KCE REPORT 269Cs

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

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FOREWORD

There are events that move us so that decades later we still know where we were when we learned the news: the attacks on 9/11, the fall of the Berlin Wall, the disaster in Chernobyl, etc. For us in Belgium the tragic denouement of the Dutroux case also belongs on the list. And the fact that after almost 20 years we still remember where and how we learned this news says something about the emotional charge of the event. Child abuse and child mistreatment in any form whatsoever touch our most fundamental moral feelings. The abuse of children and young people has unfortunately never really been out of the news since then. But in fact there are well-founded reasons to fear that the mediatised cases are only the tip of the iceberg, and that violence against children, often intra family, is still too often ignored or neglected.

This research project started with the question of why care providers still too seldom pick up on this sort of problem, let alone take action when child abuse is suspected. It soon became apparent that this framework was too narrow, because there turned out to still be quite a bit of room for improvement on a much wider scale. But in this expansion of the framework the institutional complexity in our land also of course emerged, as prevention, overall approach and sanctioning belong to different levels of competence. To the north or south of the language boundary the views of the most suitable approach may therefore also differ. The role of the KCE in this is not necessarily to find compromises – the least common denominator, one might say – but rather to remain resolutely committed to the child.

Our recommendations in the area of Health Services Research will thus more and more extend over the various competence areas. It cannot be otherwise if we consider the quality of the approach from the viewpoint of the citizen or the patient. And these recommendations will thus also appear more and more on the agenda of the Interministerial Conference on Health. And with regard to the KCE itself, we hope that official representation of the federated states in our administration is achieved soon.

Christian LÉONARD
Deputy General Manager

Raf MERTENS
General Manager

CORE MESSAGES

- The **extent** of child abuse in Belgium is unknown. The number of reported cases of (suspected) child abuse in the correctional and juvenile public prosecutors' offices, the conviction statistics and the police figures give no clear picture, because the phenomenon is recorded under various labels (e.g. "assault and battery", "child at risk"). Therefore there needs to be a focus on uniform registration.
- **Care providers**, especially general practitioners, **report few** cases of (suspected) child abuse. From the figures of the specialised services (Vertrouwenscentra Kindermishandeling or VK - [*Confidential Centre on Child Abuse*] in the Flemish Community and the Equipes SOS Enfants [*SOS Children Teams*] in the French Community) it appears that only 2 to 3% of the reports are made by general practitioners.
- General practitioners, like other care providers such as (paediatric) psychiatrists, midwives, emergency physicians, etc., could play an important role in the early detection and diagnosis of child abuse. However, this demands specific expertise. Therefore more **forensic physicians** should be employed to support the aforementioned care providers. In addition, **training** in communication skills, in the general approach to child abuse, and information about the legal framework and the existing tools and services should be included in the training programmes and continuing education of the aforementioned professionals.
- No reporting obligation exists in Belgium. This means that care providers themselves must consider whether they report a case of suspected child abuse, when they should do that and to whom (police, the judiciary, VK/SOS Enfants, consultation with colleagues). An obligatory **customised step-by-step plan** for care providers, hospitals and facilities involved can help in this.
- The communication, coordination and collaboration between the various assisting services, police, judicial services and professionals from the various sectors involved (general medicine, education, mental healthcare, paediatrics, obstetrics (including midwives), paediatric psychiatry, emergency services, childcare, etc.) must be reinforced.
- The assessment as to whether voluntary assistance is (still) adequate, or whether a report to the prosecutor's office is needed, can take place faster and more efficiently if the assistance, prosecutor's office and police exchange information and consult each other when needed/useful. To make this possible, the current framework of **professional secrecy** must be modified.
- The conflict between **professional secrecy** and the exchange of relevant information in the interest of the child should also be clarified for a better information flow between the various assisting services (e.g. between Kind en Gezin/ONE and the CLBs/PMS/PSE) and with professionals from the sectors involved (general medicine, education, mental healthcare, paediatrics, obstetrics, childcare, etc.).
- Currently the regulations on assistance in the event of child abuse are primarily based on voluntary cooperation of the parents. Sometimes that willingness has limits, however. The legislation should also therefore focus on **early diagnosis of abuse, guidance of parents who do not voluntarily**

cooperate, and situations where a risk manifestly exists for the safety and/or health of the (unborn) child.

- Children under the age of three form a vulnerable group and often slip through the net because they have no access to protective structures like school. It is therefore important to include this group of children who grow up in vulnerable families in the system early. Risk detection and reporting should therefore be an inherent part of perinatal care. In addition, postnatal care should be planned in due time (i.e., during the pregnancy) so that adequate support can be offered to young parents when they leave the maternity ward. Finally, there should be investment in **parenting support**.
- Adult assistance should be attentive to situations where a danger of child abuse may exist. Care providers who treat parents with problems should therefore do a systematic "**child check"**: "Are there children, and how are they doing?"
- Victims of child abuse are sometimes 'parked' in hospitals because it is the only care solution. In addition, they sometimes also stay a longer time in the paediatrics ward for observation and follow-up. A high-tech hospital environment is not the most suitable place in those cases. Therefore **(additional) places should be provided in rehabilitation centres** for long-term observation, accommodation and medical/psychological care of children in situations of abuse or with severe medical/psychological/social needs. This should take place in a network framework, so that if needed a hospital can be called on for diagnosis and necessary medical care of the child.
- The shortage of **places in youth care** should be assessed/monitored and a procedure for an appropriate aid offer, accessible within an acceptable waiting period, should be developed.
- Coordination of the approach to child abuse should be put on the agenda of the interministerial conference on public health.

SYNTHESIS

TABLE OF CONTENTS

1. INTRODUCTION

1.1. A common, complex problem with far-reaching consequences

Child abuse is a widespread problem with far-reaching consequences. In extreme cases child abuse causes the death of the victim. In the European Union, at least 850 children under the age of 15 die annually as a result of child abuse, and of these, children under the age of four form the largest group.[1]

However, fatalities are only the tip of the iceberg. Abuse can have a radical impact on the psychological development of the child, with consequences for the rest of his[a] life, such as mental problems and anxiety disorders, suicide attempts, problematic alcohol and drug use, aggression, and risky sexual behaviour. In addition it can lead to more absences from school, which in turn reduces the chances for a (higher-level) diploma.

In addition to the child himself, society too pays a price for abuse. In the short term there are the costs for the child's healthcare and for the accommodation and welfare services. In the longer term there is also the loss of productivity of the grown child, who is still wrestling with the problems from his early life. Moreover, victims often later become perpetrators themselves. Child abuse is often transmitted from generation to generation.

What is child abuse?

Child abuse is a concept that comprises various criminal offences in the Belgian Criminal Code: rape, indecent assault, incitement to immorality, assault and battery, female genital mutilation, torture, inhumane treatment, intentional withholding of food and care, and abandonment of a minor. Psychological abuse or neglect of minors is not explicitly included as a criminal offence in the Criminal Code. The definitions that are applied in the aid sector[b] are based on the broader definition of the International Convention on the Rights of the Child (Art. 19 ICRC) of the United Nations (20 November 1989)[4], which in Belgium has force of law; namely, all forms of physical or mental violence, injury or abuse, physical or mental neglect or negligent treatment, mistreatment or exploitation, including sexual abuse. For this KCE report the definition of the ICRC is used.

Usually hidden, and even less often reported

Unfortunately child abuse often remains unnoticed. And even if it is noticed, a report is not always made.

Data on the number of cases reported and treated can be obtained from various levels. Within the judiciary, the juvenile and correctional public prosecutors' offices have statistics on the number of reported cases of child abuse. Statistics are also available on convictions for child abuse. The available data are however limited due to a lack of uniformity in the registration of child abuse. At the police level, too, the lack of uniform registration is a factor.

We do have reliable data on the number of reports in the assistance sector, thus outside the context of the courts. In 2014, 7311 reports were made to the Vlaamse Vertrouwenscentra voor Kindermishandeling (VK). Figures on the cases where child abuse was in fact involved are however not yet available. In the French-language 'Equipes SOS Enfants', 5619 reports were made in that same year. In 2043 cases the diagnosis of child abuse was in fact established. These numbers have been further subdivided into physical abuse (22%), sexual abuse (36%), psychological abuse (17%) and neglect (22%). In the German-speaking community the Sozial – Psychologisches

[a] For good readability of this text, masculine pronouns are always used.

[b] Art. 1, 4° Decree of 12 May 2004 on Assistance to victims of child abuse[2]; Art. 2, 32° Decree of 12 July 2013 on integrated youth assistance[3]

Zentrum received 13 reports in which minors were involved from the judicial services in 2014, and the Jugendhilfedienst dealt with seven reports of sexual abuse.

One-half to three-fourths of the reports or requests for advice to the VKs or Equipes SOS Enfants come from professionals who come into contact with children through their occupations.

Professionals who report come from highly varied sectors: welfare and healthcare (general practitioners, paediatricians, psychologists, Kind & Gezin [*Child & Family*], etc.), the education sector (teachers, Centra voor Leerlingenbegeleiding (CLBs) [*Student Guidance Centres, SGCs*], etc.) and the judiciary (police, magistrates, etc.). In the French Community (Wallonia-Brussels Federation)[c], most of the reports to SOS Enfants are made by employees of the youth assistance service 'Les Services d'Aide à la Jeunesse' (SAJ). In Flanders, most reports are made by people from the school environment (22%) and especially by the CLBs (SGCs) (18%). The number of reports by the medical sector is rather small: less than 9% in the French Community, 3% of them from general practitioners, and 20% in Flanders, only 2% of them by general practitioners. Child daycare centres are represented even less: less than 1.5% of the reports to the VKs take place through them, while children under the age of three are the most vulnerable group.

1.2. Topic of the study

The reason for this study was the finding that professionals from the medical sector, and especially general practitioners, report very few cases of (suspected) child abuse. Nonetheless these professionals, because of their relationship with the family, could be one of the central figures in detection of abuse. Therefore the original research question was also how detection by first-line care providers could be improved. Detection and reporting of abuse, however, take place within a system that is much broader than that of healthcare alone. Therefore it was absolutely necessary for us to study the various participants involved and the phases of the entire decision process, from prevention to the approach taken. In this way we could identify measures that would improve the overall efficacy of the system.

We have investigated what the obstacles are at present for professionals in e.g. the medical, psychosocial, judicial, welfare and education sectors and youth assistance services in detecting, reporting and/or offering help in the event of (suspicion of) child abuse. The viewpoint of the victim himself and of his family with regard to the available assistance was not investigated here, nor was the viewpoint of the perpetrator. In this report the word 'child' is intended to mean any minor.[d]

1.3. Methodology

In our research project we used the following methods:

- Review of the international and Belgian scientific literature in relation to the barriers in detecting and reporting child abuse.
- To put the results found in a Belgian context, we have described those active in the field on the basis of grey literature, information on websites and contacts with key figures from the field.
- In addition, individual, semi-structured interviews were conducted with 29 professionals from the Flemish and French Communities in, among others, the medical, psychosocial, judicial, welfare and education sector, and youth protection services[e]. They were questioned about the barriers they experience in detecting, reporting and/or offering help in

[c] Called the "French Community" hereinafter

[d] With the exception of the unborn child (Art. 388 – 488 Civil Code)

[e] Promotion de la santé à l'école [*Promotion of Health at School*] (PSE), Centrum voor Leerlingenbegeleiding (CLB) *[Student Guidance Centres (CGS)*], Centres psycho-médico-sociaux [*Psychological, Medical and Social Centres*] (CPMS), Office de la Naissance et de l'Enfance [*Office of Birth and Childhood*] (ONE), Kind en Gezin, Ligue de Service de Santé Mentale [*Mental Health Service League*] Centra voor Geestelijke Gezondheidzorg [*Mental Healthcare Centres*] (CGG), SOS Enfants, Vertrouwenscentra Kindermishandeling, Service de l'Aide à la Jeunesse (SAJ), Ondersteuningscentrum Jeugdzorg [*Youth Care Support Centre*] (OCJ), Service de Protection Judiciaire [*Legal Protection Service*], general practitioners, paediatricians, emergency physicians, nurses, police officials from the Commission Permanente de la Police Locale [*Standing Committee of the Local Police*] and the Jeugdbrigade [*Youth Brigade*] and magistrates connected with the juvenile court.

the event of a suspicion of child abuse. In addition the already existing incentives for a proper approach were examined.

- On the basis of study of the international and grey literature and qualitative research among groups of professionals that potentially confront child abuse, we arrived at a number of recommendations, which we tested for acceptability and priority with a group of stakeholders by means of an online survey and various stakeholder meetings.
- As for all KCE projects, the report was finally validated by four experts in the field who had not participated in the study as a respondent or as a stakeholder.

In the colophon you will find the detailed list of all the participants in this study as well as the validators.

The scientific report contains a more extensive description of the methodology used.

2. POLICY IN BELGIUM

2.1. No standard procedure for handling child abuse

No standard procedure exists for handling child abuse. There are after all many different factors that play a role, such as the circumstances (urgency, abuse in or outside of the family, etc.), nature, frequency, duration, severity of the child abuse, age of the victim, underlying family issues (poverty, drug addiction, etc.), and so forth. Anyone who comes into contact with children in a professional capacity can in principle have a key role in the detection and further action taken on a suspicion of child abuse.

In Belgium professionals are not required to report abuse to the judiciary authorities. The Belgian criminal code does contain a number of provisions that specifically serve to punish perpetrators of child abuse. Punishing the perpetrator is however not always the best solution, especially if parents who abuse their child are involved. Assistance can also focus on improving the living conditions of the child and the relationship with his parents, and the three communities organise assistance starting from this philosophy (see Appendix 1 of the scientific report). In a voluntary youth assistance procedure, the parents and/or the child request help or at least consent to and cooperate with it. If voluntary assistance is not (or is no longer) possible, a mandatory help procedure (judicial youth assistance) can be imposed by the juvenile court judge against the wishes of the parents and/or the child.

2.2. Step-by-step plans and consultation structures with a view to information exchange between the parties involved

In Flanders the “Child Abuse Protocol” of March 2010, ratified by the Federal Minister of Justice and the Flemish Minister of Welfare (updated in May 2014) exists. It contains a step-by-step plan that can serve as a guideline for the various professionals for handling child abuse. On the basis of this protocol, the Vlaams Forum Kindermishandeling [*Flemish Child Abuse Forum*] (VFK) has been established as a structural consultation body between the various parties involved, and to enable advice to be given to the ministers involved.
In the French-speaking part of the country too there is a “Protocole d’intervention maltraitance des enfants entre le secteur médico-psycho-

social et le secteur judiciaire" [*Child abuse intervention protocol between the medical-psychological-social sector and the judicial sector*]. Here too a structural consultation initiative exists, namely "Conférence permanente de concertation maltraitance [*Standing abuse consultation conference*]". In addition a brochure has been drafted, "Que faire si je suis confronté à une situation de maltraitance d'enfant? – M'appuyer sur un réseau de confiance [*What should I do if I am confronted with a child abuse situation? Turn to a confidential network*]", which has been approved by the federal Minister of Justice, the French Community and the Walloon Region.

There is also 'La Coordination de l'aide aux victimes de maltraitance [*Coordination of aid to abuse victims*]', which organises training for care providers and coordinates the activities of the various government services. It is also responsible for Yapaka[5], an organisation of the French Community that attempts to support parents (soutien à la parentalité) and so works preventively. Other policy and collaboration protocols in the communities are more extensively discussed in the Appendix of the scientific report.

2.3. No obligation to report to the prosecutor's office

Care providers regularly wrestle with professional secrecy when they are confronted with (suspected) child abuse. Are they bound by it and may they not file a report? Or are they on the contrary culpable if they do not report child abuse? And with whom may they share sensitive information?

It is in fact not mandatory in Belgium for care providers to report child abuse to judicial authorities. The argument for this is that mandatory reporting could discourage victims and perpetrators from calling on assistance. It could also encourage care providers, even in the event of doubt, to file a report more quickly and so shift the responsibility onto the judiciary authorities (for a further discussion, see 6.1.3 of the scientific report). In line with this, the legislation of the communities establishes that the procedure for voluntary assistance should be exhausted insofar as possible before legally mandated assistance is involved.[f] In very severe or urgent cases (see further conditions of Art. 422bis, Criminal Code) a report to the judiciary authorities is of course necessary.

2.4. Sharing information: a careful assessment

Article 458 of the Criminal Code governs professional secrecy in the healthcare and welfare professions, such as physician, pharmacist, nurse and all other persons who "on the basis of their status or occupation" have confidential information entrusted to them. In addition there are legal provisions with regard to youth protection and youth assistance that provide an obligation of confidentiality for assistants.[g]

Can there be derogations from professional secrecy?

There can be derogations from professional secrecy, for example if violating professional secrecy was the only option to help a person in grave danger (Art. 422bis, Criminal Code– culpable omission) or if the person subject to secrecy is called to testify before a court. In addition, since 2001 there exists a legal right to speak; any professional who is obliged to professional secrecy can according to the conditions of Article 458bis of the Criminal Code report a case to the public prosecutor if a serious infringement of the physical or psychological integrity of a minor is established or if there are indications that other minors are also victims of this, and if the care provider together with any other care providers can no longer ensure the safety of the minor. More generally, jurisprudence allows professional secrecy to be violated to protect a higher interest (for example, when a serious and imminent danger exists for the physical integrity of a child) (state of emergency).

Can those involved release the person subject to secrecy from professional secrecy?

There is a certain discord on this in case law and jurisprudence. There are arguments and rulings that go in both directions.[h] There is a recent tendency

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f Art. 47, 1° Decree of 12 July 2013 on integrated youth assistance, Introductory title. - general framework to which the Decree on assistance to youth belongs, Decree of 4 March 1991 on Youth assistance [6]

g Art. 3 Decree of 12 May 2004 on assistance to victims of child abuse, Art. 7 Decree of 12 July 2013 on integrated youth assistance

h **Advocating that professional secrecy cannot be lifted by the consent of the party concerned**: Cassatie 20 February 1905, *Pas.* 1905, I, 141; Art. 64 Code of Medical Ethics; Brussels 8 March 1972, *RDP* 1971-72, 922; Arbeidshof Bergen 5 September 1980, *RDP* 1981, 99. C. Braas, *Précis de droit pénal*, Brussels, Et. E. Bruylant, 1936, 154-155, no. 227; L. Nouwynck,

in case law to allow information exchange on condition that the consent involves a clearly delimited part of the information that is given to a person identified in advance. This consent must also be given freely, explicitly and on an informed basis.[7, 8]

Shared professional secrecy between care providers

Care providers who are subject to professional secrecy and who treat the same care recipient may mutually exchange confidential information on this person if this is needed for treatment (shared professional secrecy). The care recipient must at least know which data are being transmitted to whom, and if possible this takes place with his consent and preferably in his presence. It is also important that the other care provider acts with the same objective. For example, police officials have not only an obligation to silence, but also an obligation to report.[i] Transfer between care providers in an extrajudicial context and care providers in a judicial context under shared professional secrecy is therefore not possible. In recent years more and more experimentation has been done in several pilot projects on researching the boundaries of professional secrecy in the collaboration between assistance, the judiciary and the police. Important projects are the Protocol van Moed [*Courage Protocol*] and the CO3 project, both in Antwerp, the LINK project of the Province of Limburg, and the Korte Keten project in Mechelen (see appendix of the scientific report).

Professional secrecy with regard to the parents

Care providers also have an obligation to professional secrecy with regard to the parents of the minor. As legal representatives of their minor child, however, parents also have the right to confidential information. They need this, e.g., to be able to appear in court, for example in civil proceedings. Sometimes a conflict of interest can exist between parents and children, for example if the parent is also the perpetrator. The minor can then ask that certain information not be transmitted to the parents. It is expected that as the child acquires more discernment, parents must intervene less and less, so that it is also less necessary to give them certain information.[j] For very small children it can however sometimes be a problem that a parent-perpetrator can examine the child's file.

Professional secrecy and duty of discretion in schools

Teachers, unlike employees of the CLB (SGC)[k]/PMS[l], are not subject to legal professional secrecy, because they are not professional care providers.[15,16] They do have a duty of discretion. Therefore school personnel cannot invoke a right to silence with regard to their hierarchical superiors or colleagues. The interest of the students must however always be taken into account. In data exchange with the CLB/PMS they can in principle appeal to their obligation of discretion to not simply transmit all data. They will have to make the assessment of whether the data are sufficiently relevant to exchange. For data exchange between CLB/PMS employees and other welfare and assistance agencies or individual care providers, the consent of the parents of the child (older than 14) is always needed.[14, 17, 18]

"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; ***Acknowledging professional secrecy in the interest of the party concerned***: Hof van Cassatie, 13 March 2012, *NJW*, 268, p. 597; Recommendation of the National Council of Order of Physicians of 30 April 2011 – Information to the VDAB on work-limiting disability, *T. Orde Geneesh*. 2011, no. 133; Recommendation of the National Council of the Order of Physicians of 29 October 2011 – Information to the VDAB on work-limiting disability, *T. Orde Geneesh*. 2011, no. 135

i Art. 29 *Code of Criminal Procedure*[9] and Art. 40 Law on the Police Service of 5 August 1992[10]

j Art. 8, §1, and Art. 12 Law of 22 August 2002 on the Rights of the Patient[11] and Art. 30 and 61 Code of Medical Ethics

k Art. 11 Decree of 1 December 1998 on Student Guidance Centres[12]

l Art. 12 Decree of 14 July 2006 on missions, programmes and activity report of the psychological, medical, and social centres[13]; Recommendation no. 13/1205 of the Conseil supérieur de la Guidance psycho-médico-sociale et de l'Orientation scolaire et professionnelle on professional secrecy of staff members at Psychological, Medical and Social Centres[14]

3. CHALLENGES IN THE APPROACH TO CHILD ABUSE

The difficulties and challenges in an efficient approach to child abuse that have been cited by the parties questioned during the interviews are similar to those that have been cited in the literature. When there are differences, they are usually caused by the different ways in which prevention and assistance are organised in the communities. There is a detailed description of the findings from the qualitative aspect in Chapter 7 of the scientific report.

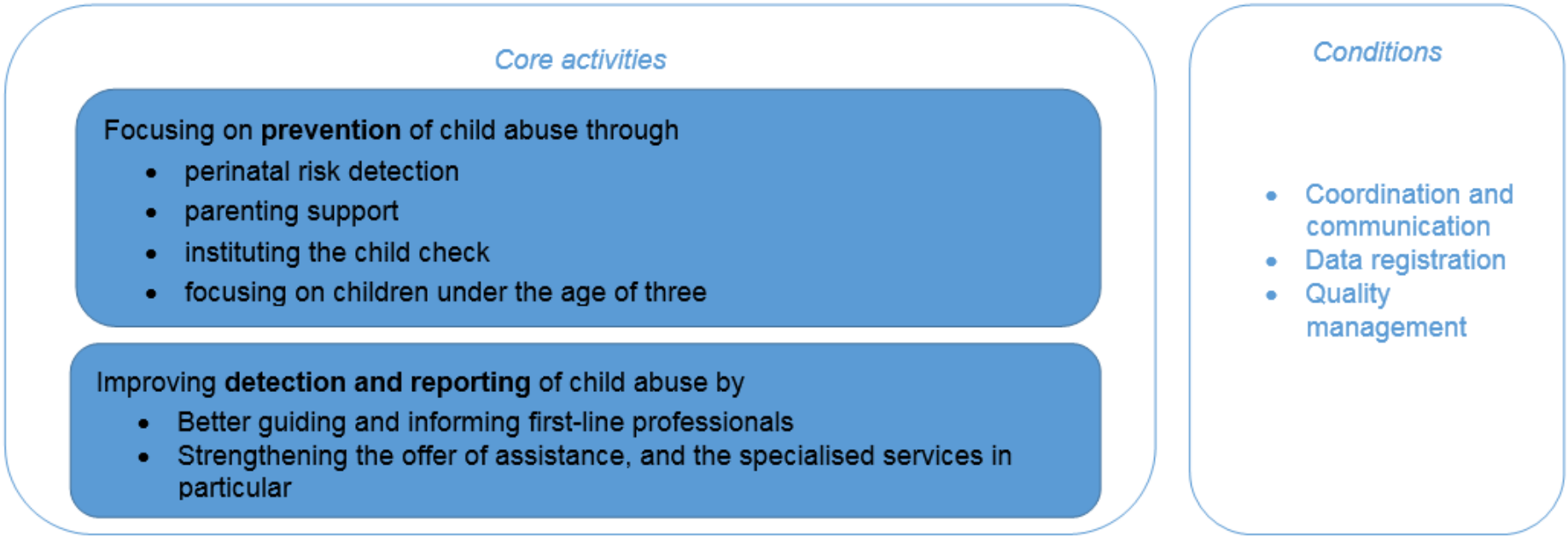
The perception among professionals and staff of **low-threshold**[m] services is that there is in particular a lack of time and resources to effectively handle the problem of child abuse. Furthermore they often feel not sufficiently competent in detecting and enabling discussion of child abuse with their patients/care recipients, and they often have too little knowledge of the network, the legal framework on professional secrecy and the ways of filing a report. They indicated that they feel inadequately trained and supported in this. In particular, professionals who work in an individual practice say that they need consultation with other professionals to come to a joint decision on the first approach to a (suspected) case of child abuse. In addition, confrontation with the phenomenon of (suspected) child abuse often heavily burdens professionals emotionally, aside from the extra workload that it brings with it. General practitioners also indicate that a close relationship with the family can hinder detection of child abuse.
For **the specialised services** (VK and SOS Enfants) and SAJ too, an excessive workload and a staffing shortage appear to be the greatest challenges. They hamper, among other things, efficient collaboration among the various parties. Moreover the various parties indicate that when they 'hand over' a case, there is little feedback on its follow-up. According to some respondents, feedback is sometimes impossible due to professional secrecy, although they admit that this argument is sometimes also unjustly used as an excuse for a failed feedback policy. The lack of information flow also sometimes makes efficient collaboration between assistance, police and the judiciary difficult. A hampering factor for all those involved is also the shortage of (non)residential accommodation (places) for abused children and (possibly) their families. Finally, the respondents also report that a policy is needed that focuses on prevention and that pays attention to the coordination and continuity of care. In this, good data registration can help to better map out the extent of the problem and the problem areas.

[m] By low-access, we mean services to which anyone can turn with any question whatsoever. In other words, they are those services that serve as the first contact point when there has never been contact with an aid worker, for example the Centra Algemeen Welzijn [*General Welfare Centres*].

4. ONLY AN APPROACH AT DIFFERENT LEVELS HELPS

A broad, systemic approach is needed to reduce the number of victims of child abuse in the long term (intergenerational transmission) and to limit the damage for every victim. The following activities are needed for this: attention to prevention and timely reporting, adequate support for professionals who are confronted with child abuse in the first line, sufficient resources for the specialised services, and adequate capacity in the specific assistance for victims and perpetrators (see also Figure 1).

Figure 1: An approach at different levels



4.1. Prevention and detection

Child abuse often arises due to an accumulation of risk factors such as poverty, unemployment, (contentious) divorces, relationship problems, partner violence, isolation, reconstituted families, lack of a supportive informal network, addictions, psychological disorders, personality disorders, having experienced child abuse oneself, poor cognitive skills, poor pedagogical skills of the parents, or disabilities of the child. Up to the present there is no, or not enough, specific focus on families with risk factors in the approach to child abuse. Nonetheless it appears from the literature that a satisfactory prevention policy is essential in an effective approach to child abuse.

4.1.1. Early investment in support to families

The literature shows that support to vulnerable families in crucial life phases such as pregnancy, childbirth, and early parenthood can reduce risk factors and strengthen families.

4.1.1.1. Perinatal services

Recommendation 1

Identify families with risk factors during the pregnancy. Make risk reporting an inherent part of perinatal care.

Action point 1.1: Provide a step-by-plan that must be followed in every maternity ward.

Effective prevention is best started before the birth of the child with prenatal guidance of (vulnerable) pregnant women/families. This is the first step in a good care chain, in which there should be a seamless transition between prenatal, postnatal and youth healthcare. Professionals (e.g. gynaecologists, midwives, general practitioners) can identify families at risk in the prenatal phase, offer support from their field and help to strengthen their social network. They should also systematically screen for the presence (of a combination) of the following risk factors: young age of the future parents, low educational level, unemployment, a child with a limitation, a parent with psychological problems and/or a psychiatric issue, a parent with a (slight) mental limitation, a parent who has experienced child abuse himself, undesired pregnancy, partner violence, single-parent families and stepfamilies, or the presence of an addiction. The information should be included in the perinatal care plan that is incorporated into the shared electronic maternity file (see Recommendation 2, Action point 2.1, KCE report 232A[19]). A perinatal care coordinator can play a key role in follow-up of worrisome factors during pregnancy, birth and postpartum, and can ensure continuity of care at crucial times, including discharge (early or otherwise) from the maternity clinic.

From the interviews it appears that neither Kind & Gezin (K&G) nor the teams from SOS Enfants and the Office de la Naissance et de l'Enfance (ONE) uses checklists to identify families at risk. Nonetheless the list of signs that is used within integrated youth assistance is accessible to every care provider, and K&G has a scientifically validated instrument, the POS scale.[20] At present, the guideline of Domus Medica on pregnancy support already contains an admonition to identify possible depression in the first contact, and the care provider should be alert for symptoms or signs of domestic violence.[21]

In French-speaking Belgium, ONE organises free prenatal consultations for medical and social guidance during pregnancy. In addition, medical and social workers (TMS) give support to future parents. There are agreements between gynaecologists and ONE to refer vulnerable future mothers to the prenatal consultations. In addition there are three perinatal services (Aquarelle (Saint-Pierre UHC), Ecoline (Charleroi) and Seconde Peau (Liège)), with a programme subsidised by ONE. They provide personal medical and social guidance to pregnant women or women who have just given birth in a vulnerable situation. Such initiatives are also being considered in other provinces.[22]

In Flanders the prenatal services take place in a local network approach, with all the relevant partners such as midwives, general practitioners, gynaecologists, maternity care and other partners within the Huizen van het Kind [*Children's Houses*]. There is to be a reorganisation of preventive family support. The regional teams of Kind & Gezin will be able to build up an offer that better suits the local needs. In addition they will be able to employ

customised resources for every family, such as a house visit, online services, the portal site mijnkindengezin.be and group contacts.[23]

Recommendation 2

Invest in postnatal care as recommended in KCE report 232-2014[19] and support mothers and fathers in their (new) role as a parent.

Action point 2.1: Strengthen the informal support networks of parents by bringing them together in educational groups during pregnancy and postpartum.

Many small-scale initiatives invite parents to meet other parents and so stimulate informal support networks. For example, there are "Mama Cafés", baby massage workshops and prenatal workshops. But often these activities do not reach the parents who need them the most.

We took the idea of parent groups, an initiative originating in the United States and already taken up by the Scandinavian countries and the Netherlands, from the literature. CenteringParenting is an interesting example of parent groups to structure postnatal care in the long term and give advice to parents.[24] Here, medical care is combined with information, education and the exchange of experiences among pregnant women, so that women are also reached who normally participate much less in pregnancy education and other courses in preparation for labour and childbirth.

Action point 2.2: Prepare for postnatal care at home during the pregnancy, so that within 24 hours after discharge a midwife who follows up mother and child for at least the first ten days comes to the house. Follow-up at home should be ensured before vulnerable mothers leave the hospital.

Due to the reduced stay, along with the more and more frequent absence of informal support networks, the postnatal period is a great challenge, especially for the most vulnerable families. Moreover the reduced hospitalisation can make it difficult to organise acquaintance with the preventive care provision of Kind & Gezin/ONE during the hospital stay in the maternity ward. To deal with this, ONE is considering offering a prenatal consultation two months before the probable delivery date.

At the time the overview is being written, seven pilot projects with the theme “childbirth with reduced hospital stay” are beginning in various hospitals that will collaborate with other facilities and with first-line care providers such as midwives, home nurses and general practitioners. In addition expertise centres, Kind & Gezin, ONE and a number of private partners are also cooperating in this. The future mothers themselves decide whether they want to participate in the project.

Action point 2.3: Develop coordinated activities to support vulnerable families and to prevent them dropping out of the perinatal care trajectory.

The White Paper on access to healthcare in Belgium (RIZIV 2014) recommends that care for mother and child be approached comprehensively.[25] This involves health risks to children in general, regardless of the cause of these risks. In this, the report stresses the importance of an integrated care programme for vulnerable families until the child goes to elementary school. Early detection by general practitioners, gynaecologists and midwives is a part of this. The postnatal care plan should be developed very carefully (especially paediatric aftercare) and well attuned to the specific needs of the family. There is also a need for more housing solutions for young mothers in need and their babies. They should be part of the offer of the maternity clinics instead of depending on private or charity initiatives.

4.1.1.2. Parenting support

Recommendation 3

Invest in coordinated parenting support for everyone, but with special attention to vulnerable families.

From analysis of the interviews it appears that difficult child-raising situations often lead to child abuse, but it is not easy to determine the moment at which a problematic child-raising situation becomes child abuse. This insight, along with foreign experiences (e.g. in the Netherlands), argues for giving **parenting support** to 1) enable discussion of child abuse, and 2) to prevent problematic child-raising situations deteriorating into child abuse.
There are already numerous initiatives in Belgium (see appendix on prevention in the Flemish and the French Community) to support parents, with extra support for families at risk. These initiatives however remain very voluntary and piecemeal, with a lack of continuity between the initiatives and little consultation between the partners involved. Consultation offices of K&G/ONE, for example, do not systematically send all the files to the CLBs/PMS as soon as children go to school, so that CLBs/PMS must start again from zero.

4.1.1.3. Child check

Recommendation 4

Ensure adequate coordination between adult assistance and youth assistance. Care providers who treat parents with problems should do a "child check": are there children, and how are they doing?

From the interviews it appears that the parent's problem, often in the form of an addiction and/or psychiatric issue, is inadequately known to youth assistance, and that there is no coordination between youth assistance and for example adult psychiatry.
In addition care providers from adult assistance pay too little attention to the risk of child abuse in the children of (a) parent(s) with a problem. In the Netherlands the so-called "child check" exists for this in the reporting code (see below); this means that the professional is required in certain cases to check whether his adult patient has minor children that he cares for at home. If due to the medical situation or other circumstances there is a risk of serious damage to those children, the professional should examine in a discussion with the patient whether further action should be taken, by following the steps of the reporting code.[26] In the Netherlands inclusion of the parent check in the reporting code is also being considered. This means that professionals from youth assistance and youth healthcare are to check whether for children with problems there is an issue of a parent with certain risk factors for child abuse (psychological problems, addiction, mental limitation, etc.).

4.1.2. Focus on the vulnerable group of young children

Recommendation 5

Invest extra resources in the prevention and detection of child abuse in children below the age of three in the form of training staff of child day care centres and childminders in risk detection, and the creation of safety nets in postnatal care and in maternity wards.

The statistics show that children between 0 and 3 years of age in particular run a greater risk of physical abuse and neglect than older children. They are more vulnerable and dependent. Moreover they are non-verbal, so that unless there are injuries that are unmistakeably the consequence of child abuse, it is very difficult to establish abuse. Good and accessible social and educational infrastructures such as child day care centres and schools offer protection from abuse. They not only preventively alleviate the "burden" of parents, but have an important warning function if things threaten to go wrong. Nonetheless it is just the group of the youngest children that often slip through the net. Places in childcare are becoming more and more scarce, especially in the major cities, and are often not a feasible option for unemployed parents or parents in a lower income category.

Kind & Gezin/ONE can invite families with children under the age of three and/or conduct home visits, but these are always voluntary. If parents systematically fail to show up, this is followed up, e.g. by telephone contact to urge families to come, or to sound out whether they have contacted other

care providers. In the child daycare centres connected with ONE, there are regular medical consultations. Parents who register their child in a ONE child daycare centre also agree to this at the same time.

Children who do not go to a child daycare centre and/or whose parents do not go to ONE/K&G consultations thus avoid the system. Because children are only required to attend school as of six years of age, they are also not subject to the required medical examinations at school. The mandatory nature of these examinations is by the way relative, as there are no sanctions connected with failure to participate.

Training staff of child daycare centres and child minders in risk detection and safety nets in postnatal care and in maternity wards can lead to an integrated approach to prevention and detection of child abuse for children in the youngest age category.

4.2. Reinforcement of knowledge and skills and support of the professionals involved

Recommendation 6

Integrate the knowledge and skills needed for prevention, detection and reporting of child abuse into the training programmes and continuing education of emergency physicians, general practitioners, gynaecologists, paediatricians, nurses, midwives and staff of child daycare centres.

Action point 6.1: Improve the knowledge of risk factors and the communication skills of care providers who may be confronted with child abuse.

First-line care providers indicated in the interviews that they feel inadequately informed about and familiar with the recognition of alarm signals (red flags), risk situations or abuse. They should therefore be trained so that they can systematically identify risk factors. In addition they find it difficult to discuss suspected abuse. They worry that they will damage the patient-care provider relation in this way and think that they do not have the communication skills needed. First-line care providers should therefore be informed about and trained in communication skills, so that they can initiate a dialog with parents in high-risk and complex situations. According to the professionals questioned such training is at present often not yet included in the curriculum, or only in a fragmentary way.

Action point 6.2: Strengthen the advisory function of the VKs/SOS Enfants to support care providers in detecting and reporting child abuse.

At present training sessions and information meetings are regularly organised for professionals, e.g. by the 'Commissions de coordination de l'aide aux enfants victimes de maltraitance', the VKs, ONE, YAPAKA, Kind & Gezin, etc. These training sessions however often take place on request, are voluntary and are not systematically planned in the further training of professionals. Moreover at present the specialised services often cannot comply with all training requests due to lack of time and inadequate financing. There is also no overview of all the training sessions/information meetings offered. Therefore it often costs professionals a great deal of time to find the desired information. VKs/SOS Enfants could systematically offer support to professionals if they receive specific resources for this.

The personnel who are responsible for the consultations and references of ONE are trained in risk detection and could, through their experience in daily practice, be responsible for training other professionals in this. The training centres of the various professional groups involved would also be able to systematically include training on dealing with child abuse in their further training programme.

Action point 6.3: Organise an information meeting regularly on the existing assistance offer and the relevant contact persons for professionals who may be confronted with child abuse.

From the literature and the experiences of participants it appears that a thorough knowledge of the existing networks and contact persons leads to more self-confidence and a more active attitude of care providers in dealing

with child abuse. A regular information meeting on the existing network and the relevant contact persons therefore seems indicated. In every Flemish province, practical consultation is formally organised from the Intersectoraal Regionaal Overleg Jeugdhulp [*Intersectoral Regional Youth Assistance Consultation]*. There, professionals inside and outside integrated youth assistance can come together to exchange anonymous cases, report difficulties and opportunities in the collaboration, etc. This channel can also be used to distribute information on the existing network. The VKs or SOS Enfants teams could also organise a regular information meeting for certain professional groups. Professionals who have very recently begun working or who would like a refresher of their knowledge of the existing network could then register for this.

Recommendation 7

Introduce a mandatory step-by-step plan for facilities in the sectors involved in order to structurally anchor detection and reporting.

In Belgium there is no obligation to report. Most respondents see this as an advantage, because it would otherwise undermine the relationship with the care recipient. On the other hand, a professional who does not report child abuse can be accused of having omitted to help to help a person in great danger.

The absence of a formal reporting requirement means that professionals bear a greater moral responsibility, but also that they have the freedom to decide whom they involve in the process (the police, judiciary, VK/SOS Enfants/SAJ) and at what time. To make the right choice, professionals should know what steps they can take and what their possible consequences are. For various professionals there now exist resources (alert list, brochures, websites, child abuse step-by-step plan, abuse intervention protocols, Domus Medica guideline, etc.) that support them in reacting appropriately to a suspicion of child abuse. From the interviews however it appears that these tools are not well known and/or that professionals do not find their way to them.

In the Netherlands, professionals in healthcare, education, childcare, social support and youth assistance have been legally required to use the reporting code in the event of suspicion of domestic violence and/or child abuse since July 2013.[27] The reporting code is a sort of behaviour code and contains, in addition to a description of the steps to follow, an alert list and a discussion guide. Every sector may develop its own reporting code internally, but it must be based on the “basic model for domestic violence and child abuse reporting code”. Professionals receive support from the government in introducing the reporting code (e.g. via newsletters, toolkit, training, campaign etc.).

A mandatory reporting code is different from a reporting requirement. With a reporting requirement the professional must report his suspicions of violence to other authorities. With a reporting code the professional is free to decide himself whether he reports suspicions of domestic violence, and the step-by-step plan of the reporting code offers guidance in this. Research shows that professionals with a reporting code intervene three times more often than professionals without a reporting code.[28]

In Flanders, accredited facilities are required to issue a procedure for dealing with inproper behaviour[n] in the framework of the quality decree[29]. A reporting requirement with the approving government service is provided in this. Care professionals however do not have that requirement. Moreover the focus lies on inproper behaviour ‘on the workfloor’ of the facility (e.g. in child daycare centres) and/or in the patient/care recipient-professional relationship, and not on other forms such as intrafamily abuse or mistreatment. Some organisations have already developed a step-by-step plan on their own initiative. The Brussels VK has developed a step-by-step plan for child daycare centres: “handling concern about and early detection of child abuse”. It offers a guideline for detecting, assessing, discussing and handling suspected problems in young children. Kind & Gezin too has developed a guideline for situations of concern based on the Dutch Reporting Code.

[n] A situation in which a child is or risks being a victim of threats or violence from a person in the facility, e.g. childcare.

Recommendation 8

Hospitals should have a protocol and a screening instrument for dealing with suspicions of child abuse. Emergency physicians and paediatricians should receive specific training on this.

Emergency services can play an important role in recognising child abuse. The figures of VKs show that in 2014 only 487 of a total of 7311 reports, or 6.6%, came from the hospital sector (hospital physicians, hospital social services, other hospital personnel) (see Table 4, scientific report for the % of reports/type of reporter). In many Belgian hospitals the emergency service lacks a protocol for reporting child abuse. Moreover hospitals do not (fully) record child abuse. For every patient who reports to the emergency unit, the reason for the consultation is to be registered. For uniform registration the label '(suspicion of) child abuse' should be included in the classification of the conditions to be registered. In the UREG registration the labels "Interpersonal violence, physical/sexual aggression, neglect" and "intra family violence" are now used.[o] For hospitalised children the diagnostic data are registered in the minimal hospital data. Stakeholders however suspect an underestimate, given that child abuse is not always (properly) registered.

Recommendation 9

Give forensic physicians a formal mandate so that they can be consulted by other physicians in diagnosing child abuse.

Diagnosis is the essential link between reporting child abuse and a customised approach. An incorrect interpretation of a bodily injury can after all cause people to be unjustly accused or even convicted, or conversely, victims do not get the proper protection. Physicians do not feel comfortable diagnosing child abuse, for various reasons. They consider themselves insufficiently competent to distinguish mistreatment from 'normal' injuries, or feel hesitant to make the diagnosis because they doubt or are afraid of the consequences for the child or for their relationship with the parents. Support by an independent and specialised third party, like a forensic physician, can be liberating in this.

Forensic physicians are now occupied with e.g. examining victims and perpetrators in sexual aggression and child abuse. These tasks can be carried out both in the context of a criminal investigation and in the framework of civil proceedings (as an expert or an advising physician). Their task can be expanded to forensic support of other professionals in clarifying physical injuries. The existing departments in some hospitals can be involved in this and reinforced with the needed forensic physicians. Another option is that the future specialised centres for victims of sexual violence, which will act as multidisciplinary centres for receiving and supporting these victims, or the VKs and SOS Enfants would play a role in this. In addition a mobile team with a forensic physician and possibly a nurse can be structurally employed, as in the Netherlands.[p] The team can then come by on request of a physician who suspects mistreatment or sexual abuse. The consent of the parents and/or the (> 14 years old) child is always required for examination of an injury.

If more forensic physicians are employed to support other physicians, more resources will need to be made available for training specialist physicians in legal medicine. There is now an acute shortage of these physicians. Moreover a possible overlap of roles should also be taken into account; forensic physicians who play a consulting role will no longer be able to act in the same case in judicial proceedings later.

[o] UREG is a registration system in real time in the emergency services in Belgian hospitals: http://www.health.belgium.be/nl/publicaties-ureg; there is also a requirement for registration of the URGADMIN module in minimal hospital data: http://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/richtlijnen_domein_5_medische_gegevens_m_2015-12.pdf. A disadvantage is that data are only available after a period of two years.

[p] For examples from the Netherlands see: Landelijk Expertise Centrum Kindermishandeling (LECK) [*National Child Maltreatment Expertise Centre*]: 24 hr per day forensic-medical advice (http://leck.nu/); Utrecht Forensic Medical Child Abuse Centre (https://www.polikindermishandeling.nl/)

4.3. Reinforcement of the specialised services for child abuse (VKs, SOS Enfants) and SAJ

Recommendation 10

Reinforce the specialised services (VKs, SOS Enfants) so that they can fulfil their various functions properly and further develop:

- **support and advise professionals from various sectors (advisory function)**
- **help children and families adequately as long as needed (second-line function)**
- **develop and introduce prevention strategies (preventive function)**
- **act as a mandated facility in collaboration with judicial services (function as mandated facility)**
- **man the 1712/103 helpline and allow it to function properly, preferably 7/7 (helpline)**
- **register and make available data related to the aforementioned core functions (informative function).**

Action point 10.1: Measure the workload and efficiency of the VKs/SOS Enfants/SAJ and adapt the human and financial resources to their functions.

In both the Flemish and French Communities a model is applied in which (subject to urgency or refusal of cooperation) voluntary assistance should be exhausted before a suspicion of child abuse is reported to the judiciary. The capacity of the chief parties involved in voluntary assistance should therefore also be commensurate. It should translate into sufficient personnel and expertise, which is not now the case. Thus, the VKs in Flanders have received the assignment to act as a mandated facility, without any adjustment of the staffing. A VK now should have a minimal basic team with a physician, a licentiate/Master in psychology or pedagogy, a social assistant and an administrative employee.

Some VKs employ the same staff members for 'regular' assistance and for the mandated facility. While the VK in its 'regular' assistance task is fully committed to the family and the child, in the role of mandated facility it also works indirectly on assignment from the government and judiciary. This double role not only makes it difficult for the assistants involved, but can also affect the trust of the family.

The Flemish government wants to modify the legislative and subsidy framework of the VKs. The intention is that, as multidisciplinary centres that offer supportive expertise and help, they can continue to fully carry out their mission for the public and professionals. The further introduction and follow-up of the Ondersteuningscentra Jeugdzorg (OCJs) [*Youth Care Support Centres*] should take place in parallel and consistently with this.

On the French-language side too, the youth assistance services are faced with increasing work pressure, also because colleagues who leave are sometimes not replaced. The policy plan of the French Community provides for continuing to guarantee at least the current staffing in the youth assistance services.[22]

Action point 10.2: Invest in a network of reference specialists.

Providing staffing for the specialised services (VKs, SOS Enfants) is a difficulty. Stakeholders indicated that competitive compensation cannot be guaranteed for specialists and that job security sometimes cannot be ensured in the long term, so that the physician position in the VKs and SOS Enfants has become a bottleneck occupation. In addition the consideration of whether to invest in a generalist or a specialised physician also enters into the choice to recruit a physician. Sometimes the share of medical care in cases appears to be inadequate to significantly involve a physician in a VK/SOS Enfants team. The availability of a budget for purchasing customised expertise as an alternative for employing a physician can then be an option. Some VKs now already call on external expertise, especially forensic paediatricians. In this scenario, investment in a Belgian network of reference specialists could be considered.

4.4. Reinforcement of the offer of assistance for victims and perpetrators of child abuse

Recommendation 11

Assess the needs and provide an adequate offer of specialised assistance for victims and perpetrators of child abuse.

Action point 11.1: (Additional) places should be provided in rehabilitation centres for long-term observation, accommodation and trauma treatment of children or young people in situations of abuse or with severe medical, psychological, and social needs. This should take place in a network context, so that if needed a hospital can be called on for diagnosis and administration of necessary medical care to the child.

Because child abuse is often accompanied by medical injuries or complaints, victims often end up at the emergency or paediatric department. At the time the report was written, there are no figures on the number of emergency consultations or admissions to paediatrics that are related to child abuse. In the future an estimate should be possible (see Recommendation 8).

Some hospitals now have an expanded operation in the accommodation and treatment of abused children by a multidisciplinary team in the paediatrics department. Experience in these services teaches that a period of 3 to 4 weeks is needed to be able to make a diagnosis, care for and follow up on the child and finally orient him toward a more permanent solution. There is now no specific financing for these multidisciplinary teams. Moreover, there are no specific beds provided for this sort of admissions. The tendency to shortening the length of stay and the establishment of high-tech care in acute hospitals however runs counter to the need for this long(er)-term observation and care. Because it is financially disadvantageous, some hospitals refuse to admit these children. There are already paediatric rehabilitation centres with a RIZIV/INAMI [*National Institute for Health and Disability Insurance*] Convention; e.g., Clairs Vallons in Ottignies offers a rehabilitation programme with boarding school to children with various pathologies. The majority of the children suffer from obesity or the consequences of abuse.[30] Long-term observation and care of children who are suffering from the consequences of abuse can take place in such centres, subject to an expansion by the necessary number of places. An expansion of the present system of RIZIV/INAMI conventions for financing the accommodation and treatment of abused children by a multidisciplinary team in these centres could be considered. Collaboration with acute hospitals is needed to be able to ensure the necessary diagnostics and specialised care.

Action point 11.2: Assess the demand for directly and indirectly accessible assistance for victims and perpetrators of child abuse, and develop a procedure for an appropriate help offer that is accessible within an acceptable waiting period.

The shortage of places in youth assistance is an old problem. With the introduction of allocation of indirect assistance (residential facilities for crisis situations, appropriate structures for young children, facilities for young people with psychiatric disorders, programmes for comprehensive family support) via de intersectoral access gate in Flanders, the needs (applications) and the number of available places (allocated) can be calculated. The annual report of Jongerenwelzijn [*Youth Welfare*] shows that in 2014, 11.569 children and young people needed indirectly accessible youth assistance, thus specialised, more intensive assistance.[31] Almost four thousand minors with a handicap and three thousand “youngsters with problems” however did not receive the help they needed.[q] The Jeugdhulp [*Youth Assistance*] action plan of the Flemish government lists a number of

[q] These figures concern the number of children and young people reported and/or on a waiting list of a facility; see p. 23 of 2014 Youth Welfare Annual Report[31]

action points, so that by 2020 children and young people can receive appropriate directly and indirectly accessible assistance within an acceptable waiting period.[32]

For the French Community the offer of services is being adjusted on the basis of objective programme criteria (socioeconomic and accessibility indicators) and the specific needs by geographic zone and by issue.[22]

4.5. Communication and coordination between the various services and professionals of the various sectors involved and between the various levels of competence

Recommendation 12

Improve communication, coordination and collaboration between the various assisting services, police, judicial services and professionals in the various sectors involved (general medicine, education, mental healthcare, paediatrics, obstetrics (including midwives), paediatric psychiatry, emergency services, childcare, etc.).

Action point 12.1: Initiate a broad social debate on the boundaries of professional secrecy and the exchange of confidential information.

The demand for exchange of information should constitute the subject of a broad social debate. Such a debate also presents itself in other social phenomena such as the radicalisation of young people. It therefore transcends the topic of child abuse.

Action point 12.2: Ensure that in the work procedures of employees of VKs/SOS Enfants/SAJ they systematically inform professionals who report that the child reported is being treated, within the boundaries of (shared) professional secrecy.

To be able to seek the best approach for every individual child optimally, good information exchange between the various participants is essential. The current legal framework on professional secrecy does not always make that possible. From the interviews it appears that those involved often come up against the boundaries of professional secrecy and/or are not familiar with the legal framework. Those who do report complain however about a lack of feedback on the follow-up of a case. This prevents their involvement in the case or tempers their motivation to make a report again a following time. Feedback between aid agencies and professionals who report can however be made possible in the framework of shared professional secrecy under certain conditions (see above). Feedback from the prosecutor's office to the reporters or aid agencies is however not possible within the current legal framework.

Action point 12.3: Make implementation of instruments for risk assessment, case consultation and case coordination legally possible.

In the interviews the concern over the lack of coordination between and joint action of police, the judiciary and assistance was clearly apparent in the various sectors, on both the Flemish and French-speaking side. In addition, a clear legal framework for information sharing seems to be lacking.

In Flanders information gathering and collaboration between welfare and the judiciary has been tested in various projects. There was the Protocol van Moed [*Courage Protocol*], with a focus on the approach to child abuse. Other examples are CO3 in Antwerp, the Korte Keten in Mechelen, Link in Limburg, and For Kids in Leuven, all involving intra family violence. The Protocol van Moed provides that care providers and representatives of the prosecutor's office consult monthly on child abuse cases (case consultation). The added value of this consultation is that an assessment can be made from within two frameworks of the willingness of and opportunity for the parents to accept help, of the family situation and of the threat to the integrity of the child.

Such initiatives have been viewed very positively. At present implementation of the instruments for risk assessment (question from the assistance to the prosecutor's office or vice versa on whether a certain person is known), case consultation and case coordination is being discussed with Justice, Internal Affairs, Education and the local and provincial administrations in Flanders. There is also a recent initiative in Brussels.

A firm legal basis is necessary to be able to use such instruments. The legal analysis of the 'Protocol van Moed' shows that for information exchange between assistance and the prosecutor's office within forms of collaboration like case consultation, a legal basis is best developed. The current exceptions to professional secrecy are sometimes however inadequate for this. First it is best to investigate the social and legal feasibility of a "modified professional secrecy". A legal ground of justification can also bring with it problems of legal competences. It involves after all areas that belong to the competence of the federal government (organisation of the judiciary, prosecutor's office and criminal investigations) and to that of the community authorities (voluntary and judicial youth protection). On the one hand, the provisions in the criminal code on professional secrecy could be modified; on the other hand, the possible options can be examined at the community level too.

Both the Flemish and the French-speaking side have opted to maximally employ dialog with the parents and to support them in their parenting within a voluntary assistance framework. On the French-speaking side, however, it is explicitly not intended to develop such instruments (with the exception of an initiative in Brussels), because it is believed that exchange of information is (too) threatening to the assistance relationship. An arrangement at community level therefore seems to be a better option than a modification of the criminal code.

Action point 12.4: Consider the possibility of family justice centres

From the interviews it also appears that physically bringing together the various parties involved in the approach to child abuse in one building could ensure a comprehensive, consistent and coordinated approach. In various Flemish provinces work is now being done on an interdisciplinary chain model. In Antwerp that has been translated into a Family Justice Centre, where all the chain partners in the approach to intra family violence – police and the judiciary, rehabilitation, reception and assistance – physically sit together in one building. Victims can come there for a declaration, help, support, reception and police protection. Assistance, police, the judiciary and local government services provide motivated and trained employees to provide the needed offer to the care recipients. Pilot projects could explore the feasibility and the methods of such centres. It is obvious that clear communication about the purpose of any Family Justice Centres and raising the awareness of the public are essential in ensuring their success and avoiding the association of these bodies with a judicial approach.

Action point 12.5: Put coordination of the approach to child abuse on the agenda at the level of the Interministerial Conference on Public Health.

The representatives of the Public Health field at the federal level have so far been involved in the approach to child abuse to a limited degree. Nonetheless, this is an issue that also affects this field (see e.g. the organisation of the stay in the maternity ward, the financing of rehabilitation centres via RIZIV/INAMI conventions, etc.) and that makes consultation between the federal and the community level necessary.

4.6. Data registration, knowledge management and research

4.6.1. Invest in a child abuse policy that is documented by figures

Recommendation 13

Invest in the centralisation and standardisation of numerical data from different services (specialised services, the judiciary, the death review teams that may be established, etc.) to make research on the extent of child abuse and informed policy choices possible.

Action punt 13.1: Adapt the current instruments for diagnosis to the Belgian context.

At present the VKs and SOS Enfants reach a diagnosis in different ways, and they do not use instruments that have been adapted to the Belgian context for this. A first step toward this could consist of using validated instruments that have been adapted to the Belgian context to make a diagnosis.

Action point 13.2: Invest in uniform registration of child abuse in the prosecutor's offices and the police.

Data on the number of cases involving child abuse can be obtained from various levels. The number of cases of child abuse can be examined at the criminal level. This involves files on child abuse with an adult perpetrator, opened with the criminal prosecutors, and the conviction statistics. In addition statistics are produced on the cases before juvenile court prosecutors. However, there is a lack of uniformity in the registration for child abuse files. Child abuse is a generic term that comprises various categories of offences (rape, assault and battery, murder, but also neglect, family abandonment, failure to surrender children in the event of visiting rights, etc.). Although a specific 'child abuse' prevention code/indictment code[r] has been provided, these cases are sometimes registered under other less specific codes like for example 'assault and battery' or 'child at risk'. Because of this it is not possible to make a statement on the number of cases of child abuse on the basis of the existing statistics. At the police level too this problem is a factor, and it is at present not feasible to draw up a file with the number of formal reports in connection with mistreatment of children.

Action point 13.3: Consider emotional or psychological abuse and neglect to be 'child abuse' in the Criminal Code.

Emotional or psychological child abuse is at present not explicitly listed as a punishable offence in the Criminal Code. This form of child abuse therefore cannot be extracted from the figures of the judiciary and police.

[r] Code that refers to a punishable offence for which someone is reported to the prosecutor's office. It is possible to record several indictment codes in a single case.

Action point 13.4: Centralise information on physical, psychological and sexual integrity of minors and violence. Invest in the analysis of data available and to be generated on child abuse, and document and analyse new forms of child abuse such as cyber-bullying, child prostitution via "loverboys", etc.

In Flanders the integration of the information policy on inproper behaviour is fully underway in various sectors. In line with the "violence, reported and tabulated" research report of the Kinderrechtencommissariaat [*Children's Rights Commissioner*][33], the Department of Welfare, Public Health and Family, in consultation with the education and sport policy fields, will conduct a quantitative investigation every five years of the incidence and prevalence of violence against children and young people between 10 and 18 years of age, within the family, at school and during free time. The intention is also that the bundling and provision of information on the physical, psychological and sexual integrity of minors and all forms of violence will take place via an "integrity knowledge platform" as a structured collaboration between the existing organisations. At the time the report was written, the modalities for this Knowledge Platform are however not yet available.

4.6.2. Quality monitoring and process optimisation

Recommendation 14

Consider pilot projects with experts who investigate the entire case after family traumas or suspicious deaths of minors ('child death review teams' that examine what happened, who could have done something differently and how similar situations can be recognised and prevented) to evaluate the existing assistance on an ongoing basis and modify it where needed (process optimisation).

At present any physician can autonomously establish the death of a person. If the physician decides that there is no legal medical objection, the death is classified as a natural death and in principle no further investigation can be conducted. Only in the event of an unexpected and unexplained death of a child younger than 18 months is further investigation possible. In Great Britain, child death review teams have been set up that investigate what happened and how the tragedy could have been prevented after a suspicious death or after family traumas. Such an investigation provides important data for prevention and can guide policy. The Vlaams Forum voor Kindermishandeling [*Flemish Child Abuse Forum*] has had a policy report drafted on the feasibility of such teams in Flanders. First of all, the report offers a proposal for a treatment protocol for the death of minors. This can involve the need for investigating a death in a multidisciplinary way and making a reconstruction. The report also recommends starting a pilot project to explore this further in Flanders. On the Flemish side the start-up of such a pilot project with the Vlaams Forum voor Kindermishandeling will be discussed with Justice and Internal Affairs.

4.7. Additional protective measures

Recommendation 15:

Organise a broad ethical social debate on additional protective measures for (unborn) children when a manifest risk exists for their safety and/or health.

At present the regulations of both parts of the country on assistance in the event of child abuse are primarily based on the voluntary cooperation of parents. The intention is to offer parents maximum support in their parenting and prevent unsafe situations for children. However, parents sometimes find themselves in such difficult circumstances that they do not/cannot recognise the problem and/or are not prepared to allow themselves to be guided. In families where repeated abuse has occurred and where there is no willingness to allow guidance, can additional protective measures be provided for the (unborn) children to avoid a repetition in the future? Can alternative measures, such as removing the perpetrator from the house, perhaps offer a solution? Should society organise accommodation options in such cases? Such considerations demand a broad ethical, social and legal debate in which the rights of the (unborn) child are weighed against the individual right of the perpetrators to a private life. The following recommendations go into this in more depth.

4.7.1. Arriving at a differentiated approach according to the type of parent/perpetrator

Recommendation 16:

Differentiate the approach to child abuse according to the type of parent/perpetrator and, for the group of parents/perpetrators who are difficult to treat and avoid help, develop a different approach that is based less on voluntary cooperation and more on mandatory help.

Action point 16.1: Give VKs/SOS Enfants/SAJ a mandate to diagnose parents with a personality disorder or addiction, refer them to services specialised in this, and follow up their compliance with therapy with these services.

Child abuse is widespread, and the cause of abuse by the parents is not always clear. The risk of child abuse does appear to be greater when parents have problems themselves or cannot deal well with (the problems of) the child, or when the family lives under difficult circumstances. The approach to (suspected) cases of child abuse should therefore be differentiated depending on the underlying issue. The interviews show that the voluntary assistance procedure works well with parents who abuse due to inadequate knowledge of the normal development and upbringing of a child. They have good intentions with their child but fail in child-raising knowledge. They usually accept outside help. The focus here is on a pedagogical approach.
In addition there are parents who abuse under pressure of external circumstances (poverty, relational problems, etc.). In these families the balance between capacity and burden is often out of equilibrium. These parents, too, often accept assistance and guidance.
A third group of parents consists of perpetrators who are difficult to treat, who are dealing with an addiction, psychiatric disorder, personal past of

abuse or mental handicap. This group often avoids help because they do not/cannot recognise the problem. It is important in this that a diagnosis of the underlying parental issue is made so that it can be dealt with. At present, great emphasis is given to voluntary cooperation in the legislation of both parts of the country. The legislation should however also be oriented toward early diagnosis and guidance of these parents who do not voluntarily cooperate, and intervening in situations where there is manifestly a risk to the safety and/or health of the (unborn) child.

At present a person can be involuntarily admitted to a psychiatric institution if he is mentally ill, is experiencing a crisis and presents a danger to himself or others, and there is no suitable alternative to this measure. Personality disorders and addictions however do not fall under this, unless there are additional complications. The VKs/SOS Enfants/SAJ have no mandate at present to conduct diagnostic examination of parents or to contact any therapist for e.g. a psychiatric issue without the consent from the parent.

Box 1: The example of the supervision order in the Netherlands

In the Netherlands there exists a measure limiting authority (supervision order) under which the parent(s) receive(s) mandatory help and support so that the threat to the child can be eliminated. Thus the family guardian can ensure that the parent(s) receive(s) the required medical care and can make this compulsory, with written proof, if the parent(s) do(es) not keep to the agreements. Written proof, such as a required urine test or medical examination, can be approved by the juvenile court judge.

There are also other measures that the Dutch government can take, such as imposing a temporary ban from the house (on a family member who is a threat to the child) or placing the parent under guardianship.

4.7.2. Protective measures for the unborn child

Recommendation 17

Develop and implement protective measures for the unborn child and include these in legislation.

Action point 17.1: Consider introducing a separate legal basis for explicit protection of an unborn child when its development is seriously threatened.

In contrast to Dutch law, Belgian law offers no explicit protection for the unborn child when its development is seriously threatened. In Dutch law, Article 255 in combination with Article 2 of Book 1 of the Civil Code does offer this protection explicitly. Article 255 Book 1 of the Civil Code specifies that the juvenile court judge can place a child under supervision (see above) if its development is seriously threatened. This can also be a child that is not yet born, as follows from Article 2 Book 1 of the Civil Code, which provides that the unborn child is deemed already born if its interest requires it.

The fact that an unborn child cannot be legally considered a “person” does not mean that no extra protective measures could be introduced into Belgian law. There already exist various protective measures for the unborn child in Belgian legislation at present.[s]

Action point 17.2: Consider introducing an explicit mandate to enable the specialised services (VKs, SOS Enfants), SAJs and OCJs to open files and to act in the interest of an unborn child.

[s] See for example the legislation on abortion, which elaborates protective measures for the unborn child (Art. 348-352 Criminal Code), the guarantees offered to pregnant women in connection with ionising radiation (Art. 20.1.1.3, par. 2 and 3, Royal Decree of 20 July 2001 on general regulations for the protection of the public, employees and the environment from the hazard of ionising radiation[34]); for a legal analysis concerning the legal status of the embryo and the foetus, see the Belgian Advisory Committee on Bioethics, Recommendation no. 53 of 14 May 2012 on refusal of medical care by a pregnant woman with consequences for her foetus.[35]

Both the VKs and SOS Enfants appear to sometimes also receive reports on unborn children. It is not clear whether the specialised services can open a file for an unborn child. The SAJ argues that a child that is not yet born cannot be included in a care procedure either. Nevertheless it can be argued that the parents also 'fall under the decree', although there is still discussion of whether this also holds for future parents of a first child. A pilot project on this is underway in Bergen/Mons.

4.8. Community problems

Recommendation 18

Ensure that for children who are entitled to care in one community, a request for care can if needed also be made in another community.

Action point 18.1: Organise a consultation between the youth assistance services of the different communities on the agreements made on youth assistance for minors who live outside the community concerned.

Young people who live in the French Community but e.g. are Dutch-speaking can also call on youth assistance in the Flemish Community and vice versa. The parties questioned reported however that the organisation of such assistance to minors who live outside the community concerned was not simple. Nevertheless there exist among other things collaboration protocols between the Flemish and the French Community for persons with a handicap, agreements between the Jongerenwelzijn [*Youth Welfare*] agency and the 'Aide à la jeunesse' [*Youth Assistance*] administration in the framework of a draft collaboration protocol on assistance to young people, and European legislation with regard to youth assistance.[t]

[t] Regulation (EC) no. 2201/2003 of the Council of 27 November 2003 on jurisdiction, recognition and enforcement of decisions in matrimonial matters and in matters of parental responsibility, revoking Regulation (EC) no. 1347/2000[36]; see also the references in the report "De bevoegdheid van de Intersectorale Toegangspoort buiten Vlaanderen" [*The Competence of the Intersectoral Access Gate outside Flanders*].[37]

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