux gens: « voilà où on en est ». Donc en termes de respect de droits, mais oui de rassurer des gens. Parce que alors vous êtes dans un espèce de magma indifférencié que chaque acteur peut utiliser à sa guise. Un jour, on ne sait pas pourquoi, on va signaler là, un jour on va signaler là etc. Mais de savoir aussi que votre dossier est en investigation ou que votre dossier maintenant il va passer devant le conseiller, aucun suivi etc. Les gens aussi ils ont des droits qu'ils peuvent activer à des moments venus. Se faire accompagner par un avocat ou que sais-je etc. C'est ça une procédure aussi, vous comprenez. Bon, c'est pas simplement pour emmerder les gens. Et c'est aussi pour apporter de la rigueur dans le travail. (Specialized services, SAJ)

Insufficient support measures for staff specialised services

Respondents confirm that some of the institutions set up measures to support their workers: training sessions, logistic units, and additional staff in crisis situations.

Donc mon idée, on a une cellule de prévention qui ne fait que deux ou trois personnes. C'est un peu comme si vous aviez un peu, dans le management on dit… une structure logistique, enfin une infrastructure un peu logistique intellectuelle. C'est-à-dire que ma question avec la prévention c'est de dire: « Comment on peut aider des délégués à faciliter et améliorer leur travail ?».



Et notamment en les informant au mieux. Que ce soit sur les outils, sur les structures. (Specialized services, SAJ)

Pendant ce certain temps on peut, et ça, notre direction est là également pour nous soutenir, peut mettre à notre disposition d'autres membres du personnel, voilà. Donc automatiquement… (Policeman)

Nevertheless, respondents deplore cost-saving measures imposed by subsidizing authorities (French Community , Ministère de la Justice): non-systematic renewal of the retired staff, refusal to continue collaboration when not paid (which undermines work with collaborators) and refusal to finance supervisions.

Elle a de moins en moins de moyens et elle est obligée de cadenasser un peu. Alors les paiements ne suivent pas, les services ne veulent plus travailler avec nous parce qu'ils ne sont pas payés. Voilà, c'est tous les problèmes qu'on a maintenant. A l'administration ils ont les mesures qui est: un remplacement pour cinq pensionnés. (Specialized services, SAJ)

7.5.7.2 *Specificities for Flemish Community*

Collaboration between specialised services and other institutions/professionals is impaired by lack of information sharing and feedback

- Unfulfilled expectations, control loss and lack of feedback at the nexus between health care providers and specialised services

Often health care providers are not aware that asking advice from a specialised service (VK) is considered reporting. Specialised services (VK) often stimulate and support health care providers to continue the process they started, but this may violate the expectations of the care providers who mostly contact the VK as a last resort. At that point they usually have already exhausted their own resources and capabilities. This leaves care providers with the impression that specialised services (VK) take up fewer cases than in the past.

Ik denk dat onze ervaring ermee te maken heeft, omdat we zelf een heel uitgebreid stappenplan hebben. Dat we zelf een heel stuk opnemen: wat kunnen we doen, hoe kunnen we dit opnemen en zo meer. En dat de situaties die we dan melden aan het VK, diegene zijn waardat we echt wel verwachten van het VK dat ze effectief stappen ondernemen. Terwijl dat er heel wat, in het geheel van de meldingen, vragen zijn naar advies en dat we dat voor een deel zelf ook opnemen. Ik denk dat dat een van de grote elementen is waarom dat we veel minder dan vroeger doorverwijzen. Als we doorverwijzen, dan gaat het over: en hier verwachten we, we hebben hier wat vastgesteld, als we doorverwijzen dan zitten we zelf met de handen in het haar: pak het nu over! En onze ervaring is ook van: als we melden met een situatie, waar we nog mogelijkheden zien, ja, dat we nog zelf benutten en dat we. In die zin zijn we slecht voor de cijfers van het VK en ligt dat ook zeer gevoelig, dat we zo weinig melden, maar u vraag daarstraks was: heeft de ervaring daarmee te maken? Ja, de ervaring heeft daarmee te maken: als we ons niet geholpen voelen, dan melden we niet om cijfers te geven! Als we melden, willen we dat er effectief iets mee gebeurt. (Preventive and health promotion, K&G)

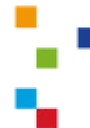
However, at the same time health care providers experience control loss once judicial services are involved. From that time it is out of their hands and they get no information about what happened with a child or a family.

Een gerechtelijke melding, daarna daar heb je geen controle meer over. Dan kan je alleen nog samenwerken, eens er een consulent is aangesteld, rond hulpverlening: wat stukje nemen wij op, wat jullie? Maar daar heb je geen enkele controle meer: het gerecht zegt ook vanaf dat je een melding hebt: vanaf hier nemen wij het van u over. dat is heel duidelijk, he. En dan weet je van: ik heb daar geen, in beslissingen he, wat je dan doet naar contacten met ouders, daar heb je natuurlijk nog zelf wel controle over, dat is iets wat je nog zelf in de hand hebt, maar wat er gebeurt, de beslissing die genomen wordt, die liggen volledig buiten u. (Prevention and health promotion)

Lack of feedback or involvement in the follow-up is pointed out to be a barrier for future reporting.

Dat is waar he, als je niet weet wat dat er verder met de kinderen gebeurt of uiteindelijk de oplossing is die aangeboden is, motiveert u misschien minder om in het vervolg de stappen te zetten, he. Neem nu dat je toch hoort, dat er niets mee gebeurd is, seg ja, maar met wat zijn wij bezig he? Nu allee, ja, goed, zo ver ben ik nog niet. (Paediatrician)

Het is natuurlijk wel aangenaam om te weten: hoe situeert mijn rol in het hele proces? Wat gebeurt erna en zo. (…) Je stelt de diagnose van een appendicitis bij wijze van spreken, dan vraag je je ook wel af, als je hem



eruit haalt: was het er een of was het er geen? Zo is dat hier ook het geval. Maar het zou kunnen dat we dat missen, maar daar krijgen we geen feedback over. Of daar hebben we nog geen feedback over gehad. Dus is dat omwille van het feit dat we er een missen of er een gemist hebben? Of is dat omwille van het feit dat men daar ons geen feedback over geeft? Ik zou, moest ik huisarts zijn, zou ik de spoedgevallendienst een keer contacteren en zeggen: zeg, jullie hebben daar dat kind gezien, maar achteraf bleek dat dat daar ging.. en zo verder. Dus eerlijkheidshalve kan ik mij daar niet over uitspreken of dat we ze missen of omwille van het feit dat we niet verwittigd worden. (Emergency, Doctor)

One of the important barriers is the professional secrecy especially when the case is reported to justice.

Wij geven meer dan we krijgen. Er is in Vlaanderen geen feedbackcultuur. En dat blijft een hele grote gevoeligheid. En als er feedback gevraagd wordt dan komt heel snel het negatieve. Je hebt een dossier en dan wordt dat verengd tot ervaring in een dossier. Mensen kunnen dikwijls moeilijk onderscheid maken tussen hun persoonlijk verlangen in een dossier en wat was daar realistisch mogelijk? Zo vraagt men: zou je er niet voor kunnen zorgen dat mensen mijn kinderen niet meer mogen krijgen? Nee, dat is niet wettelijk. Dus dat is beperkt, dat is beperkt. (Specialized services, VK)

Goh, heel veel gaat afhangen van wie de melder is. Als de melder nog actief betrokken is in het verder traject, dan ga ik er bijna vanuit dat die wel geïnformeerd gaat worden, omdat we tegenwoordig meestal via netwerkoverleg werken, dus dan gaat die persoon ook mee aan tafel zitten. Het klopt dat als de melder iemand is die niet meer betrokken is in het verder traject, dat die ook geen terugkoppeling gaat krijgen. Wij zeggen daarin ook wel van: jullie mogen ons daarvoor nog terugbellen, maar ik ben daar heel eerlijk in, dat wij heel erg ook weer vanuit de werkdruk en de beperkte tijd en mogelijkheden dat we hebben, dat we meer gaan investeren in het huidige netwerk dan in het vorige netwerk. Ja, dat wij niet systematisch melders meer terugbellen als ze geen rol meer hebben, dat klopt. (Specialized services, VK)

The ‘protocol van MOED’ tried to give an answer to some of these difficulties by installing a platform for consultation between partners in justice, specialised services and regular health care providers. Health care providers could anonymously ask advice from justice. Although actors in the field valued this initiative, the project has stopped by lack of resources.

De jeugdrechtbank heeft natuurlijk ook een stuk hulpverlenende functie, dus het is niet alleen. De jeugdrechtbank is misschien de enige rechtbank die niet repressief werkt, maar die dus maatregelen kan opleggen aan ouders of omgeving van kinderen waar dat er problemen zijn. Dus ik denk dat er daar wel en daarmee vind ik dat protocol van moed zo belangrijk eigenlijk, ik weet niet hoe dat functioneert, ik heb er eigenlijk niks meer van gehoord. Het is wel belangrijk dat er daar één of andere overleg is tussen beide zodanig dat zij onderling kunnen zien van: ja kijk hier zwijgen wij als rechtbank, houden wij het dossier al slapend of noem het zoals ge wilt en geven we zoveel mogelijk de kans aan hulpverlening en hier in deze casus ok, komt hulpverlening in. Dat ze de hulpverlening zullen zeggen: sorry jullie moeten ingrijpen. Dus ik denk dat dat heel belangrijk is dat de samenwerking er is. (GP)

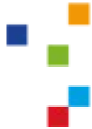
- Lack of information sharing within the medical field

Also information sharing between different health care professionals and specialised services (VK) is suboptimal. For example, communication by e-mail is no option because VKs have no secure electronical system.

Ik ga gemakkelijk het VK opbellen. Ik ga een mail sturen naar de arts van het VK, wat ik eigenlijk ook niet mag doen, want ik mag dat niet via mail doen, ze hebben geen medibridge he. De veilige methode is via Medibridge, maar dat hebben ze niet. (Paediatrician)

Also within the medical field (e.g. between primary and secondary care), access to information is limited in counterproductive ways. For example, hospital staff has no access to the electronic medical record (Globaal Medisch Dossier). A lack of information is one of the main barriers hampering collaboration.

Meestal bellen huisartsen ons als we de bal misgeslagen hebben of ons bellen om bijkomende inlichtingen te geven. Zeg, hou er rekening mee dat zo en zo. Wat natuurlijk heel heel welkom is, zeker wanneer dat de beheerder is van het globale medisch dossier. Dat is wel een tekortkoming. Wij geven nu inzage in het hele dossier van een patiënt in het ziekenhuis, maar wij krijgen eigenlijk geen inzage in het globaal medisch dossier van een patiënt. En moest dat kunnen georganiseerd worden dan denk ik dat er



heel wat overbodige onderzoeken zouden kunnen vermeden worden. Dat er heel wat richtinggevende evidenties bij ons zouden kunnen ontstaan. Dat er ook heel wat overbodig administratief werk zou kunnen vermeden worden. (Emergency, Doctor)

- Differences in approach and working procedures

Being familiar with each other's staff and procedures is one of the most important facilitators for a well-functioning system.

Als hulpverleners op een lijn zitten, dan werkt dat meestal goed. Als er binnen hulpverleners meningsverschillen zijn of als hulpverlening niet op één mijn staan dan gaan trajecten soms verschillende richtingen uit en is dat ook weer heel verwarrend, zowel voor gezinnen als voor hulpverleners. Wij zetten hier ook heel erg in op netwerking en ook heel veel proberen om via het netwerkoverleg tot samenwerking te komen, omdat we ook wel weten van: dat is echt wel nodig. (Specialised services, VK)

Local meetings are of great value to get to know each other.

Dus, ja, het kan allemaal beter. Dat is zeker. Maar in die zin is het wel goed dat we nu, ik ben daar ook lid van, hier in X, is de commissie tegen kindermishandeling wat in elk arrondissement die commissies zijn opgericht sinds een paar jaar. En vanwaar er eigenlijk van alle sectoren, het gaat soms heel ver, bij ons zit er iemand van de huisartsenvereniging in tot de politie tot de CLBs, de scholen, wie dan ook, justitiehuis. Die zitten er altijd in en wij komen twee keer per jaar samen, waarin dat we elkaar leren kennen. Dat gaat meestal niet over hele concrete zaken, maar er wordt gesproken van: wat doen jullie? Hoe doen jullie dat? En als we zoiets tegenkomen, dit is wat we kunnen doen. Dan wordt er over gepraat. En dat is een zeer goede manier om elkaar te leren kennen. En dat kan misschien een beetje een oplossing zijn naar het misbegrepen voelen van bepaalde hulpverlening. En ook van ons uit, soms die frustratie van: jullie hebben ermee gewerkt en jullie willen die informatie niet doorgeven. Het is niet van niet willen, het is van niet mogen, maar dat heeft meer met de wetgever te maken he. (Juridical services)

On all levels there is a different perspective on the problem of child abuse between health care and justice. On the governmental level there is a large cultural difference between the two ministries (health and justice). They take alternatively the lead of the work field, but they have a different style and vision. These differences can be enriching but also frustrating and hamper collaboration.

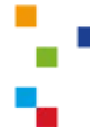
En dat is zo typisch. Dat voorzitterschap dat wordt elk jaar doorgegeven. En het ene jaar is dat het ministerie van welzijn en het andere jaar is dat het ministerie van justitie. Dat is gigantisch. Zowel het bijwonen van die vergaderingen als de verslagen die je daarvan krijgt. Hoe groot verschil dat dat is. Dat van justitie is kort en dat is heel to-the-point en dat van welzijn dat is altijd zo.. verbloemd. Zo van: zullen we daar nog eens over nadenken en wat denken jullie daarvan? Dat is echt zo'n gigantisch groot verschil. Dat is eigenlijk, ja. En dan merk je wel dat je twee verschillende werelden bent. Ik geloof er rotsvast in dat je een manier kunt vinden waarop dat je elkaar tegemoet komt. Echt wel en dat is gebleken met dat protocol van MOED en daar blijf ik bij. (Juridical services)

Ook het feit van, wij vallen onder het ministerie van justitie. Zij vallen onder het ministerie van welzijn. Geeft al spanningen. Het zijn andere regels, andere. Stomste voorbeeld. Mijn sociale dienst heeft andere feestdagen dan wij. Ja, maar ik word geconfronteerd met een vordering van parket. Ik heb mijn sociale dienst nodig. Ja, ze hebben een feestdag die dag. Dat is een heel onnozel voorbeeld, maar dat geeft wel aan dat je voelt van.:het ligt moeilijk, he. En dan voel je wel, wij vertrekken vanuit de visie van justitie en zij vanuit de hulpverlening. En die nog altijd vertrekt vanuit een andere visie. En dat zou verrijkend moeten zijn, maar soms geeft dat ook wat spanning. (Juridical services)

- When to stop follow-up

Another concern is the decision about when to stop the follow-up of a family. Judges express doubt: they need to be sure the child is safe and the abuse has stopped. They regret to be obliged to discontinue follow-up when the victim becomes 18 years old.

Tenzij natuurlijk dat de jongere achttien jaar is geworden, dan wordt het dossier sowieso afgesloten. En dat is natuurlijk wel een probleem omdat je wel voelt vaak in dossiers dat, ja. Het is niet afgelopen op achttien jaar. Die thuissituatie is niet opgelost. Die jongere is niet volwassen. Die jongere staat niet op eigen benen. En dat je heel vaak voelt van, oei, je wordt achttien jaar en het is echt letterlijk de boeken toe hier he. Wij hebben niets meer te zeggen, niets meer te doen, we mogen zelfs ons dossier niet meer



opendoen. En dan hopen dat die jongere binnen de vrijwillige hulpverlening voor volwassenen een beetje de weg vindt. Dat is een beetje de taak van ons en van onze consulenten, om aan de jongere uit te leggen van: wat na uw achttien jaar. Als een jongere geplaatst is of nog onder begeleiding staat, is dat ook de taak van de begeleiding, om met die jongere te zeggen. Kijk, wat na uw achttien jaar? Wat zijn de mogelijkheden? En daar wordt soms al jaren op voorhand aan gewerkt. Wat na achttien jaar? Dus dat maakt echt wel, je voelt dat ook bij jongere die iets hebben van: ik ben daar niet klaar voor. Ook begeleiding die zeggen van, die jongere is daar niet klaar voor. Wij zijn er niet klaar voor om alleen nog met jongeren te werken zonder dat ons iemand een beetje de gezagsfunctie gaat uitoefenen. Dat voel je heel vaak in zo'n dossier. Ok, maar de wet zegt nu eenmaal: je wordt achttien en je wordt meerderjarig op uw achttiende. En ja, dan stopt het gewoon. Dan kunnen wij niet verder. Dan mogen wij niet verder. Dat geeft soms wel wat problemen. (Juridical services)

- The new decree: no clear added value

Some respondents criticised the new decree (Decreet integral): it brings along more judiciarisation, more administrative workload, less clarity, longer delays and worse quality of care

En bovendien, ik ben niet echt een fan van het nieuwe decreet integrale jeugdhulp, ik ben er mee akkoord. Ik geef dat toe. En waarom ben ik er geen fan van? Omdat wij natuurlijk, en ze horen dat niet graag in Brussel, maar wij hebben altijd een hele goede samenwerking gehad. Niet alleen met het jeugdparket maar ook met het comité bijzondere jeugdzorg in het verleden. En met de bemiddelingscommissie. En we waren echt heel laagdrempelig en we belden heel veel met elkaar. En inderdaad, er was altijd, net over de grens misschien, altijd in het belang van het kind. En dan is er gezegd van: ja, maar het decreet is eigenlijk geworden wat het is omdat er nu teveel gezinnen in de justiciële sector zitten. Dat is de opzet daarvan. Ja, dat kan misschien wel waar zijn. Ik weet het niet. Maar nu zien we een omgekeerde weg. En nu komt er niets meer naar de justitie, waarbij dat wij heel erg het gevoel hebben van: is dat nog wel correct? Want, we moeten er eerlijk in zijn, als je nu iets meldt, een grote verontrusting naar de veiligheid van een kind toe en dan merken als maatschappelijk assistente van: ja, de gemandateerde voorzieningen hebben wel zestig dagen. Zestig dagen om daarover na te denken. Sorry, maar, dat is lang. En als je dan inderdaad een verontrusting hebt maar niet genoeg om de jeugdrechter.. dan staan wij met onze rug tegen de muur. Is toch zo? (Juridical services)

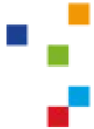
Overall the new reporting system is described by the respondents as being too complex. Health care providers who are confronted with child abuse assume a long and emotional process of detection and care taking. Once they decide to report, they face limited access to services, a complicated law and a restrictive professional association ('Orde van Geneesheren').

Goh, als ze hier komen, dan hebben ze eigenlijk ons al gemeld eigenlijk. Ik bedoel, mensen komen hier misschien om dat bv een CLB merkt van kijk, daar is wel sprake van kindermishandeling en die mensen willen we daar wel een gesprek mee aangaan, maar weigeren hulp of die willen daar niets mee doen. We hebben het VK ingeschakeld, maar die willen daar niets doen, we maken ons ongerust. Dan maakt die een M-document op en is dat eigenlijk al de bedoeling dat dat toch wel een stuk doorsproken is, he. Als het parket aanmeldt en we hebben van feiten van kijk er is misbruik of er is mishandeling, dan staat dat ook al in het verslag. (Specialized services, OCJ)

Some respondents deplore the introduction of the M-document, which is a new administrative nuisance in the reporting system. More administration is required and this is identified as a real barrier.

Ik denk dat ze het VK wel kennen en het Comité Bijzondere Jeugdzorg ook, dus ik denk dat ze dat, maar ik denk dat ze nu voelen dat die drempel een stuk hoger is geworden. Bijvoorbeeld ook het invullen van zo'n formulier, daar hebben wij geen opleiding voor gehad, dus dat doen wij ook niet. Ik weet zelfs niet hoe het noemt, dat formulier. (GP)

In het begin zeker niet. Nu zeg ik: kom, sociale dienst, doe maar he. Volg maar uw lijnen, ik laat hen dat doen he. Terwijl ik vroeger zelf eens het Comité Bijzondere jeugdhulp belde, maar nu doe ik dat niet meer he. Ik ga zo geen M-document invullen, he, ik heb daar geen tijd voor. Ik zit nu al de helft van mijn weekend administratie te doen en mijn avonden. Dat is voor de sociale dienst. En wij hebben gelukkig iemand die niet volledig voor pediatrie ingeschakeld is, en een stuk voor geriatrie moet doen, maar eigenlijk ze kan fulltime pediatrie doen, he. Dat is er niet op verbeterd. (Paediatrician).



Also the sectoral entrance (sectorale poort) which is a gateway for specialised services is questioned. This gateway does not solve the problem of a lack of services; on the contrary, it creates even longer delays.

En wij merken nu dat integrale werkt, dat we nog altijd met die vraag zitten. Wat is er nu concreet verbeterd? Wat is er nu verbeterd voor de jongere, voor de ouders? Ik zie het niet. Ik zie alleen maar dat jongeren nog veel en veel langer moeten wachten op gepaste hulp in vergelijking met vroeger en dat is een negatieve evolutie die al aan de gang was, maar die nu wordt verstrekt door het nieuwe systeem van integrale. Ik denk niet als jeugdrechter dat ik daarin alleen sta. Ik ben ervan overtuigd dat ik daar niet alleen in sta. Maar ja…(Juridical services)

Moreover, respondents feel that their expertise is questioned because the employees working for the Sectoral Entrance assess whether the demand is justified. According to the respondents these employees are unaware of the details and the specific therapeutic possibilities of cases.

Ja, ik denk gewoon de tijd die we nu steken in zo documenten invullen en zo, ik bedoel, dat is zeker een verschrikking. Of onze expertise die dan eigenlijk toch een beetje voor de grabbel wordt gegooid, te denken dat het dan niet oke is en dat je dan een aanvraag doet, dan hebt je daar een poort die daarover beslist dat dat niet de juiste aanvraag is of die dat dan allemaal herbekijkt, ja. En vooral naar onze cliënt toe, hoe leg je het uit? (Health care providers,CGG)

Local collaboration has become impossible. Before the new decree there was more autonomy to organise care within professionals own regional network.

Dat geeft spanningen tussen, met de ouders, dat geeft spanning met de jongere. Maar dat geeft ook spanning met de instelling. Dat maak ik nu heel vaak. Wat dat wij vroeger, vroeger kreeg ik telefoon van parket in het weekend: dat was 'ok, we zitten met een jongere, wat moeten we daarmee doen?' Ik pakte mijn telefoon, ik had mijn sociale lijst en ik belde gewoon de instellingen af. En ik kende die mensen, dat was die en die. Ik zei: hebben jullie geen plaats? Wat kunnen we doen? Ik mag dat nu allemaal niet meer doen. Nu moet het allemaal via de consulent in de computer worden gedaan. Het moet erin gezet worden. Dan komt het in een systeem terecht. En dan heb je wachtlijsten, en die wachtlijstten, dat zijn mensen van integrale die gaan bepalen: wat is er hoogdringend en wat niet? Heb ik daar iets in te zeggen? Blijkbaar niet, want ik wist niet eens dat dat systeem bestond. (Juridical services).

By creating these large inefficient structures, there are even less resources for fieldwork.

Maar ik blijf ervan overtuigd dat het vroegere systeem minstens even goed, zo niet beter was dan het nieuwe, maar er waren te weinig middelen. En die middelen zijn nog schaarser geworden en de structuren zijn nog logger geworden. (Juridical services)

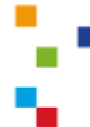
Finally, the organisation of care is Community specific: the new decree renders it impossible for services belonging to the Flemish Community to organise care in another Community.

Het is een multiproblem - familie. We hebben een thuisbegeleiding nodig. Maar nu, onder het Franse gewest kunnen wij geen thuisbegeleiding aanvragen want de ouders spreken alleen Nederlands. Onder de actuele, want het is maar sinds de verandering van integrale, kunnen wij in Vlaanderen geen aanvraag meer doen voor iets dat drie kilometer over de taalgrens ligt. (Specialised services, VK)

- The specialised services' (VK's) new role, organisation and functioning

Especially preventive services and judicial respondents criticised the new tasks of the specialized services (VK).

Wat dat ik wel niet snap, en ik ben nog altijd bereid om te luisteren als iemand mij het wel kan uitleggen, maar nu hebben ze ineens van het VK een dubbele organisatie gemaakt. Lang de ene kant het VK van vroeger, maar langs de andere kant ook, eigenlijk een organisatie gelijkaardig aan het OCJ, met een gans andere werking en met een gans andere filosofie. En ik zie de combinatie van die twee totaal niet. Ik zie het niet. Ik zie niet in wat die twee met elkaar mogen te maken hebben of moeten te maken hebben. En ik denk eerlijk gezegd dat die mensen die daar werken dat die ook constant zitten te worstelen. Ze zeggen letterlijk tegen mij soms van: ja, ik moet van het ene lokaal naar het andere lopen en dan een ander petje gaan opzetten. Hier mag ik dat zeggen, hier mag ik dat zeggen. Maar dat is toch niet normaal, dat is toch niet werkbaar. Maar ja, ok, dat is zo beslist. Dat is in het kader van de integrale. Dat heeft te maken met het ministerie



van welzijn die het zo beslist heeft. Maar ik vind het een zeer, zeer rare constructie die daar is opgezet. (Juridical services)

Zucht, ik vind het goed dat men dat onderscheid wil maken tussen: dat is een problematische leefsituatie en dat is een situatie van KM, moet dat per se door de VK's gebeuren? Daar ben ik niet zomaar van overtuigd. Ik denk dat wij heel vaak als VK ... het moeilijke vind ik, als we als VK gevat zitten in die rol van onderzoeker, waar kan ons diagnostisch werk dan nog zijn plek krijgen? En in die zin denk ik, dat onderzoek kan even goed door het OCJ gebeuren, de andere gemandateerde voorziening. En dat wij als VK regulier kunnen ingeschakeld worden om ons diagnostische oppuntstelling te doen. (Juridical services)

Respondents feel that a more efficient and centralized organization of these centres in general is needed. There is no agreement on how they should function.

Wat al een eerste belangrijk beleidspunt is dat, naar mijn mening, dat ik vind een centrum rond kindermishandeling zou moeten functioneren op basis van consultatie, het zien van kinderen, en niet louter wat vaak gebeurd: het managen van het dossier door een achtergrondrol te vervullen. En door vooral te werken via aansturing van hulpverleners, ronde tafels en zo meer. Ik denk dat er een expertise moet opgebouwd worden door raadplegingen te doen. En dus door kinderen en hun ouders te ontmoeten. En op die manier een organisatie te zijn die een verticale structuur heeft, die zich eigenlijk zowel op een eerste-, tweede- en derdelijns niveau beweegt. (Specialized services, VK)

Moreover, the registration and interpretation of the reported cases by the specialised services (VK's) has not been standardized.

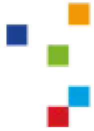
Dus vele mensen geloven in het model dat we hier hebben, maar staan natuurlijk te kijken dat wij zo weinig cijfers kunnen voorleggen. Dat je de cijfers van de registratie X eigenlijk niet kan vergelijken met die van Y, want dat bijvoorbeeld in een gezin waar er vier kinderen zijn, dat wij dat beschouwen als één melding, het is één gezin. En Y zegt: nee, nee, dat zijn vier dossiers, dus dat zijn vier meldingen. Dus hele eenvoudige dingen komen al heel verschillend terecht. Dat de registratie merkwaardiggewijs meer belang hecht aan: hoe noemen mensen zelf het probleem als ze contact namen? Ja, iedere echtscheiding spreekt over seksueel misbruik. Ik zou niet verschieten dat mijn man zijn handen niet thuis hield. Dat wordt gekwalificeerd als incest, terwijl dat, ga kijken in de uitstroom. De uitstroom wordt niet geregistreerd, incest is spectaculair gedaald en toch kan je die cijfers niet aan het Vlaamse publiek tonen. (Specialized services, VK)

There is an overall perception of the need for a better description of the tasks and better support for the mandated service (forensic paediatricians or psychiatrists) and more local collaboration.

Maar natuurlijk dat wij, dus nu in de voorbije negen maanden 100 dossiers als maatschappelijke noodzaak kregen, dus dat zijn dossiers waar wij ons door het gerechtelijke moeten werken, we moeten forensisch onderzoek doen. Die opdracht is er gekomen zonder enige aanpassing in de personeelskader. Het zijn dossiers waar ik absoluut nog een forensisch pediaters zou nodig hebben. Ja, ik maak afspraken met Rob Bilot in Nederland daarvoor, want ik kan het hier niet vinden. Wij hebben bij momenten kandidaten, maar die zeggen: ik zoek wel een fatsoenlijk contract.(Specialized services, VK)

The non-anonymity of the reporter is welcomed by some respondents because it implies that he/she is considered to be the contact person and is better informed and more involved. This entails a more responsible position and more work for the referrer whose vision and year- long experience with the family is taken into account. However, specialised services themselves fear that non-anonymity is a barrier for especially general practitioners as it can endanger the doctor-patient relationship.

Vroeger werd het, maar dat was dan het feit dat we het ganse pakketjes doorgaven en er soms ook niet meer van hoorden. Dat klopt. Nu als we doorgeven, zeker naar een gemandateerde voorziening, blijven we ook wettelijk contactpersoon-aanmelder en dat heeft zijn voordelen, omdat we meer op de hoogte worden gehouden, maar het is ook een extra werkbelasting, dus het zit dubbel, dat voordeel. Want dat betekent ook dat wij blijvend verantwoordelijk blijven voor overlegmomenten, dat we ook terug ja binnenkrijgen dat het daar stopt en zo. Dus die controle van wat er aan het gebeuren is, is beter, het feit dat we ook bij het overleg zitten en het feit dat we met die mensen van het OCJ of van het VK, ook wij kunnen in overleg gaan, dat is ook zinvol, denk ik, omdat wij, dat was ons vroeger wel eens de frustratie, dat de aanmelding vrij beknopt gebeurde, daar wordt dan plots een andere visie gezien op dat gezin en dan is onze eigen ervaring van al die jaren soms wordt gewoon aan de kant geschoven en dat was ook



heel frustrerend. Ik denk dat dat beter ligt nu, dat die, dat we daar meer zicht op hebben. Maar met als effect dat we ook meer werk gaan hebben natuurlijk. We pakken er wel wat bij. (Prevention and health promotion)

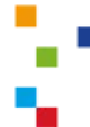
Een van de problemen van het huidige M-document, om maatschappelijke noodzaak aan te vragen, men moet zich kenbaar maken. Men moet aan de ouders zeggen: ik meld jullie aan. Dat is wel een enorme miskenning van de kwetsbare positie van iedereen in de eerste lijn. Een huisarts, een CLB-medewerker, een leerkracht.. we kunnen moeilijk verlangen dat iedereen zijn nek uit steekt. (Specialized services, VK)

7.5.8 Reported solutions from the qualitative research

Respondents were asked to suggest solutions for the mentioned barriers. In the following tables, the findings have been listed according to the phases in the management process they relate to (detection, first approach, reporting, intervention after reporting). Depending on the phase, the respondent may be a (potential) reporter or a receiver of reportings. Some of the solutions spontaneously came up and are not directly linked to a barrier.

Table 11 — Barriers and solutions linked to detection

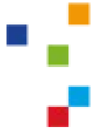
<table>
<tr><th>IDENTIFIED BARRIERS</th><th>SOLUTIONS</th></tr>
<tr><td colspan="2">FACTORS INHERENT TO THE PROBLEM</td></tr>
<tr><td>A complex problem with a broad spectrum, often hidden and characterized by doubt</td><td rowspan="2">Education and training of (health care) professionals to increase the vigilance for child abuse (knowledge about the problem, the clinical signs and behavioral indicators helpful in identifying child abuse cases)</td></tr>
<tr><td>Multiplicity of symptoms and the subtlety of behavioural factors</td></tr>
<tr><td>Medical shopping and/or school hopping</td><td>Systematic registration and centralisation of medical records/data</td></tr>
<tr><td colspan="2">FACTORS INHERENT TO THE PROFESSIONAL</td></tr>
<tr><td>Aversion to see</td><td rowspan="3">Education and training of (health care) professionals in defining their role, mission, the knowledge of the problem and network
Specific and unique source of information
Booklet containing a reminder of how to deal with abuse
Directory of specialists</td></tr>
<tr><td>Misconceptions</td></tr>
<tr><td>Management of the doubt: decisions made under uncertainty and the long detection delays</td></tr>
</table>



Insufficient basic education	Include training on child abuse management in curriculum
FACTORS LINKED TO ORGANISATION/SYSTEM	
Lack of services	See table intervention after reporting
Lack of time factor and ressources	Supporting services to enable better management of time and resources
	Notification point in schools
	Surprise medical visits

Table 12 — Barriers and solutions linked to the first approach

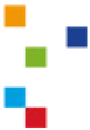
IDENTIFIED BARRIERS	SOLUTIONS
FACTORS INHERENT TO THE PROBLEM	
Little research	Investment in the research
FACTORS INHERENT TO PROFESSIONAL	
Sharing concerns and calling out abuse is risky	• Organizing training- and awareness sessions on their role, on communication skills with the patient, on risk assessment and on referent services • Development of tools
The difficulty of the risk assessment	
The difficulty of case-management	
Working in a single-handed practice	• Doing paired medical consultations



	• Working with independent social workers • Increasing case intervisions and supervisions • Appeal to forensic doctors earlier in the process
FACTORS LINKED TO ORGANISATION/SYSTEM	
Excessive workload	• Strengthening of preventive services (PMS/PSE) • Creating mobile teams for immediate intervention • Increasing the availability of specific (preventive, psychological, psychiatric) services • Improving and extending acute and interventional services (at home) • Development of a general action plan • Take better care of the staf of the services
Lack of overview and coordination	• Enrolment of the family in one single primary care practice or favouring (imposing) one fixed family doctor • Case manager • Taking time to coordinate
Patient-oriented care	Medical file for the whole family
The saturated network	Research on the reasons of waiting lists and on the respective solutions
Little exchange of information (ONE, PSE/PMS)	Protocol with ONE

Table 13 — Barriers and solutions linked to reporting

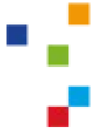
IDENTIFIED BARRIERS	SOLUTIONS
FACTORS INHERENT TO PROFESSIONAL	
Fear of breaking/changing the relationship	• Training/Raising awareness: definition of the role and the missions, procedures of reporting, the support and services availabe • Telephone line offering support for professionals
Fear of being the informer	
Fear of being blamed by authorities and the media	



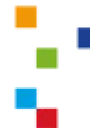
Fear of worsening the situation for the family	
Uncomfortable balance between assistance to people in danger (art. 422bis Penal Code) and professional secrecy	• Training/Raising awareness – to have diagnostic tools • A more accurate legal frame relating to the concept of danger and severity and the concept of minor
Ignorance of the article 458bis	
Ignorance of the deontological rules	
Insufficient knowledge of specialized services and their missions	Information by specialized services to increase knowledge, promote the facilities in place
Negative representations of specialized services	
Difficulty to convince a family of the need of consulting specialized services	Training in communication skills
FACTORS LINKED TO ORGANISATION/SYSTEM	
Specialized services overload	Reinforce staff

Table 14 — Barriers and solutions linked to intervention after reporting

IDENTIFIED BARRIERS	SOLUTIONS
FACTORS INHERENT TO THE PROBLEM	
Fear/anger of being marked as bad parents when oriented to SOS-Enfants	Informing the public
SOS-Enfant is seen as a universal solution, a common illusion among psycho-social Professionals	Prevention and information work done by specialized services (see table on reporting)



FACTORS INHERENT TO PROFESSIONAL	
The difficulty of evaluating child abuse	Videotaped auditions are a helpful tool Efficient collaboration with forensic doctors
The difficulty of risks assessment inherent to these situations	Think tanks in the mental health sector
The case-management • lack of foresight or experience in handling child abuse cases • parental attitude of denial and psychiatric disorders	Prevention and information work done by specialized services: see table on reporting
Mandated work : lack of compliance of procedures and unreliability of the mandated services	Reinforcing existing partnerships
Lack of training and supervisions for magistrates	Training magistrates and raising their awareness
FACTORS LINKED TO ORGANISATION/SYSTEM	
Insufficient offer of services	Increasing available services
Network overload	Strengthening existing teams
Long distances and travel costs	Defining new intervention models (all services in one location, house calls)
Lack of uniformity in the management	Continuing the development of the collaboration protocol
Difficulty to establish a partnership with the medical world	Working transversally Creating and reinforcing existing partnerships
Lack of feedback to the ones reporting	Adapting legal framework



7.5.9 Conclusion: A system approach

7.5.9.1 Training is necessary but insufficient to increase detection of child abuse

According to respondents, dealing with child abuse could be improved by dedicated training. Indeed, lack of knowledge, appropriate skills and experience make professionals poorly equipped to deal with abusive families. Professionals overlook or underestimate signs of abuse.

Et ce qu'on constate c'est quand même souvent dans les suivis alors plutôt qui sont gardés dans des équipes tout venant, ben finalement la maltraitance est là, un peu tout le monde sait qu'elle est là. Voilà mais donc dans ces cas-là souvent ce qu'on se rend compte, c'est que souvent la famille a un peu soit embobinée consciemment ou inconsciemment l'intervenant et donc on a perdu du temps. Soit la famille a carrément, dans un fonctionnement plus pervers, joué avec l'intervenant en distillant un peu d'infos et puis pas et puis en ayant un certain plaisir à se dire (en chuchotant) :« Ben finalement on parle de maltraitance, on parle de coups. Mais pfft, ou on parle d'abus mais finalement ça n'a pas l'air de plus les inquiéter que ça. Ils nous laissent rentrer chez nous chaque fois après la séance, c'est que c'est pas si grave », vous voyez ? Donc c'est en ce sens-là que voilà, la croyance que finalement, c'est pas très grave. Au niveau des adultes et donc aussi au niveau des enfants. (Specialized Services, SOS-Enfants)

The obvious quick fix is to include training modules in the core curriculum of professions working with children (e.g. general practitioners, teachers, nurses, paediatricians, etc.). In addition, continuous learning modules could be offered to professionals working with children. Other organisations, such as professional organisations or hospitals could also organise workshops on for example ethical issues based on real cases.

Dus ik vind bijvoorbeeld dat men, gelijk in een ziekenhuis -ook als we denken aan misbruik door personeelsleden: hoe werk je daar preventief rond?- dat men eigenlijk binnen de accreditering van jeugdhulpverleningen, binnen de accreditering van iedere persoon die met minderjarigen werkt, zou moeten eisen dat die één keer in het jaar deelneemt aan een ethisch seminarie waarbij er een casus besproken wordt. Geen theorie, daar heeft iedereen de pest van, maar dat er een casus waarin dat je dat dilemma ontmoet. Wat ga ik doen? Melden of niet melden? Waarom zou ik dat doen? Wat zijn mijn ervaringen daarmee geweest? Zodat men mensen alert houdt.(Specialized services, VK)

Overall, professionals feel that training should not only address detection skills, but should also include practical topics such as the available specialised services and their working procedures. Currently professionals are insufficiently informed about who to refer children to or who they can contact in case of suspicions. Training sessions could also improve communication skills as many professions find it very difficult to discuss their suspicion with the child and his family.

Ja, ik denk dat we, zoals met al onze patiënten, proberen om gezonde, zowel psychisch als fysiek gezonde patiënten te hebben. Dus, ik denk dat we daar zeker een plicht in hebben. Anderzijds is dat ook bij de empowerment van de patiënten, is dat voor een stuk ook hun verantwoordelijkheid en moeten wij niet alleen aan die kar trekken, maar kunnen we wel wat coachen, he. Dus ik denk dat we een gezin moeten verantwoordelijk maken voor wat er misloopt en hen aanreiken om daar iets aan te veranderen, maar dat we dat niet moeten overnemen. Ik denk dat dat de toekomst is, ook naar andere ziektebeelden, maar dit is er een van. (GP)

Although lack of training is put forward by the respondents as an important barrier in the detection of child abuse, it also appears that training efforts are not enough. If training is implemented as a stand alone solution it is more a kind of quick fix which in the best case leads to temporary heightened responsiveness, but not in a sustained improvement of detection (See Figure 6). A long lasting effect on detection is hampered mainly by time pressure and disappointment in specialised services (VK's/SOS enfants) because they do not provide the support, advice and feedback, professionals hope for. Also professional secrecy and the fear to undermine the trusting relationship with the family and continue to refrain professionals from taking action.

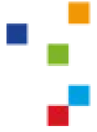


Figure 6 — Reinforcement of specialised services, prevention efforts and residential care to increase detection and reporting of child abuse

SYMPTOM CORRECTING PROCESS

TRAINING OF SKILLS & KNOWLEDGE

MORE READINESS TO DETECT & REPORT

TIME PRESSURE & EMOTIONAL DISTRESS

REINFORCEMENT OF PREVENTIVE ACTIONS

DETECTION & REPORTING OF CHILD ABUSE

REINFORCEMENT OF RESIDENTIAL CARE

PROBLEMS CORRECTING PROCESS

MORE NEED FOR SUPPORT FROM SPECIALISED SERVICES

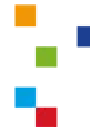
SUPPORT & FEEDBACK TO PROFESSIONALS

WORKLOAD SPECIALISED SERVICES

LESS RELAPSE

REINFORCEMENT OF SPECIALISED SERVICES

MORE CONTINUITY OF CARE & FOLLOW-UP



7.5.9.2 *Reinforcement of specialised services to increase detection and reporting*

In order to facilitate professionals in detecting and reporting child abuse we need a system approach, taking into account the connections between actors in the field. Looking at, for example, the GP in a larger network of services it becomes clear that GPs act differently if they feel supported and backed up by colleagues and a larger network of services. Therefore reinforcement of specialised services such as VK's/SOS enfants, but also other care providers such as centres for mental health care, could initiate a positive reaction from potential reporters of child abuse (See Figure 6). Currently all services taking care of maltreated children struggle with a high caseload and many demands for advice, support and feedback from professionals in the field. Especially specialised services, (VK's and SOS enfants) are overloaded with new cases, administration and a whole array of other tasks, to such a degree that they question the quality of their work.

Ik denk ook eens samen met ons nadenken over de verschillende opdrachten die we moeten doen. Er wordt naar het VK gekeken voor sensibilisering, er wordt naar het VK gekeken voor vorming. Er wordt naar het VK gekeken voor advies. er wordt naar het VK gekeken voor diagnostiek. We bemannen mee 1712. We zijn gemandateerde voorziening. We hebben eigenlijk wel heel veel opdrachten. Als we dan bedenken dat dé VK's in totaal een 80tal mensen zijn om die opdrachten te doen, ja.... dan denk ik dat is weinig realistisch. (Specialized services, VK)

Specialised services feel they became highly bureaucratic: all the time spent on administrative tasks is not spent on the care for children and families. Respondents feel the need to be more directly involved in the field. Specialised services are not always available and delays increase.

Ik denk, op dit moment zit iedereen zo in het nauw dat ook maakt dat iedereen muren op aan het trekken is, en zich heel erg aan het afbakenen is en aan het afgrenzen is. Ja, geld, meer middelen, meer mogelijkheden en meer mensen. (Specialized services, VK)

Que quand une déléguée du SAJ gère, je sais pas moi, 200 dossiers comment voulez-vous que toutes les semaines elle se dise: « Je vais appeler cette famille, voir où ça en est, est-ce que il y a eu de la place, est-ce qu'ils sont rentrés ». Je ne leur jette pas la pierre, je suis souvent insatisfaite. Mais je pense que voilà, c'est comment faire autrement on ne peut pas leur demander de s'investir plus que le temps dont ils disposent. (Specialized services, SOS-Enfants)

Peut-être parce que j'étais un peu déçue et beaucoup de généralistes sont un peu déçus de SOS Enfants maintenant peut-être parce que trop débordés ou pas assez de disponibilités. Donc on fait un peu quelque part malheureusement ou pas notre popote, quoi. Et quelque part on utilise nos lieux de signalements. (GP)

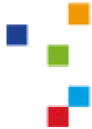
Reinforcing specialised services will feed the system in such a way that all parties involved benefit: professionals, but most importantly children and their families.

Reinforcement of specialised services allows them to:

- Be available to provide professionals such as GP's with advice and support
- Invest in awareness raising among professionals
- Inform professionals about the activities of their service and how they can collaborate around a family
- Spent more time on the care for children and their family over a longer period of time, including follow-up, hence avoiding discontinuity of care and relapses
- Provide professionals with feedback about the progressions families make.
- Invest more in multidisciplinary collaboration

Specialized services experience that professionals, who were *informed* about the services' activities are more inclined to contact them. Information about the services and availability of the services increases their perceived trustworthiness and helpfulness. This is expected to affect not only individual first line professionals, such as GP's, but whole professional networks as professionals recommend specialised services to their colleagues. Overall positive experiences with specialised services in general and reporting in particular can be expected to facilitate detection and reporting.

Ik heb de ervaring dat eens mensen, goh, als wij vorming gaan geven, wij promoten onze adviesfunctie heel erg. We durven dan zeggen: bel voor advies, beter te vroeg dan te laat. (…) bvb we hebben nu een training



gegeven (…) en de helft van de deelnemers niet wist van de adviesfunctie. dat we dat de eerste keer heel erg onder de aandacht gebracht hebben, dat er tussen de eerste en de tweede dag een aantal mensen effectief advies gevraagd hadden en dat we de tweede dag inderdaad merkten dat ze bij elkaar aan het zeggen waren van: je moet dat echt wel doen. Als die mensen die stapjes zetten van advies vragen, naar melding doen, en ook ervaren hebben dat dat ook goed kan lopen, dat dat de drempel verlaagt, maar ja, mensen moeten zich daar ook veilig genoeg bij voelen. Dat heeft ook vaak te maken met training krijgen. (Specialized services, VK)

Les professionnels ont une expérience avec SOS au niveau clinique. Ils la retiennent et d'une fois à l'autre ils font plus facilement appel. (Specialized services, SOS-Enfants)

The respondents note that the expertise of specialized services, such as VK and SOS Enfants, is helpful in dealing with the reported case. The guidance and reassurance offered even by phone influences their decisions. The professionals feel less alone and do not have to deal with this emotional challenging problem on their own.

Ne fusse que par téléphone, vraiment, de soutien quoi, pour accompagner. Pour ne pas tout de suite (grande respiration) vraiment entrer dans l'urgence. Parce qu'on a tendance à le faire. C'est tellement, je veux dire, laisser l'enfant sachant qu'il y a une suspicion d'abus, c'est DUR, C'EST ARCHI DUR pour nous à supporter. (GP)

It will take some time before the reinforcement leads to more readiness to take action among professionals such as GP's. But once the positive feedback loop is installed, it can be expected that professionals will be more able and willing to detect and report child abuse. Moreover, if they feel backed up and skilled (e.g. through additional training), and part of a larger network, they will more easily approach families, initiate help trajectories, yes or no in close collaboration with specialised services, and in last instance refer to specialised services if their own efforts do not seem to work. This way they act as a filter and specialised services get only the most severe cases who could not be helped in primary care. This implies a smaller but more severe caseload. Specialised services are no longer overwhelmed and have time to keep fulfilling their support role towards (health care) professionals.

7.5.9.3 *Enough capacity for adequate interventions and follow-up will result in more willingness to detect and report*

Respondents complained about the important lack of places in protective custody. There are too few foster care structures adapted to young children capable to evaluate the problem of abuse. In addition there is a lack of institutions dedicated to teenagers suffering from psychiatric disorders. The participants deplore the closure of the "mother-and-child" unities. The lack of services offering follow up to children and families makes health care professionals sceptic about detection and reporting. They do not see the use of detection and reporting if the capacity to help the children in the short and long run lacks.

La détection, je pense que parfois on détecte moins parce que on sait que la possibilité d'intervention est limitée aussi ça c'est la paradoxalité aussi du système. (Judge)

Ik vind niet dat het – kinderpsychiatrie – daar krijg je ze ook niet binnen. Hoeveel korte opnames, time-outs, dat wij doen op pediatrie, voor iemand die pillen pakt, krast, waardat we niet in de psychiatrie binnen geraken, en de psycholoog, daar moeten ze voor betalen he. (Paediatrician)

By creating more capacity for adequate interventions and more residential places to take care of children who are not safe in their own family, this negative feedback loop can be turned into a positive one.

An additional facilitator in the detection of child abuse are the presence of a specialised service/department/reference person within hospitals, schools or other institutions potentially encountering maltreated children. Respondents expect that the presence of a service specialized in child abuse in hospitals makes hospital staff more inclined to detect and seek help in case of suspicion.

Comme l'équipe (Cellule Maltraitance) fonctionne depuis plusieurs années donc que les pédiatres sont fort attentifs et donc n'hésitent pas à nous solliciter. (Specialized services, Paediatrician)

Specialized services value the presence of such a service inside hospitals: professionals can obtain immediate help or advice. The proximity of this kind of service makes them also less reluctant to report.

A l'intérieur de l'hôpital on sait que vous existez ? R: Voilà c'est ça et que les gens font appel à nous et que donc les gens sont moins réticents à… Les gens communiquent plus sur certaines situations qui les inquiètent puisqu'ils savent qu'ils peuvent appeler, qu'ils peuvent demander un avis, qu'ils peuvent ne serait-ce que venir communiquer sur le cas. (Specialized services, Paediatrician)

Currently the sources of information are scattered and fragmented. Easy access to one specific source for health care providers and others concerning child abuse would facilitate access to the correct information. A "contact point (meldpunt)" would facilitate transmission of information.

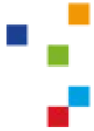
Wat de overheid kan doen om die scholen extra te ondersteunen met problematische leerlingen toch beter te kunnen begeleiden. En dat daar in die scholen ook een soort van meldpunt komt en dat die informatie gemakkelijker kan door. (GP)

7.5.9.4 *Reinforcement of prevention efforts*

Finally, it is clear from the interviews that reinforcing prevention efforts could make detection and reporting superfluous. The other way round, the detection of alarm signals or risk factors or the identification of vulnerable families is part of prevention. Although a lot of initiatives are already in place regarding the direct or indirect prevention of child maltreatment (e.g. soutien à la parentalité yapaka.be; ouderschapsondersteuning K&G), respondents believe prevention merits more efforts and should be prioritized, especially because it is an important way to stop the intergenerational transmission of abusive situations.

We identified four layers of prevention:

- The identification of vulnerable families
- Supporting vulnerable families, the expansion of the family's resources is one way of doing that
- A child check or an increased awareness among a broad range of professionals working with adults dealing with difficulties such as psychiatric disorders, divorces, addiction, or other conditions considered as red flags in the detection of child abuse. In these contexts asking about the presence of children and their wellbeing may prevent abusive situations.
- Awareness raising and informing the public in general



8 GENERAL CONCLUSION

8.1 Findings from the international literature and from the Belgian context converge to a large extent

Two sources of information were used to learn about the barriers professionals encounter in dealing with child abuse. At the one hand we searched the international scientific literature to list the difficulties documented by other researchers, at the other hand we collected data on the Belgian situation by means of interviews with a broad range of professionals in the field. Generally, the findings from both sources converge to a large extent, i.e. most of the difficulties and barriers reported in the international literature also hold for Belgium. This is quite remarkable since national contexts differ in terms of the organisation of youth welfare services, child protection services, health care provision, education and the legal framework (e.g. related to mandatory reporting and professional secrecy), in short, every sector that is implicated by child maltreatment.

For Belgium we succeeded to get a more detailed view but the issues that came out most strongly were also mentioned in the literature. These most relevant barriers in the detection and reporting of child abuse are situated at the level of individual first line professionals and at the level of collaboration between actors in the field. At the level of individual first line professionals strong barriers are:

- lack of knowledge and skills, including not knowing how to address suspecion with the family, what to expect from specialised services or who to contact in case of suspicion
- time pressure,
- lack of peer and institutional support (e.g. absence of protocols, multidisciplinary consultation)
- fear adverse effects of addressing suspicions such as losing the family or eliciting even more violence.

Collaboration between actors in the field is self-evidently also impacted by these difficulties, but the most relevant issues at the level of interprofessional collaboration are:

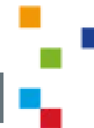
- considerations related to professional secrecy and confidentiality,
- lack of confidence in child protection services (e.g. because of adverse experiences with reporting)

First line professionals and services are mostly confronted with a lack of resources, which means they feel incompetent to detect child abuse and to address suspicion with families. They are not familiar with the field of specialised services and the legal framework, including professional secrecy. Solo professionals feel the need to discuss cases with other professionals. Also dealing with the suspicion of child abuse is time consuming and emotionally demanding.

Although our sample of respondents is not representative, we understood from the interviews that specialized services are overburdened. Their staff is not proportionate to the workload. This seems to be a crucial nexus in the field of professionals dealing with child abuse. Overloaded specialized services cannot meet the expectations of first line professionals in terms of advice, training, support, follow-up in the long run etc. First line professionals are not confident that the children they report will get the immediate and adequate help it needs, and therefore doubt whether reporting is the right option. Also first line professionals get little or no feedback about the children they reported. They denounce the lack of coordination and continuity of care. Sharing information and registration are crucial elements in enabling a more adequate approach.

The information transmission is hampered mostly because of professional secrecy, which renders collaboration between first line professionals, specialised services, police and justice very difficult. In addition the lack of residential short and long term places does also install barriers in dealing with child abuse. As there are no places available, professionals do not report and seek other solutions. Finally, respondents emphasised the importance of prevention, which should start early, more specifically with the detection of vulnerable families during pregnancy.

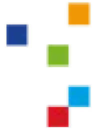
The synthesis of the report provides a more extensive overview of the findings and presents the recommendations and action points.



8.2 Rationale for selected methodologies

The study was initially designed to find answers to the question why general practitioners are underrepresented in the statistics on reporting child abuse. This questioned has been gradually broadened because the research team anticipated a very limited and partial conclusion if general practitioners had to be isolated from the larger field of professionals working with children. Early in the scoping of the project it became clear that to be able to formulate useful and relevant recommendations we needed a broad and in depth approach. Broad in a sense that we needed information from different actors dealing with child abuse. Since child abuse is situated at the crossing of many sectors, this meant involving professionals from youth welfare, child protection, health care, education, justice, and police. In depth means that this delicate social problem could only be addressed adequately in individual semi-structured interviews. This technique in qualitative research is especially suited to collect data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored[108]. It enables the researcher to elicit a vivid picture of the participants perspective[108]. Interviews provide much more detailed information than what is available through other data collection methods, such as surveys[109]. Nevertheless, some limitations are inherent to the technique of individual semi-structured interviews. Data from interviews are not generalisable in a statistical way because small samples are chosen and no random sampling methods are used, but they are theoretically transferrable. Individual semi-structured interviews however, provide valuable information, particularly when supplementing other methods of data collection (here an international literature review). It should be noted that the general rule on sample size for interviews is that when the same stories, themes, issues, and topics are emerging from the interviewees, the data is saturated and a sufficient sample size has been reached[109]. Our sample counted 29 individuals with very heterogeneous backgrounds. The strongest barriers and difficulties as mentioned above (see 7.5) have been repeatedly raised by the interviewees and we are confident that the major issues have been covered. Also to be sure we did not miss an important topic in the findings, we met four times with experts in the field who got the opportunity to comment on the text. At these occasions we completed the text with new information, which resulted in even more depth.

We used an inductive approach to learn about the barriers professionals encounter in dealing with suspicions of child abuse. We puzzled insights we retrieved from the literature and from the interviews together and checked them with experts in the field during expert meetings. We formulated recommendations in order to overcome the barriers and difficulties that have been raised. However, during the reflection leading to the recommendations we missed information on how professionals and services in other countries deal with issues such as professional secrecy, but also (unborn) children's' rights, how to make professionals collaborate etc. This is not surprising since the initial literature search especially focussed on the underreporting of health care providers. Hence we missed an international comparison which could have resulted in a number of good practices as a source of inspirations for our recommendations.



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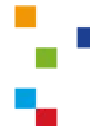

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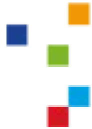

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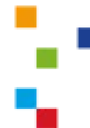

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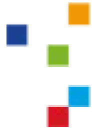

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