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CHAPTER 8

ONE-YEAR FOLLOW-UP OF CHILDREN OF PARENTS ATTENDING HOSPITAL EMERGENCY DEPARTMENTS AFTER INTIMATE PARTNER VIOLENCE, SUBSTANCE ABUSE OR SUICIDE ATTEMPT

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ABSTRACT

Background: A new protocol identifies children whose parents visit the emergency department due to intimate partner violence, substance abuse or a suicide attempt, and refers these families to support services. During cross-sectional evaluation, 51%–98% of the identified children were found to be maltreated, and 80% of families were referred to various services. No follow-up data of these families have been reported yet.

Objective: This is a one-year follow-up study, aiming to evaluate wellbeing of children and parents and involvement of support services in the year after the emergency department visit.

Methods: Data were gathered from child protective services (involvement) and parent- and child self-reports (childrens’ and parents’ wellbeing and psychosocial problems, parents’ opinion).

Results: In total, 399 children of 234 families were included in the study, of which 67 families reported themselves (34% attrition). We found that, in the year after the emergency visit of parents, 20% of the families have no or small problems, 60% have problems that are handled by voluntary support services and 20% have severe, ongoing problems and are in need of child protective measures. Children’s psychosocial problems were not increased compared to their first assessment, although this could be an underestimation due to selective response. Although most parents report a decrease in their problems, for a minority, problems are ongoing. Finally, most parents are positive about the protocol, but 12% indicate that they will avoid the emergency department in the future.

Conclusion: We conclude that the protocol can be valuable to screen children and refer families to voluntary support services, but, given the ongoing problems in some families, professionals need to carefully monitor if the support services are sufficiently effective.
INTRODUCTION

To improve in-hospital detection of, and early intervention in, child maltreatment, a new protocol (‘Amsterdam protocol’) was implemented in hospitals in Amsterdam, The Netherlands in 2010. This protocol is based on the ‘Hague protocol’ and states that all adults attending the emergency department seeking care for their own medical problems caused by intimate partner violence, substance abuse or a suicide attempt, three important risk factors for child maltreatment, are asked whether they are responsible for the care of minor children. If so, in the Hague protocol, all children are reported to the Child Abuse Counseling and Reporting Centre (Dutch abbreviation AMK, new name: ‘Safe Home’) for an assessment and further referrals to support services or for more serious measures. In contrast, in the Amsterdam protocol, instead of reporting all children to the AMK, parents and their children are referred to the outpatient pediatric department for a consultation and subsequent referrals to support services, only in exceptional circumstances are children reported to the AMK. The AMK can report children to the Child Care and Protection Board (Dutch abbreviation RvdK) for child protection measures.

To evaluate the Hague protocol and the Amsterdam protocol, cross-sectional studies have been performed. Results indicated that shortly after the emergency visit of their parents, 51%-98% of the identified children were suspected or confirmed to be maltreated, and a large majority of the families (80%-82%) were referred to various support services. Furthermore, although there may have been some underestimation due to a selection bias, children in the Amsterdam protocol did not report more psychosocial problems than community children. However, in order to conclude that the policies are valuable to the involved families, it is important to assess follow-up outcomes. Currently, the only follow-up data available are from AMK records of children in the Hague protocol at 3-months follow-up. At that point, 84% of the AMK records stated that families and professionals judged the received support to be sufficient. Because no other follow-up
data have been reported, we do not know the wellbeing of children and parents longer after the emergency visit.

This is a one-year follow-up study of families who were identified because a parent visited the emergency department due to intimate partner violence, substance abuse or a suicide attempt. We aim to evaluate wellbeing and involvement of support services of families in the Amsterdam protocol in the year after the emergency department visit. To compare our results to the Hague protocol, we include families from a hospital in Groningen (a city in the North of The Netherlands using the Hague protocol) as well. We aim to answer the following research questions:

1) Which proportion of children is reported to the AMK or the RvdK in the year after the emergency visit of parents?
2) What are the levels of psychosocial problems (posttraumatic stress levels, anxiety and depression symptoms, internalizing and externalizing behavioral problems and impaired health-related quality of life) of children identified in the Amsterdam protocol at one-year follow-up and what is the difference with the first measurement?
3) What are the levels of self-reported problems of parents at one-year follow-up and what is the difference with the first measurement?
4) What is the opinion of parents about the Amsterdam protocol and the well-being of their family at one-year follow-up?
5) What are the differences between the results of families in the Amsterdam protocol and the Hague protocol?

**METHODS**

Study design and setting

We conducted a cohort study to evaluate the Amsterdam protocol. This paper reports on the analyses at one-year follow-up, which we compare to the data of the first measurement. Participants were first included between
July 2012 and February 2014 in all 6 hospitals in Amsterdam and 1 hospital in Groningen; follow-up data were gathered between July 2013 and March 2015. This follow-up study consists of two parts: (1) a study of AMK and RvdK records in which the complete study sample (Amsterdam and Groningen) was included and (2) a questionnaire study in which only families who already participated in a questionnaire study at the first measurement (Amsterdam only) were included.

Participants
For part (1) we included all consecutive families with children under 18 years of which a parent visited the emergency department due to intimate partner violence, substance abuse or a suicide attempt during the study period in an Amsterdam hospital and in 1 hospital in Groningen (UMCG) in the study of AMK and RvdK records. For part (2) we approached all families who participated in our questionnaire study at baseline, and had indicated that we could approach them again, to participate in the follow-up questionnaire study. Parents reported on their adverse life events, wellbeing, opinion of the Amsterdam protocol and about the psychosocial problems of their oldest child under 18 years. Children of eight years and older reported on their psychosocial problems themselves.

Procedure
Amsterdam protocol
After the emergency visit, parents and their children are referred to the outpatient pediatric department for a consultation. During this consultation, any medical, social or psychological problems are evaluated. When judged necessary, informants around the family (e.g. family doctor, staff of already involved support services) are contacted for information. To determine appropriate next steps, the situations of all the families are discussed anonymously in hospital child protection teams, in which doctors of the AMK participate. Referrals to various support services are made when judged appropriate. Thereafter, outpatient pediatric staff either monitor the effects of support services themselves, or they ask the services
or other professionals to monitor the effects, but there is no set timeframe. When parents are unwilling to cooperate, or if there is severe maltreatment, children are reported to the AMK.

Follow-up
For part (1), for all included children, one researcher (EHvK) searched the AMK and RvdK databases for involvement at anytime before the emergency visit of parents, and for involvement in the year after the visit. The AMK is a non-judicial organization where everyone can ask for advice and report suspicions of child maltreatment. The AMK investigates reports and refers to various support organizations if necessary. Serious cases and cases in which parents refuse to cooperate are handed over to the RvdK, which is a division of the Ministry of Security and Justice. The RvdK has several tasks, including child protection, authority and contact arrangements and punishment. In child protection, after investigation, the RvdK can request the court to impose a child protection measure. In authority and contact arrangements, the RvdK advises the court about a parental plan after separation of parents. Finally, in punishment, after investigation the RvdK advises the public prosecutor and the court about possible punishments and assistance for minor offenders from a pedagogical point of view.

For part (2), families participating with the questionnaires at the first measurement were contacted by telephone or email at one-year follow-up, and asked to fill in questionnaires again. If the family agreed, a researcher would visit them at home or meet at another place such as a hospital. After filling in the questionnaires, families received a 15 euro gift card, and parents and children > seven years both received a pamphlet with telephone-numbers of support services and the researcher, in case they wanted to talk later.

This study was presented to the Medical Ethics Committee of the Academic Medical Center, and subsequently to the boards of all other hospitals, AMK and RvdK, who decided that the Medical Research Involving Human Subjects Act did not apply and that the study could be conducted. Parents
and children provided verbal informed consent for participation in the questionnaire study. To maximize the protection of privacy of all included families, all personal information was kept by a trusted third party and only available to the researcher (after signing a confidentiality agreement) during the search period in the AMK and RvdK records.

Measurements
Sociodemographic characteristics of non-participating families were extracted from reports of health care professionals at the first assessment, sociodemographic characteristics of participating families were reported by parents using a general questionnaire.

Children’s levels of posttraumatic stress were measured using the Dutch version of the Children’s Revised Impact of Event Scale (CRIES-13) in children 8-17 years \(^\text{10} \text{11}\). The CRIES-13 is a self-report questionnaire, developed to screen children at risk of PTSD after a traumatic event. Children were asked to rate the items in relation to the worst event they had ever experienced. The total score (range: 0 – 65) indicates the severity of posttraumatic stress levels, with a score of 30 or higher indicating probable PTSD \(^\text{12} \text{13}\). In various samples reliability and validity of the CRIES-13 were found to be satisfying \(^\text{11} \text{12} \text{14} \text{15} \text{16}\).

Children’s levels of anxiety and depression were measured using the Dutch versions of the Revised Child Anxiety and Depression Scale (RCADS and RCADS-Parent Version, RCADS-P) in children 8-17 years \(^\text{17} \text{18} \text{19}\). These assess children’s symptoms corresponding to specific DSM-IV anxiety disorders and depression \(^\text{19}\). Six sub-scales, a total anxiety score and a total internalizing score are derived. Previous studies showed that the reliability (including test-retest) and validity of the RCADS and RCADS-P are good \(^\text{19} \text{20} \text{21} \text{22} \text{23}\).

Children’s internalizing and externalizing behavioral problems were measured using the Dutch parent report version of the Child Behavior Checklist 1.5-5 years (CBCL 1.5-5), and 6-18 years (CBCL) and the Dutch child report version of the Youth Self-Report (YSR) in children 11-17 years \(^\text{24} \text{25}\). These questionnaires assess a wide range of children’s internalizing
and externalizing behavioral problems, aimed to identify children at high risk of a psychiatric disorder. Total scores are derived for internalizing, externalizing and total behavior problems. We converted raw scores to T-scores based on age and gender; T-scores over 63 reflect clinical behavioral problems. Current and earlier versions of the CBCL and YSR have been used extensively and show high levels of reliability and validity.

Health-related quality of life was measured using the Dutch child report versions of the generic Pediatric Quality of Life Inventory 4.0 (PedsQL), for children aged 8-12 years and 13-17 years respectively. These questionnaires were developed to measure health-related quality of life in both healthy and ill children. Four sub-scales, a psychosocial health summary score and a total score are derived. Previous studies of the PedsQL have shown adequate reliability and validity.

Parents reported on their adverse life events using a modified version of the ‘Life-events Questionnaire’, in which they indicated whether they experienced certain adverse events, and if so, when.

Finally, we used an ad hoc 11-item questionnaire to assess parents’ opinion of the wellbeing of themselves and their families and of the Amsterdam protocol.

Statistical analyses
IBM SPSS Statistics version 21 was used for descriptive statistical analyses. Missing items were handled according to published guidelines for each instrument.

RESULTS
Demographic characteristics and involvement of services of the complete study sample are presented in Table 1. In Amsterdam, using the Amsterdam protocol, 360 children of 212 families were included and in Groningen, using the Hague protocol, 39 children of 22 families. Prior to the emergency visit of one of their parents, the AMK or RvdK were already involved with 76
|                      | Amsterdam n=360 children$^c$ | Groningen n=39 children$^d$ |
|----------------------|-------------------------------|-----------------------------|
| **Children**         |                               |                             |
| Median age in years (range) | 8 (1-18)                     | 7 (1-18)                    |
| Boys n (%)           | 183 (53)                      | 24 (62)                     |
| Ethnicity$^{a,b}$ n (%) |                              |                             |
| Dutch                | 71 (25)                       | 23 (70)                     |
| Western immigrant    | 22 (8)                        | 6 (18)                      |
| Non-western immigrant| 195 (68)                      | 4 (12)                      |
| **Parents**          |                               |                             |
| n (parents who visited the emergency department) | 212                           | 22                          |
| Median age in years (range) | 36 (20-60)                   | 34 (22-48)                  |
| Males n (%)          | 41 (19)                       | 1 (5)                       |
| Ethnicity$^{a,b}$ n (%) |                              |                             |
| Dutch                | 57 (34)                       | 14 (74)                     |
| Western immigrant    | 16 (10)                       | 3 (16)                      |
| Non-western immigrant| 96 (57)                       | 2 (11)                      |
| **Reason for emergency department visit n (%)** |                             |                             |
| Intimate partner violence | 111 (52)                     | 5 (23)                      |
| Suicide attempt      | 59 (28)                       | 14 (64)                     |
| Substance abuse      | 42 (20)                       | 2 (9)                       |
| **Services**         |                               |                             |
| Parent visited the emergency department for the same reason again during study period (yes) n (%) | 7 (2)$^d$ | 2 (5)$^e$ |
| Child was reported to the AMK$^b$ (yes) n (%) |                         |                             |
| prior to the emergency visit of parent | 30 (9)$^d$ | 15 (39)$^f$ |
| in the year after the emergency visit of parent (total), of which | 37 (11)$^d$ | 38 (100)$^f$ |
| first reports        | 35 (10)$^d$                   | 23 (61)$^f$                 |
| still involvement after 6 months | 14 (4)$^d$  | 15 (39)$^f$ |
| still involvement after 1 year       | 6 (2)$^d$                     | 5 (13)$^f$                  |
| RvdK$^c$ involvement (yes) n (%) |                       |                             |
| prior to the emergency visit of parent (total), due to (multiple options possible) | 54 (16)$^d$ | 6 (16)$^e$ |
| child protection     | 41 (12)$^d$                   | 4 (11)$^e$                  |
| punishment           | 9 (11)$^{ef}$                 | 1 (14)$^{ef}$               |
| authority and contact| 8 (2)$^{de}$                  | 0 (0)$^{e}$                 |
| in the year after the emergency visit of parent (total), of which | 31 (9)$^d$ | 7 (18)$^e$ |
| first involvements   | 12 (4)$^d$                    | 6 (16)$^e$                  |
| due to (multiple options possible) | 18 (5)$^d$  | 5 (13)$^e$ |
| child protection     | 18 (5)$^{ef}$                 | 1 (14)$^{ef}$               |
| punishment           | 8 (2)$^{de}$                  | 1 (3)$^e$                   |
| RvdK$^c$ or AMK$^b$ was involved with child prior to the emergency visit of parent | 76 (22)$^d$ | 18 (47)$^e$ |
| AMK$^b$ or RvdK$^c$ was involved with child in the year after the emergency visit of parent | 67 (20)$^d$ | 38 (100)$^e$ |

Percentages given are of available data (due to missing data, not all numbers given add up to the total number of study subjects). $^a$ Reported by health care professionals at the first assessment; $^b$ AMK = Child Abuse Counseling and Reporting Centre. AMK data are only available for the regions Amsterdam and Groningen, if children have lived in another region, information may be missing; $^c$ RvdK = Child Care and Protection Board; $^d$ Unknown for 19 children because personable identifiable information was missing; $^e$ Unknown for 1 child because personable identifiable information was missing; $^f$ Percentages are of children who were 12-17 years during the emergency visit, because RvdK punishment involvement is only possible at that age.

182  Table 1: Demographic characteristics and involvement of services of the complete study sample.
(22%) and 18 (47%) children in Amsterdam and Groningen, respectively. In Amsterdam, the AMK or the RvdK was involved with 67 children (20%) in the year after the emergency visit. Thirty-seven children were reported to the AMK (11%) of which 35 were first reports; the RvdK was involved with 31 children (9%), of which 12 were first involvements. In Groningen, according to the Hague protocol, all children were reported to the AMK. In the year after the emergency visit, the RvdK was involved with seven children (18%), of which six were first involvements. For the majority of children in both protocols, de RvdK was involved because of child protection and punishment issues.

Characteristics of families participating in the questionnaire study are presented in Table 2. Of 101 eligible families (these are the families participating in the first assessment) 67 families participated in the one-year follow-up assessment (66%). The median (range) number of months between the visit to the emergency department and the one-year follow-up assessment (filling in questionnaires) was 13 (11-18) months. Families who were lost-to-follow-up could not be reached (17) or refused to participate again (17). See Figure 1 for a flowchart. At the follow-up assessment, parents reported that support services aimed at children personally were involved in 25% (currently) and 45% (ever); services aimed at family support in 25% (currently) and 43% (ever); and services aimed at parents personally in 42% (currently) and 58% (ever). Fourteen families (21%) reported that no services had ever been involved.

Results of the questionnaires about psychosocial problems of children are presented in Table 3 (sum scores) and in Appendix 1 (scores of subscales). For post-traumatic stress symptoms (CRIES-13), anxiety and depression symptoms (RCADS) and health-related quality of life (PedsQL), scores of children at 1-year follow-up were better than their first assessment, but differences were small with large variability. With regard to behavioral problems, child reported scores (YSR) were somewhat worse compared to the first assessment and parent reported scores (CBCL) were mixed. However, differences were small.
**Table 2: Demographic characteristics of families participating with the one-year follow-up assessment and families who were lost-to follow-up.**

| Characteristics                              | Participants n=67 | Lost-to-follow-up n=34 |
|---------------------------------------------|-------------------|------------------------|
| **Children**                                |                   |                        |
| Median age in years (range)                 | 9 (1-18)          | 11 (1-18)              |
| Boys n (%)                                  | 39 (58)           | 16 (47)                |
| Ethnicity (n=67)                            |                   |                        |
| Dutch                                       | 14 (21)           | 11 (33)                |
| Western immigrant                           | 6 (9)             | 2 (6)                  |
| Non-western immigrant                       | 46 (70)           | 20 (61)                |
| Median number of children < 18 years in family (range) at first assessment | 2 (1-4) | 1 (1-4) |
| Parental authority n (%)                    |                   |                        |
| Mother                                      | 35 (52)b          | 15 (48)c               |
| Both parents                                | 32 (48)b          | 16 (52)c               |
| Living arrangements n (%)                   |                   |                        |
| Single parent household                     | 39 (58)b          | 19 (61)c               |
| Two-parent household                        | 27 (40)b          | 12 (39)c               |
| Kinship care                                | 1 (2)b            | 0 (0)c                 |
| Involvement of services for child personally (yes) n (%) |               |                        |
| Yes, currently                              | 17 (25)b          | 4 (13)d                |
| Only at some time in the past               | 13 (19)b          | 2 (6)d                 |
| Never                                       | 37 (55)b          | 25 (81)d               |
| Involvement of educational support for the family (yes) n (%) |            |                        |
| Yes, currently                              | 17 (25)b          | 12 (39)d               |
| Only at some time in the past               | 12 (18)b          | 4 (13)d                |
| Never                                       | 38 (57)b          | 15 (48)d               |
| Parents visiting the emergency department   |                   |                        |
| Median age in years (range)                 | 35 (21-52)        | 40 (22-52)             |
| Males n (%)                                 | 9 (13)            | 8 (24)                 |
| Ethnicity (n=67)                            |                   |                        |
| Dutch                                       | 20 (32)           | 11 (32)                |
| Western immigrant                           | 6 (10)            | 3 (9)                  |
| Non-western immigrant                       | 37 (59)           | 20 (59)                |
| Reason for emergency department visit n (%) |                   |                        |
| Intimate partner violence                   | 39 (58)           | 16 (47)                |
| Suicide attempt                             | 17 (25)           | 8 (24)                 |
| Substance abuse                             | 11 (16)           | 10 (29)                |
| Highest finished educational level biological mother n (%) |          |                        |
| No education or primary school              | 10 (15)b          | 4 (13)c                |
| Secondary school                            | 20 (30)b          | 7 (23)c                |
| Secondary vocational school                 | 22 (33)b          | 14 (47)c               |
| Higher vocational education or university   | 14 (21)b          | 5 (17)c                |
Adverse life events of parents are presented in Table 4. Nine percent of the parents reported having attempted suicide during the past year compared to 20% at the first assessment. Having experienced intimate partner violence at any time was reported by 67% and 66% at the first assessment and at follow-up, respectively; 49% and 30% of parents reported intimate partner violence during the past year at the first assessment and at follow-up, respectively. Substance abuse of parents themselves or their partners during the past year was reported at the first assessment by 12% and 19%, respectively and by 3% and 6%, respectively (follow-up). Thirty percent of the parents reported having been a witness of intimate partner violence as a child and, depending on the type of maltreatment, 8% to 27% reported having been a victim of other types of maltreatment.
Figure 1: Flowchart of study participants.
|                      | First assessment | 1 year follow-up | Difference* |
|----------------------|------------------|------------------|-------------|
|                      | mean  | SD    | median (range) | mean  | SD    | median (range) | mean  | SD   |
| CRIES-13             |       |       |                |       |       |                |       |      |
| Total                | 22.5  | 14.1  | 21 (0-55)      | 20.7  | 13.2  | 23 (1-44)      | -0.5  | 13.5 |
|                      |       |       |                |       |       |                |       |      |
| RCADS Child report   |       |       |                |       |       |                |       |      |
| Total anxiety        | 21.5  | 14.4  | 18 (0-74)      | 17.5  | 16.5  | 13 (3-76)      | -5.1  | 13.1 |
| Total internalizing  | 26.4  | 17.5  | 23 (0-84)      | 22.5  | 16.5  | 18 (4-67)      | -5.2  | 14.9 |
|                      |       |       |                |       |       |                |       |      |
| RCADS Parent report  |       |       |                |       |       |                |       |      |
| Total anxiety        | 13.8  | 12.8  | 11 (1-69)      | 11.5  | 9.1   | 9 (1-41)       | -4.8  | 12.4 |
| Total internalizing  | 17.1  | 16.2  | 14 (1-63)      | 14.9  | 12    | 12 (1-56)      | -5.3  | 16   |
|                      |       |       |                |       |       |                |       |      |
| CBCL T-scores        |       |       |                |       |       |                |       |      |
| Internalizing        | 51.1  | 12.3  | 50 (29-90)     | 53.4  | 10.3  | 52 (29-83)     | 2.2   | 9.3  |
| Externalizing        | 50.1  | 10.4  | 51 (32-74)     | 50.4  | 9.3   | 51 (33-72)     | -0.3  | 8.4  |
| Total                | 50.5  | 11.7  | 51 (24-83)     | 50.9  | 9.8   | 50 (24-71)     | -0.6  | 9.2  |
|                      |       |       |                |       |       |                |       |      |
| YSR T-scores         |       |       |                |       |       |                |       |      |
| Internalizing        | 52.8  | 11    | 55 (32-76)     | 54.4  | 7.5   | 54 (44-73)     | 2.9   | 8.5  |
| Externalizing        | 48.2  | 11    | 46 (29-70)     | 48.3  | 7.5   | 49 (37-68)     | 3.1   | 7.5  |
| Total                | 50.2  | 10.4  | 51 (31-69)     | 50.7  | 7.8   | 52 (40-70)     | 2.9   | 6.9  |
|                      |       |       |                |       |       |                |       |      |
| PedsQL 8-12          |       |       |                |       |       |                |       |      |
| Psychosocial health summary | 77.8  | 15.1  | 78 (32-100)    | 76.2  | 15.1  | 82 (42-95)     | 2.6   | 11.9 |
| Total                | 79.6  | 14.3  | 82 (38-100)    | 77.7  | 14.1  | 82 (48-91)     | 1.2   | 8.9  |
|                      |       |       |                |       |       |                |       |      |
| PedsQL 13-18         |       |       |                |       |       |                |       |      |
| Psychosocial health summary | 77.7  | 13.2  | 82 (50-100)    | 83.4  | 9.6   | 83 (67-98)     | 0.4   | 7.3  |
| Total score          | 80.6  | 12.8  | 86 (53-100)    | 85.9  | 8.5   | 87 (67-99)     | 0.8   | 7.8  |

* Mean difference per child, follow-up assessment – first assessment (only for children with repeated measures).
| Adverse life events | First assessment n=93 | 1 year follow-up n=64 |
|---------------------|----------------------|----------------------|
| Suicide attempt (yes) n (%) | | |
| ever                | 25 (27)             | 16 (25)             |
| during the past year | 19 (20)             | 6 (9)               |
| Suicide attempt of partner (yes) n (%) | | |
| ever                | 6 (6)               | 5 (8)               |
| during the past year | 3 (3)               | 3 (5)               |
| Suicide attempt of child (yes) n (%) | | |
| ever                | 1 (1)               | 2 (3)               |
| Intimate partner violence (yes) n (%) | | |
| ever                | 62 (67)             | 42 (66)             |
| during the past year | 46 (49)             | 19 (30)             |
| Intimate partner violence in family of origin (yes) n (%) | | |
| ever                | 26 (28)             | 19 (30)             |
| Substance abuse (yes) n (%) | | |
| ever                | 17 (18)             | 7 (11)              |
| during the past year | 11 (12)             | 2 (3)               |
| Substance abuse of partner (yes) n (%) | | |
| ever                | 30 (32)             | 18 (28)             |
| during the past year | 18 (19)             | 4 (6)               |
| Substance abuse in family of origin (yes) n (%) | | |
| ever                | 13 (14)             | 11 (17)             |
| Victim of sexual abuse (yes) n (%) | | |
| ever                | 16 (17)             | 13 (20)             |
| Childhood physical neglect (yes) n (%) | | |
| ever                | 4 (4)               | 5 (8)               |
| Childhood physical abuse (yes) n (%) | | |
| ever                | 14 (15)             | 10 (16)             |
| Childhood emotional neglect (yes) n (%) | | |
| ever                | 20 (22)             | 17 (27)             |
| Childhood emotional abuse (yes) n (%) | | |
| ever                | 15 (16)             | 10 (16)             |

*a Reported by 88 parents who visited the emergency department themselves (78 mothers, 10 fathers) and 5 parents who did not visit themselves (4 mothers, 1 father); *b Reported by 55 parents who visited the emergency department themselves (52 mothers, 3 fathers) and 9 parents who did not visit themselves (6 mothers, 3 fathers).

Table 4: Self-reported adverse life events of parents

Parents’ opinions about the wellbeing of themselves and their family and the Amsterdam protocol are reported in Table 5. A large majority of parents report doing better (51%) or much better (31%) during the past three months compared to a year or longer ago, for their children they report that they
are doing the same (34%), better (37%) or much better (25%). Fifty-one percent of parents indicate that they have received an increase in services for themselves, 37% report an increase in services for their children. The majority of parents report to have a neutral to positive opinion about the referral to the pediatrician; the median evaluation score is eight, range 3-10 (1-10 scale). Parents mostly agree with the Amsterdam protocol, but 39% thinks that, instead of the current practice of referring all families to the pediatrician, families should only be referred if they want to. Although the majority of parents are encouraged (22%) or neutral (63%) about visiting the emergency department again with a similar problem, eight parents (12%) are discouraged to do so, knowing that there will be a referral.

**DISCUSSION**

As far as we know, this is the first study to follow families up one year after one of the parents visited the emergency department due to intimate partner violence, substance abuse or a suicide attempt, to monitor the wellbeing and services involvement. We found that before the emergency visit of their parents, 22% (Amsterdam) and 47% (Groningen) of the children were already involved with the AMK or the RvdK, indicating that the emergency visit was not the first psychosocial problem in the family. Of all children who were referred to the pediatrician according to the Amsterdam protocol, 20% were involved with the AMK (11%) or RvdK (9%) in the year after the emergency visit, indicating that there were severe ongoing problems. In comparison, only 1% of the general Dutch population between zero and 17 years were reported to the AMK in 2013\(^7\). Involvement of the RvdK was lower in Amsterdam than in Groningen (Hague protocol), in which the RvdK was involved with 18%, and also compared to the results of an earlier evaluation of children in the Hague protocol, in which 24% were referred to the RvdK by the AMK\(^7\). Since in general, of all children who are reported to the AMK for various reasons, 10% are subsequently reported to the RvdK\(^7\), the AMK seems to handle the children in the Hague protocol more seriously than
Parents’ opinion  

| Change in support services in the past year n (%) | 1 year follow-up n=67a |
|-------------------------------------------------|------------------------|
| for parents                                     |                        |
| increase                                        | 34 (51)                |
| no change                                       | 25 (37)                |
| decrease                                        | 8 (12)                 |
| for childrenb                                   |                        |
| increase                                        | 25 (37)                |
| no change                                       | 39 (60)                |
| decrease                                        | 3 (5)                  |

| Feeling of wellbeing in the past 3 months compared to a year or longer ago n (%) |
|---------------------------------------------------------------------------------|
| for parents                                                                     |
| much better                                                                     | 21 (31)               |
| better                                                                          | 34 (51)               |
| the same                                                                       | 9 (13)                |
| worse                                                                           | 2 (3)                 |
| much worse                                                                      | 1 (2)                 |
| for childrenb                                                                   |
| much better                                                                     | 17 (25)               |
| better                                                                          | 25 (37)               |
| the same                                                                       | 23 (34)               |
| worse                                                                           | 2 (3)                 |
| much worse                                                                      | 0 (0)                 |

| Opinion about (effects of) referral to pediatrician n (%) |                        |
|----------------------------------------------------------|------------------------|
| for parents                                              |                        |
| very positive                                            | 8 (12)                 |
| positive                                                 | 31 (46)                |
| neutral                                                  | 22 (33)                |
| negative                                                 | 1 (2)                  |
| very negative                                            | 2 (3)                  |
| for childrenb                                             |
| very positive                                            | 8 (12)                 |
| positive                                                 | 28 (42)                |
| neutral                                                  | 24 (36)                |
| negative                                                 | 2 (3)                  |
| very negative                                            | 1 (2)                  |

Evaluation score of Amsterdam protocol on 1 (worst) to 10 (perfect) scale median (range) | 8 (3-10) |

Table 5: Parents’ opinion about the wellbeing of themselves and their family and about the Amsterdam protocol reported at 1-year follow-up.
Opinion about hospital tasks when adults visit the emergency department due to psychosocial problems (yes) n (%)

- check if adult takes care of children: 62 (93)
- refer families for evaluation and support:
  - yes, compulsory: 36 (54)
  - only voluntarily: 26 (39)
  - no: 0 (0)
- evaluation should be conducted by:
  - pediatrician: 38 (57)
  - family doctor: 13 (19)
  - AMK: 2 (3)
  - other: 9 (13)

Opinion about visiting the emergency department with psychosocial problems again knowing that there will be a referral to the outpatient pediatric department

- encouraged: 15 (22)
- neutral: 42 (63)
- discouraged: 8 (12)

* Reported by 57 parents who visited the emergency department themselves (54 mothers, 3 fathers) and 10 parents who did not visit themselves (6 mothers, 4 fathers); † Reported by parents.

Table 5: Parents’ opinion about the wellbeing of themselves and their family and about the Amsterdam protocol reported at 1-year follow-up (continued).

their regular cases. Because all children in the Hague protocol are reported to the AMK, we think that they may be watched more closely, and have a higher chance of ending up to be involved with the RvdK (surveillance bias), compared to children in the Amsterdam protocol, most of whom are only involved with voluntary support services. Also, compared to support services, the AMK could be more inclined to report children to the RvdK.

It was worrisome that 11% of the 12-17 year-olds (nine children) in the Amsterdam protocol were involved with the RvdK because of punishment after a severe or repeated criminal offense, compared to 2% or less in the general Amsterdam population 40.

Of the families participating with the follow-up assessment, 21% reported that no services had ever been involved. Although there could be a selection/
attrition bias (possibly families with less problems were more inclined to participate in the study, although reports in the literature are mixed \textsuperscript{41 42 43}), this is in line with our findings at the first assessment: 17\% (Hague protocol) and 20\% (Amsterdam protocol) of families were not referred to any services because this was not necessary according to the AMK or outpatient pediatric department, respectively \textsuperscript{5}. We assume that these families have no or small problems, however it is also possible that problems were not picked-up by professionals \textsuperscript{44}.

Psychosocial problems of children
During the first assessment, participating children did not experience more psychosocial problems compared to community samples \textsuperscript{6}. We hypothesized that children might develop more problems in the future. However, at one-year follow-up, participating children’s reports of their psychosocial status were similar to their first assessment or a little better. This is in line with results of test-retest studies \textsuperscript{13 23 28 45 46} showing attenuation at the second test, although the long one-year interval makes this re-test effect less likely. Only child-reported behavioral problems were somewhat worse at follow-up, but differences with the first assessment were small. Thus, at this point, we have no evidence that children whose parents visit the emergency department due to intimate partner violence, substance abuse or a suicide attempt develop more psychosocial complaints over time. However, since only 32\% of all eligible children participated with the follow-up assessment, there could be a selection/attrition bias and we need to be very careful in interpreting these results. Furthermore, it could be that problems will arise even later in adolescence or adulthood. For example, in a study of maltreated Dutch children who were reported to the AMK, quality of life (measured with the PedsQL questionnaire as well) increased at first, but decreased later on \textsuperscript{47}. On the other hand, it could also be that support services are effective for these families.

Adverse life events of parents
Parents reported high rates of adverse life events, both during their
childhood and in adulthood. Parental adverse childhood experiences are strongly related to current adversity of children, according to a recent study 48. Although at follow-up, much less participating parents reported adverse events compared to the first assessment, a third of the parents reported having experienced intimate partner violence during the past year and suicide attempts and substance abuse were ongoing for a small minority as well. Although this could have happened just after the emergency visit, it could also be that the problems were not resolved after one year, indicating that, for these families, the Amsterdam protocol and support services were insufficient to improve their situation. Resolution of intimate partner violence is very important for children, because it is associated with improved behavioral and emotional outcomes 49 44.

Parents’ opinion
Compared to the period of the emergency visit, at follow-up, most parents reported improved wellbeing for themselves, and to a lesser degree for their children (many parents commented that their children had been fine the whole time). Parents were mostly positive about the Amsterdam protocol, but 39% would prefer to change the protocol to refer only families who are willing to be referred.

Finally, it is important to consider that a minority of parents (eight, 12%) indicated that the experience of the Amsterdam protocol discouraged them from visiting the emergency department in a future, similar situation. In contrast, in an evaluation study in the Hague protocol, no decline in emergency department visits was noted after implementation of the protocol 50. Of 14 parents reported to the AMK in The Hague who were interviewed, 10 indicated that they would visit the emergency department again 50. So, although we have no evidence that parents are truly avoiding the emergency department, a minority of parents does report so, and given the selection of responders, the real number may be even higher. Since this would be a very undesirable effect of the Amsterdam and Hague protocol, we think that professionals need to be aware. Possibly, improved education and communication with parents could decrease the problem.
CONCLUSION AND IMPLICATIONS

In conclusion, based on reports of professionals, we found that one year after the emergency visit of their parents because of intimate partner violence, substance abuse or a suicide attempt, about 20% of children have no or small problems, 60% have problems that seem to be handled adequately by voluntary support services, and 20% have very severe problems and are in need of serious child protection measures. Children and parents report similar psychosocial problems of children compared to the first assessment, although this could be an underestimation due to selective response. Although most parents report a decrease in their problems, for a minority, parental problems are ongoing. Finally, most parents are positive about the Amsterdam protocol, but 12% indicate that they will avoid the emergency department in the future.

All in all, we think that the Amsterdam protocol can be a valuable way of screening children and referring them to voluntary support services without involvement of the AMK. However, because problems are serious and ongoing for a minority of children, professionals should assess prior involvement of child protective services, and they need to carefully monitor (or ask another organization to monitor) if support services have the desired impact, and if not, report children to the AMK or the RvdK for child protective measures.
APPENDIX 1

Psychosocial problems (posttraumatic stress levels – CRIES-13; anxiety and depression – RCADS; behavioral problems – CBCL, YSR; and health-related quality of life – PedsQL) of children participating at one-year follow-up compared to the first assessment.

|                       | First assessment n=55 | 1 year follow-up n=36 | Differencea n=32 |
|-----------------------|-----------------------|-----------------------|------------------|
|                       | mean  SD  median (range) | mean  SD  median (range) | mean  SD |
| CRIES-13 Scale        |                       |                       |                 |
| Avoidance             | 8.9  5.6  9 (0-20)      | 8.8  6  9 (0-20)       | 0  6.8 |
| Intrusion             | 5.9  5.1  4 (0-20)      | 5.1  4.4  4 (0-14)     | -0.4  5.4 |
| Arousal               | 7.5  6.6  6 (0-21)      | 6.8  5.9  5 (0-20)     | -0.1  6.4 |
| Total                 | 22.5  14.1 21 (0-55)    | 20.7  13.2 23 (1-44)   | -0.5  13.5 |

a Mean difference per child, follow-up assessment – first assessment (only for children with repeated measures).

Levels of posttraumatic stress symptoms of children
| Scale                                | First assessment | 1 year follow-up | Difference<sup>a</sup> |
|--------------------------------------|------------------|------------------|------------------------|
|                                      | mean  | SD  | (range) | mean  | SD  | (range) | mean  | SD  |
| RCADS child report n=53 n=36 n=32   |       |     |         |       |     |         |       |     |
| Separation Anxiety Disorder          | 2.5   | 3.3 | 1 (0-16) | 2     | 1.9 | 2 (0-7) | -0.5  | 3.3 |
| Social Phobia                       | 7.2   | 4.4 | 8 (0-22) | 6.5   | 4.5 | 5 (1-20) | -0.7  | 4.4 |
| Generalized Anxiety Disorder        | 3.6   | 3.3 | 3 (0-12) | 3.5   | 3.1 | 3 (0-13) | -0.8  | 3.7 |
| Panic Disorder                      | 4.1   | 3.5 | 3 (0-16) | 2.8   | 3   | 2 (0-12) | -1.5  | 2.7 |
| Obsessive Compulsive Disorder<sup>b</sup> | 4     | 3.1 | 4 (0-14) | 2.8   | 3.1 | 2 (0-13) | -1.7  | 3   |
| Major Depressive Disorder           | 4.9   | 3.8 | 4 (0-19) | 5     | 3.6 | 4 (0-13) | -0.1  | 3   |
| Total anxiety score<sup>c</sup>     | 21.5  | 14.4| 18 (0-74) | 17.5  | 13.6| 13 (3-56) | -5.1  | 13.1|
| Total internalizing score<sup>c</sup> | 26.4  | 17.5| 23 (0-84) | 22.5  | 16.5| 18 (4-67) | -5.2  | 14.9|
| RCADS parent report n=46 n=37 n=32  |       |     |         |       |     |         |       |     |
| Separation Anxiety Disorder          | 2.1   | 2.7 | 1 (0-14) | 1.5   | 1.6 | 1 (0-6) | -0.7  | 2.8 |
| Social Phobia                       | 5.3   | 3.9 | 4 (0-17) | 4.6   | 3.2 | 4 (0-12) | -1.3  | 4   |
| Generalized Anxiety Disorder        | 3.4   | 3   | 2 (0-12) | 2.7   | 2.5 | 2 (0-12) | -1.4  | 3.2 |
| Panic Disorder                      | 2     | 3   | 1 (0-18) | 1.6   | 2.3 | 1 (0-9) | -0.7  | 2.8 |
| Obsessive Compulsive Disorder<sup>c</sup> | 1.2   |     |         | 1.8   | 1.5 | 1 (0-6) | -0.4  | 1.8 |
| Major Depressive Disorder           | 3.7   | 4.2 | 3 (0-17) | 3.4   | 3.3 | 3 (0-15) | -0.6  | 3.8 |
| Total anxiety score                 | 13.8  | 12.8| 11 (1-69)| 11.5  | 9.1 | 9 (1-41) | -4.8  | 12.4|
| Total internalizing score           | 17.1  | 16.2| 14 (1-83)| 14.9  | 12  | 12 (1-56) | -5.3  | 16  |

<sup>a</sup>Mean difference per child, follow-up assessment – first assessment (only for children with repeated measures).

Levels of anxiety and depression of children
### Levels of behavioral problems of children

|                       | First assessment | 1 year follow-up | Difference*  |
|-----------------------|------------------|------------------|--------------|
|                       | mean  | SD   | (range) | mean  | SD   | (range) | mean  | SD   |
| CBCL T-scores         |       |      |         |       |      |         |       |      |
| Internalizing         | 51.1  | 12.3 | 50 (29-90) | 53.4 | 10.3 | 52 (29-83) | 1.2   | 9.3   |
| Externalizing         | 50.1  | 10.4 | 51 (32-74) | 50.4 | 9.3  | 51 (33-72) | -0.3  | 8.4   |
| Total score           | 50.5  | 11.7 | 51 (24-83) | 50.9 | 9.8  | 50 (24-71) | -0.9  | 9.2   |
| YSR T-scores          |       |      |         |       |      |         |       |      |
| Internalizing         | 52.8  | 11   | 55 (32-76) | 54.4 | 7.5  | 54 (44-73) | 2.9   | 8.5   |
| Externalizing         | 48.2  | 11   | 46 (29-70) | 48.3 | 7.5  | 49 (37-68) | 3.1   | 7.5   |
| Total score           | 50.2  | 10.4 | 51 (31-69) | 50.7 | 7.8  | 52 (40-70) | 2.9   | 6.9   |

*Mean difference per child, follow-up assessment – first assessment (only for children with repeated measures)

### Health-related quality of life of children

|                       | First assessment | 1 year follow-up | Difference*  |
|-----------------------|------------------|------------------|--------------|
|                       | mean  | SD   | (range) | mean  | SD   | (range) | mean  | SD   |
| PedsQL 8-12 Scale     |       |      |         |       |      |         |       |      |
| Physical functioning  | 82.9  | 15.1 | 88 (41-100) | 80.7 | 15.4 | 84 (41-100) | -1.4  | 8.5   |
| Emotional functioning | 72.7  | 20.6 | 75 (25-100) | 74   | 18.3 | 75 (30-100) | 7.8   | 20.6  |
| Social functioning    | 82.7  | 18.5 | 90 (20-100) | 79.8 | 18.9 | 80 (35-100) | 0.3   | 10.2  |
| School functioning    | 78    | 15.4 | 80 (40-100) | 74.8 | 16.3 | 80 (40-100) | -0.3  | 19.4  |
| Psychosocial health summary score | 77.8 | 15.1 | 78 (32-100) | 76.2 | 15.1 | 82 (42-95) | 2.6   | 11.9  |
| Total score           | 79.6  | 14.3 | 82 (38-100) | 77.7 | 14.1 | 82 (48-91) | 1.2   | 8.9   |
| PedsQL 13-18 Scale    |       |      |         |       |      |         |       |      |
| Physical functioning  | 86    | 14.5 | 91 (50-100) | 90.6 | 8.8  | 94 (66-100) | 1.6   | 12.4  |
| Emotional functioning | 73.6  | 21.7 | 80 (25-100) | 81.7 | 20.4 | 90 (35-100) | 4.6   | 16.3  |
| Social functioning    | 89.3  | 13.7 | 95 (60-100) | 93.7 | 7.2  | 95 (75-100) | 0     | 8     |
| School functioning    | 70.2  | 17.1 | 73 (35-100) | 75   | 11.6 | 70 (60-100) | -3.3  | 10.5  |
| Psychosocial health summary score | 77.7 | 13.2 | 82 (50-100) | 83.4 | 9.6  | 83 (67-98) | 0.4   | 7.3   |
| Total score           | 80.6  | 12.8 | 86 (53-100) | 85.9 | 8.5  | 87 (67-99) | 0.8   | 7.8   |

*Mean difference per child, follow-up assessment – first assessment (only for children with repeated measures)
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