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BRIEF COMMUNICATION

# VERTROUWENSARTSCENTRUM—ANTWERPEN

## Confidential Doctor Center of Antwerp

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HOW TO DEAL with the phenomenon of CA/N (Child Abuse and Neglect) is a concern that arose almost simultaneously in different European countries. In France the authorities came to the conclusion that Article 378 of the Penal Code concerning strict preservation of confidentiality between the professional and the client, hereinafter referred to as the duty of confidentiality, is a serious handicap in contending with the CA/N phenomenon. They also recognized that reporting every case of CA/N to judicial authorities did not lead to an adequate solution. To deal with this difficult situation, the proposition of Mme. Tome-Paternotre became law in June 1971 with the following important aspects:

- the obligation of everybody who is not subject to the duty of confidentiality to report cases of CA/N to "les autorités médicales et administratives chargées des actions sanitaires et sociales" rather than to the judicial authorities.
- persons subject to the duty of confidentiality are not obliged to report, but, in case they do report, they are not to be prosecuted.

Belgium has had no changes in the law concerning the duty of confidentiality or duty to report. The law of May 15, 1912, adjusted and increased some penal provisions in cases of CA/N. The law of April 8, 1965, concerning juvenile protection provided for the creation of Juvenile Protective Agencies. One of their functions is to take measures whenever a child is maltreated, but action can only be taken if all parties involved agree to intervention. The CA/N problem was never adequately dealt with in Belgium due to the duality of the law: although there is a Royal Decree stating every case of CA/N is to be reported and is to be without risk of prosecution should the reporting be done by persons subject to the duty of confidentiality, Article 458 of the Penal Code still stipulates that the duty of confidentiality is to be respected. As a result, no existing organization is prepared to deal with cases of CA/N, and until recently very few cases were reported. High officials of the Departments of Health and Justice, worried about this inactivity and inspired by the recommendations made by the Council of Europe in 1969, have been proposing amending acts since 1976:

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- In that year two members of Parliament (Brimant and Ryckmans-Corin) proposed a bill obliging everybody to report all cases of CA/N to the judicial authorities.
- In 1978 the Minister of Justice Van Elslande introduced a *moral* rather than a legal obligation to report cases of CA/N to *Confidential Doctors*. Reporting would be compulsory, but without prosecution if it were neglected. The moral obligation would apply to everyone, even to persons subject to the duty of confidentiality. The Confidential Doctor would be assisted by a multi-disciplinary team for advice and active treatment. In order for the teams to work effectively, the Minister suggested that nationwide information be given about the existence of these teams.
- In 1980 Senator Vanderpoorten, who later became the Minister of Justice, made a similar proposition, but added an exemption from prosecution in the case of persons subject to the duty of confidentiality.

## THE PRESENT SITUATION

The problem still has no legal solution, without any progress, due, in part, to the game of musical chairs within succeeding Belgium governments. While the need of action grew clearer day by day and no palpable legal initiative was taken, four projects were set up in October 1979 to study and deal with the problems of child abuse and neglect under the leadership of NWK (Nationaal Werk Voor Kinderwelzijn), a national organization for mother and child care by four universities (Antwerp, Louvain, Brussels and Liege). NWK provided financial means and personnel and the universities elaborated the theoretical framework.

In Antwerp the project is called "Vertrouwensartscentrum," a name derived from the Dutch "Bureau Vertrouwensartsen," after which it was modeled. The "medical" model was chosen rather than the "legal" model (that is compulsory reporting to judicial or other social authorities as is the case in the USA, England and France) which is confined to the treatment of symptoms and does not reach into the background of CA/N. The "medical" model offers an alternative approach to the problem. Three elements are typical in this particular approach:

1. A very wide definition of CA/N that comprises cases of physical abuse and neglect as well as cases of sexual and emotional abuse and neglect. Until recently cases of sexual abuse and cognitive neglect were not included because no cases were reported on those types of abuse.
2. The recognition of CA/N as an "SOS" signal, emitted by a family dealing with very serious problems, as a point of departure for our approach.
3. A new way, in the Belgian context, of handling cases of CA/N is *psycho-dynamic* in nature. In each case the team endeavors to understand the underlying determinants of the dysfunctional behavior of the parents. Understanding that dysfunctional behavior can be recognized at an early stage, our attention is focused on the recognition of early signals, well known from literature, as they are emitted by parents and children. Each time a case is reported, information is gathered that allows the team to assess the risk of CA/N. This information is obtained from social work agencies, schools, officers of justice, the police, members of the family, etc.

The assessment of the risk is based upon the following elements:

- Concerning the parents: An assessment of the CA/N potential including a study of childhood experiences of CA/N (our figures* show that 86% of the parents involved had been maltreated as children, themselves), social isolation (77% of the cases), disturbed partner relationships (88% of the cases), unrealistic expectations about the child's future.
- Concerning the child: A study of elements in the child's history that might place him at risk

*Figures obtained from an epidemiological study of families reported to the "Vertrouwensartscentrum" during the first year.

for CA/N. (38% of the children involved were "special." They were adopted, handicapped, premature or dysmature, illegitimate, etc.)

- Concerning the present situation: A study of stress factors, e.g., financial problems (78%), housing problems (56%), professional problems (59%), mental or physical diseases (60%), drug or alcohol problems (47%), etc.

A study of these factors allows the family situation to be assessed objectively without negative reactions from the team and allows the team to be in a position to offer family supporting care.

The team discovered that parents who were abused as children could be singled out as a major risk-factor for their children which leads us to believe that trying to understand the parents' problems is helpful in attacking the problem of CA/N.

The risk-assessment allows the team to determine what sort of action is needed:

- If the child is considered to be in mortal danger, intervention by hospitalization in the Children's Hospital of Antwerp, which is socially acceptable to the parents, is suggested. This allows contact with the rest of the family and the start of family-supporting care. In most cases, however, immediate supporting care at home by the team or a social worker is sufficient. In rare cases when neither the first or second mode of action is acceptable to the parents, judicial intervention is sought.
- When there is no emergency, a "case conference" is held for which contact is made with all kinds of social workers, including officers of justice who know or may have known the family. In our experience in most cases the families are already known to several social agencies, but have never received adequate help by one or more of them. During the case conference:
- We study all the risk factors in order to get deeper insight into the complex problems of the family and pass on this knowledge to the social workers.
- We coordinate the supportive care by appointing an informal "case-officer" who, at that particular time has the best relationship with the family and who will accept the responsibity of guiding them.
- An understanding is reached in which all participants agree to stay in contact with the "case-officer," particularly by bringing to his attention new information, but at the same time agree not to interfere with the treatment. The same type of case conference is held after an emergency intervention.

## PREVENTION

The aim of our team has been secondary prevention or prevention of repeated CA/N by efficient family-supporting care by which our understanding and aid finally allow a family to gain insight into their own situation and break the "chain" of CA/N. Of course time and confidence are needed to arrive at this goal, and a change in the behavior of the families is not our only objective.

Many social workers and the greater part of the public still think of CA/N in purely moral terms. To overcome this we give lectures to especially interested audiences and provide information for the news media. Primary intervention offers more promise in dealing with the problem, and Belgium has unique possibilities for primary prevention because medical and social services provided by the NWK are free of charge. Every family expecting a baby, every young mother having children up to the age of 6, can avail themselves of these services. Clearly, NWK can play a key role in primary prevention. To this end NWK nurses are asked to fill in questionnaires evaluating the major risk factors and these questionnaires then are used as screening instruments in the maternity hospitals. After screening, every family recognized as a "high-risk family" is closely attended by the NWK. An evaluation of the results of screening and follow-up is in progress.

## CONCLUSION

The large number of cases reported to the "Vertrouwensartscentrum," which in itself is little known to Belgians, allows us to infer that the Center responds to a need and that the Center has been right in choosing the medical model. From October 1979 to April 1981, 252 cases involving 344 children were reported to the Center. After a press conference with the Center in September 1980 the number of case reports increased dramatically, 140 in number. An examination of the source of reports indicates the difference between the Dutch and Belgian experience. In Belgium cases were reported from the following: NWK, 83 cases; Children's Hospital of Antwerp, 78; social agencies, 21; members of the family, 25; self reporting, 9 cases; others, 24; and from doctors, 12 cases. In The Netherlands large numbers of reports are received from doctors. In Belgium the smaller number of reports from doctors may be due to the duty of confidentiality; to simple ignorance for many doctors still do not know there is a Center dealing with CA/N; to a lack of motivation to report in view of the fact that the doctors' fees come from their own patients whom they fear they might lose by reporting; or doctors' fears of becoming involved in judicial procedures.

At this time research is less important to Belgium than immediate action. The phenomenon of CA/N has been studied thoroughly all over the world. Rather than indulging in theoretical discussion, Antwerp has approached the problem from a practical point of view. At the same time we are trying to convince judicial authorities that our way of handling treatment and prevention of CA/N is feasible within the legal and social framework of our country, a fact which has been shown by the increasing numbers of reported cases.

The growing number of requests for intervention to the "Vertrouwensartscentrum" points to the need for the government to immediately undertake creating centers after the model of the Antwerp "Vertrouwensartscentrum" in every Belgian province. Information gathered by confidential doctor centers would enable the centers to adapt their strategies for each situation.

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