Professionals' preferences and experiences with inter-organizational consultation to assess suspicions of child abuse and neglect

Annemieke A.J. Konijnendijk^{a,*}, Magda M. Boere-Boonekamp^b, Maria E. Haasnoot^c, Ariana Need^d

^a Departments of Health Technology and Services Research, and Public Administration, Institute of Innovation and Governance Studies, University of Twente, Enschede, the Netherlands

^b Department of Health Technology and Services Research, Institute of Innovation and Governance Studies, University of Twente, Enschede, the Netherlands

^c Department of Preventive Child Healthcare, Municipal Health Service GGD Twente, Enschede, the Netherlands

^d Department of Public Administration, Institute of Innovation and Governance Studies, University of Twente, Enschede, the Netherlands

ARTICLE INFO

Keywords:

Child abuse and neglect
Information sharing
Inter-organizational consultation
Prevention

ABSTRACT

This study addresses the following questions in cases of suspected child abuse and neglect (CAN) in children up to four years of age: 1) How many professionals intend to seek inter-organizational consultation? 2) What types of organizations do professionals prefer to consult? and 3) What factors can be identified as facilitator(s) or barrier(s) regarding inter-organizational consultation, based on professionals' experiences? Professionals working with children in 101 organizations in a medium-sized Dutch city were invited to fill in an online questionnaire. The questionnaire included a vignette about a suspected case. Quantitative, qualitative, and social network analysis approaches were used to analyze the data. Seventy-eight questionnaires were available for analysis. Fifty-five respondents (71%) intended to seek inter-organizational consultation. Ten different organization types were mentioned. The most frequently mentioned organization was preventive child healthcare. In total, 82 text fragments from 39 participants were available to analyze barriers and facilitators to inter-organizational consultation, 60 fragments that entailed a facilitator and 22 fragments that entailed a barrier. The text fragments were subdivided into twelve factors. The three factors that were most often identified as a facilitator were 'support', 'undertaking action', and 'regard'. Barriers were found in relation to all twelve factors. No specific barrier(s) stood out. This study demonstrated that most professionals are inclined to seek inter-organizational consultation when they suspect CAN. They are especially likely to seek consultation from preventive child health care organizations. Their experiences mainly revealed facilitators and few barriers. The implications for research and practice are also discussed.

1. Introduction

Child abuse and neglect (CAN) is a major public health concern worldwide. In 2010 approximately 1 in 33 Dutch children suffered

* Corresponding author at: Institute for Innovation and Governance Studies, Department of Health Technology and Services Research, University of Twente, P.O. Box 217, 7500 AE Enschede, the Netherlands.

E-mail address: a.a.j.konijnendijk@utwente.nl (A.A.J. Konijnendijk).

<https://doi.org/10.1016/j.chiabu.2018.10.013>

Received 30 April 2018; Received in revised form 17 September 2018; Accepted 23 October 2018
0145-2134/ © 2018 Elsevier Ltd. All rights reserved.

from sexual, physical or emotional abuse or witnessed domestic violence (Alink et al., 2011). CAN has serious consequences for the mental and physical health of children in childhood and beyond (e.g. Hillis, Mercy, & Saul, 2017; Taillieu, Brownridge, Sareen, & Affi, 2016) and results in high economic costs for society (Thielen et al., 2016). Therefore, preventing (ongoing) CAN is crucial.

Increased knowledge about the prevalence and consequences of CAN, and the low chance of caregivers or maltreated children seeking help themselves (Association of Dutch Youth Care, 2013; Deater-Deckard, 1998; Hoefnagels & Zwikker, 2001), have led to increased demands on professionals working with children and families to become more involved in early detection of, and response to, CAN. In various countries, the responsibilities of these professionals have been emphasized in policies, laws and guidelines that mandate or recommend professional handling of suspicions of CAN (e.g. Cukovic-Bagic, Welbury, Flander, Hatibovic-Kofman, & Nuzzolese, 2014; Paavilainen & Flinck, 2013; Saperia, Lakhanpaul, Kemp, & Glaser, 2009). Professionals' expertise in assessing CAN concerns is particularly important with regard to families with children younger than four. Children that young are not yet able to articulate their experiences of CAN and caregivers can keep their children at home with little involvement with children's services ('children's services' is used here to refer to any organization having direct contact with children). As caregivers may not feel comfortable admitting that they are experiencing problems in bringing up their child, CAN may remain unrecognized.

Children and families make use of a lot of different services. With the growing emphasis on the responsibility to respond to child protection concerns, professionals are increasingly encouraged to cross organizational boundaries (Horwath & Morrison, 2011; Percy-Smith, 2006). One reason to cross organizational boundaries is for consultation. In our study, performed in the Netherlands, we define inter-organizational consultation as one professional (consulter) talking to another professional from another organization (consultee) involved with the same child to obtain client information and/or the other professional's opinion about the child or family's situation. In the Netherlands, a national reporting code on domestic violence and CAN (Statute book of the Kingdom of the Netherlands, 2013), obliges all children's services professionals to seek advice from the local child protection service (Advice and Reporting Center). Also, professionals should report suspicions of CAN to this center if they cannot organize help themselves. Advice and Reporting Centers are then responsible for the assessment of these suspicions and referral to the necessary care and support for children and families (Netherlands Youth Institute, 2011). The reporting code also recommends that these professionals obtain relevant information from other professionals involved with the family when there are suspicions of CAN, in principle with the caregivers' consent. Professionals are only allowed to speak to another professional without the caregivers' permission after careful consideration and in the interest of good care, for example when involving caregivers puts a child in a dangerous situation (Dutch Ministry of Health Welfare & Sport, 2013).

Inter-organizational consultation in response to suspicions of CAN can be beneficial to children, their caregivers and professionals. In some cases, assessment of the family situation through seeking advice or sharing information can be essential to protect children from harm and even from death (e.g. Brandon, Dodsworth, & Rumball, 2005). Reviews of (near) fatal CAN cases have demonstrated practice failings, including inadequate inter-organizational communication and information-sharing (Douglas & Cunningham, 2008; Vincent & Petch, 2017). Integrating information held by various professionals on, for example, signs, risk factors or critical events can result in a more comprehensive view of the child's situation. As a result, professionals can make better informed decisions about further action that best suits the needs of the child. Furthermore, talking with other professionals involved with the family provides professionals with the opportunity to verify their concerns with regard to signs of CAN (Ikkink et al., 2010). In addition, inter-organizational consultation may facilitate progress in a case (Bross, Ballo, & Korfmacher, 2000), reduce ambiguity and uncertainty about the level of suspicion (Bross et al., 2000; Gunn, Hickson, & Cooper, 2005; Jones et al., 2008), and increase professionals' confidence in their approach to the case (Bross et al., 2000). Multiple studies have described professionals' need for consultation to invalidate or strengthen concerns about a child's situation (e.g. Brandon et al., 2005; Talsma, Boström, & Östberg, 2015; Tiyyagura, Gawel, Koziel, Asnes, & Bechtel, 2015).

Because of its potential value in assessing whether a child is likely to be(become) a victim of CAN, it is important that professionals are not reticent in seeking inter-organizational consultation. However, little is yet known about what type of organizations professionals prefer to consult. Also, information on how professionals experience inter-organizational consultation is scarce. Findings from studies with a broader (inter-organizational collaboration in the field of childcare) or narrower scope (reporting CAN to child protection services) may also apply to inter-organizational consultation. The factors that were found in these studies mainly relate to the consultee from the perspective of the consulter. Factors found to contribute to well-functioning collaboration include trust (e.g. being confident about professionals' abilities) (Feng, Fetzer, Chen, Yeh, & Huang, 2010; Herendeen, Blevins, Anson, & Smith, 2014; Spath, Werrbach, & Pine, 2008; Talsma et al., 2015), clearly defined roles and responsibilities (Darlington, Feeney, & Rixon, 2005; Percy-Smith, 2006), good communication (e.g. staying informed about the follow-up situation for a child) (Feng et al., 2010), good awareness of services (Kanste, Halme, & Perälä, 2013), and mutual respect (e.g. feeling supported) (Darlington et al., 2005; Feng et al., 2010; Johnson, Zorn, Yung Tam, Lamontagne, & Johnson, 2003). Positive regard (e.g. being flexible, interested), the ability to respond calmly and competently, being treated in a personal way, and willingness to cooperate also facilitate good inter-organizational collaboration (Darlington et al., 2005; Vulliamy & Sullivan, 2000). Many barriers to inter-organizational collaboration have been reported, including frustration with inaction, difficulty contacting appropriate people (Gunn et al., 2005), and different practices regarding confidentiality (Darlington et al., 2005).

This study addresses the following questions with regard to suspected CAN in children up to four years of age: 1) How many professionals intend to seek inter-organizational consultation? 2) What types of organizations do professionals prefer to consult? and (3) What factors can be identified as facilitator(s) or barrier(s) with regard to inter-organizational consultation, based on professionals' experiences? As the government encourages Dutch professionals to seek inter-organizational consultation, the Netherlands was deemed an interesting setting to study consultation preferences and experiences. Insight into consultation seeking intentions and preferences and factors that promote or impede inter-organizational consultation will allow organizations and local government to focus their efforts to improve inter-organizational consultation on strengthening facilitators and overcoming barriers.

2. Methods

2.1. Research design

An exploratory single case study was performed as we were interested in exploring a phenomenon that occurs within a local network of professionals (Rowley, 2002). We used a short self-constructed vignette-based online questionnaire collecting both quantitative and qualitative data. We chose a single municipality as a case, as families usually make use of services provided by organizations in one municipality. As a result, professionals involved with these families will contact organizations within the same municipality when they wish to consult another professional who is involved with the family. Data collection took place in May and June 2015.

2.2. Research setting

In 2015, approximately 3.3 million children 0–18 years of age were living in the Netherlands. (Siderius, Carmiggelt, Rijn, & Heerkens, 2016). The Dutch health and social care system consists of universal services, primary care and secondary care. Universal services include basis services for all citizens, such as (pre)school. Primary care services focus on the early detection of problems and are also accessible for all citizens, such as general practice, preventive child healthcare, and obstetric care. Especially, preventive children's services are uniquely organized in the Netherlands compared to other countries (Siderius et al., 2016). One of the main tasks of preventive child healthcare professionals is to monitor children's growth and development, detect (risks for) health and social problems early (including child abuse and neglect) (Siderius et al., 2016). Virtually all children are checked 15 times by child healthcare physicians and nurses alternately during the first four years of their lives (Benjamins, Damen, & van Stel, 2015). Primary care professionals can refer people with problems for further assessment or treatment to more specialized services, such as pediatric care, gynecology, mental healthcare or more specialized youth work, social care or care of the disabled. Furthermore, pregnancy is monitored and birth is assisted by obstetric care providers. After birth, women are provided with a home maternity nurse to support care of the infant in the first week after delivery.

The study was performed in the municipality of Almelo. This municipality of Almelo has just over 72,000 residents and comprises one small city and two small villages. This municipality was chosen as an informative case because of its moderate size, which enabled us to involve all children's services and study a complete network. Almelo also offers an appropriate set of circumstances to study inter-organizational consultation because risk factors that are associated with CAN are relatively high compared to other Dutch municipalities. For example, in 2012, nearly twice as many teenage mothers lived in Almelo as the Dutch average (1.0% vs. 0.5%), a relatively high percentage of families with children received a social security payment from the government (7.7% vs. 5.6%), and citizens were more often unemployed (7.1% vs. 5.9%) (The Association of Dutch Municipalities, & Quality Institute Dutch Municipalities, 2017). In 2014, with 9.4 incidents per thousand citizens, Almelo had the highest incidence of domestic violence, including CAN, compared to the other thirteen municipalities in this region of the Netherlands (Kruize, Boendermaker, & Bieleman, 2015). Consequently, professionals working in the municipality of Almelo are probably more familiar with inter-organizational consultation than professionals in municipalities where the incidence of (risk factors for) CAN is lower.

2.3. Study population

The subjects of this study were professionals who had to meet four criteria: (1) operating in one of the following fields: health care (general practice, maternity care, obstetric care, preventive child healthcare, mental healthcare, dietetics, physical therapy, speech therapy, home care for children (i.e. nursing provided at home), and hospital departments focused on healthcare for children (pediatric care, obstetric & gynecologic care, physical therapy, occupational therapy, and medical social care), social care (social work, youth work, and care for the disabled), and preschool services; (2) having personal contact with children younger than four as part of their work; (3) being legally authorized to contact other organizations to request information when they have suspicions of CAN; and (4) working in Almelo, a municipality located in the region of Twente in the east of the Netherlands. In total, 101 organizations, including autonomous practices, met these criteria.

2.4. Data collection

In May 2015, 101 organizations received an email with a request to participate in the study. If the organizational representatives (contact persons) agreed to participate, they received an email including an online questionnaire to be forwarded to professionals in the organization who fell under the scope of the research. The online survey included a letter of consent outlining the purpose of the study and giving an assurance of confidentiality. Contact persons in the organizations were asked to report the number of professionals to whom they forwarded the questionnaire. Follow-up to the contacts persons of each organization was conducted to encourage participation and professionals' completion of questionnaires, with two emailed reminders.

The self-report questionnaire contained 22 questions (see Appendix A in Supplementary material) and was digitalized using the online survey tool LimeSurvey. The estimated completion time was five to ten minutes. After demographic questions, respondents were given a vignette describing a family situation that contained risk factors and signs of CAN. The vignette is presented in text Box 1. Vignettes have been described as the most feasible method for studying variations in professionals' decision-making and assessing factors that might contribute to the extent of these variations (Converse, Barrett, Rich, & Reschovsky, 2015). The vignette was

Box 1

Vignette

Sonja is a mother of 25 years old. She lives in the city of Almelo. Sonja works twelve hours per week. She has two children: Tom, who is 3.5 years old, and Rose, who is two weeks old. Sonja's husband was recently admitted to a mental institution for mental health problems. As a consequence, Sonja cares for her children alone and also needs to do all the housekeeping herself. She has no family close by who can support her. Tom goes to preschool. Since Tom's father was admitted to the mental institution, Tom has tantrums. Also, Tom wakes his mother Sonja four to five times per night. Sonja tells you that she is broken and cannot manage to clean the house properly. She also tells you that she hits Tom on his bottom and places Tom in the hallway roughly when he refuses to listen to her.

followed by the question: 'Imagine that you encountered this situation during your work. Do you, based on the description, intend to consult a professional outside your own organization, to examine your suspicion and further assess the situation? Consultation may be requesting factual client information or asking for a professional's opinion. Please assume that you have made your concerns explicit to the mother.' If respondents answered 'no', they were asked to explain why they would not consult professionals outside their own organization. If respondents answered 'yes', they were asked to report a maximum of three organization types (free recall) that they would consult about the case provided in the vignette. Subsequently, respondents were asked whether there were organization types that they would also like to consult, but for some reason would refrain from consulting. Again, respondents could report a maximum of three organization types.

Next, respondents were asked to describe their general experiences with consulting professionals from the organizations they would intend to consult. Their answers may reveal positive experiences of facilitators for consulting that organization type. A question was also included asking respondents to describe experiences with organizations they would like to, but would not, consult. This question may disclose negative experiences, revealing barriers.

2.5. Data analysis

Respondents were excluded from the data analyses when they did not meet the inclusion criteria or did not complete the questionnaire. Three different techniques were used to analyze the data: quantitative analyses, qualitative analyses, and social network analysis.

2.5.1. Quantitative analyzes

IBM SPSS Statistics 24 was used to calculate descriptive statistics with regard to background variables. An independent sample *t*-test analysis was performed to investigate whether the group of professionals who would or would not consult professionals outside their own organization differed with regard to mean number of years in professional practice or working hours per week. SPSS was also used to calculate Cohen's kappa values to assess the inter-observer reliability of qualitative data analyzed by two assessors.

2.5.2. Qualitative analyzes

String data about professionals' experiences with inter-organization consultation were exported from LimeSurvey to Excel. Inductive content analysis (Elo & Kyngas, 2008) was performed to expose common themes in professionals' experiences. First, two assessors independently coded the text fragments about experiences. Each fragment could be labelled with one code. The first author (AK) analyzed the data first. The second author (MB) coded the same text fragments independently from the first author, using the coding scheme provided by the first author. Cohen's kappa was calculated to provide a measure of interrater reliability (Viera & Garrett, 2005). Fragments about which the assessors disagreed were discussed until consensus was reached.

Second, both assessors labelled each text fragment as a facilitator, barrier, not applicable (the respondent had no experiences with consulting that organization type) or missing. The missing label was assigned when no answer was given by the respondent and for fragments for which no facilitators or barriers could be identified, for example, because the answer was too general. Again, Cohen's kappa was calculated and labels about which the assessors did not agree were discussed until consensus was reached.

2.5.3. Social network analysis

Social network analysis was performed to visualize consultation relationships between professionals and different organization types. A social network consists of a finite set(s) of actors, e.g. people or organizations, and the relation(s) defined between them. Social network analysis involves mapping relationships among people or organizations, and has proved fruitful in a wide range of social and behavioral science disciplines (Wasserman & Faust, 2009). Representing social network data visually in a graph allows researchers to uncover patterns that might otherwise go undetected (Wasserman & Faust, 2009). The network under study can be viewed as an affiliation network, i.e. two-mode networks formed by two different set of nodes: one set of nodes representing individual professionals and another set of nodes representing organizations. A connection between a professional and an organization type is present when the professional reported the organization as an organization with which they would like to seek consultation, based on the information in the vignette. As we were interested in inter-organizational relationships, professionals could not report the organization type that they represent.

As the network is a directed network - we are interested in the ties directed to organization types - we only calculated in-degree centrality (and not out-degree centrality, i.e. the number of ties directed from one organization to other organizations) (Wasserman & Faust, 2009). To do this, the two-mode network was transformed into a single-mode representation, in which individual professionals represent their employing organization type. The degree measure reflects the popularity of organization types in relation to being contacted for consultation by professionals from other organization types. In-degree centrality is an indicator of an organization's centrality, or popularity, in a network. In-degree centrality is defined as the number of ties a node (i.e. organization type) has. In-degree centrality scores were normalized, which means that the number of ties directed to an organization type is expressed as a percentage of possible connections. For example, when two out of 55 respondents are general practitioners, general practice as organization type can receive 53 ties from 53 respondents. When 23 of these 53 respondents mentioned general practice, in-degree centrality is $23 \div 53 \times 100 = 43\%$.

2.6. Ethical considerations and data protection

According to the criteria of the Dutch [Medical Research \(Human Subjects\) Act \(1998\)](#), this study did not need to be submitted for ethical approval by a Medical Ethical Committee. Data were collected through a safe online survey and stored on a secure institutional drive. This research was approved by the ethical committee of the Faculty of Behavioral, Management and Social sciences of the University of Twente (reference number 15,179), which also assessed and accorded the way of handling data confidentially and anonymously. No personal data were collected.

3. Results

3.1. Respondents

Seventeen of the 101 invited organizations agreed to participate (17%). All invited organization types were represented, except for one specialized service that provides home care for children with complex needs. In total, the questionnaire was sent to 162 professionals in these 17 organizations. Eighty professionals completed the questionnaire (response rate = 49%; 99% female). Two respondents were excluded; one respondent did not operate in Almelo and one respondent did not work with children younger than four years of age.

3.2. Intentions to seek inter-organizational consultation

Fifty-five of the 78 respondents that were used in the analyzes (71%) indicated that they would consult a professional outside their own organization based on the situation described in the vignette and 23 reported no intention to seek such consultation as a first step (see [Table 1](#)). Twenty-two of the 23 respondents who reported having no intention to seek inter-organizational consultation clarified their answer in an open follow-up question: first undertaking other activities ($n = 13$); undertaking another activity instead

Table 1

Background information of the respondents ($n = 78$).

	Total sample ($n = 78$)	Intention to consult professionals outside own organization ($n = 55$)	No intention to consult professionals outside own organization ($n = 23$)
Type of services and organizations	<i>n</i>	<i>n</i>	<i>n</i>
<i>Health care services</i>			
General practice	2	1	1
Maternity care	19	17	2
Mental healthcare	8	5	3
Obstetric care	2	1	1
Pediatric care	4	3	1
Preventive child healthcare	6	5	1
Specific healthcare services ^a	8	6	2
<i>Preschool services</i>	14	9	5
<i>Social services</i>			
Care for the disabled	2	2	0
Social care	6	4	2
Youth work	7	2	5
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Years in professional practice (range 0.5 – 35.0)	16.4 (9.6)	17.1 (9.8)	16.3 (9.3)
Working hours per week (range 8–60)	26.1 (9.2)	25.8 (8.6)	26.8 (10.4)

^a Specific healthcare services include dental care (DENT) ($n = 1$), dietetic (DIET) ($n = 2$), speech therapy (SPEE) ($n = 3$) and physical therapy (PHYS) ($n = 2$).

($n = 8$); no need to seek consultation outside their organization ($n = 1$). The other activities that were reported were expert consultation within the organization ($n = 9$); discussing concerns with the mother ($n = 5$); providing support ($n = 3$); intra-professional consultation and discussing concerns with the mother ($n = 2$); performing steps of the reporting code ($n = 1$); reporting concerns to child protection services ($n = 1$). One participant did not specify what activities (s)he would undertake (first).

Table 1 displays the background variables for all 78 respondents, for the group of respondents that intends to consult professionals outside their own organization ($n = 55$) and for the group of respondents without the intention to seek inter-organizational consultation as a first step ($n = 23$). Table 1 shows that most of the respondents ($n = 49$, 63%) were employed in a healthcare organization or practice with smaller numbers in social care ($n = 14$, 19%) and preschool services ($n = 15$, 18%). No response was received from professionals working at the hospital departments for medical social care, obstetrics & gynecology or occupational therapy. Respondents had on average 16.4 years of work experience and worked an average of 26.1 h per week. No differences were found between the groups of professionals who would and would not intend to consult a professional outside their own organization with regard to years in professional practice ($t_{.354}$, $p = .725$) or working hours per week ($t_{.393}$, $p = .695$).

4. Inter-organizational consultation seeking preferences

The 55 respondents who would seek inter-organizational consultation reported, on average, that they would consult with two organization types (range 1–5). Based on the vignette, they would prefer to consult to gather additional client information. In total, respondents mentioned ten types of organization.

Table 2 presents in-degree centrality measures, reflecting the popularity of organization types. As can be seen from this table, preventive child healthcare is the most popular organization type with which to seek consultation (normalized in-degree centrality: 35 out of 50 possible ties = 70%), especially among maternity care professionals. The second, third and fourth most popular organizations are general practice (normalized in-degree centrality: 43%), preschool services (normalized in-degree centrality: 37%), and the Advice and Reporting Center (normalized in-degree centrality: 35%).

4.1. Barriers and facilitators to inter-organizational consultation

Forty-nine out of 55 respondents described their experiences with inter-organizational consultation. They reported experiences with ten organization types, resulting in 124 fragments to be analyzed (mean = 2.3 fragments per respondent, range 0–7 fragments). From this data, we identified a set of twelve factors that appear to influence professionals' decisions on where to seek consultation in case of suspicion of CAN. The agreement between the two encoders was 94% (116/124). Cohen's kappa was 0.88, indicating almost perfect agreement (Viera & Garrett, 2005). The twelve factors were placed in one of two categories: factors associated with the consultee, i.e. type of organization or professional, or factors associated with the consuler, i.e. the professional that seeks consultation.

Eighty-two out of the 124 text fragments could be labelled as a facilitator or barrier to consultation. Sixty of the 82 fragments entailed facilitators, all related to the consultee. The other 22 of the 82 fragments entailed barriers: 15 were related to the consultee and seven to the consuler. Table 3 shows these factors, their descriptions, the number of fragments per factor and example quotes. Appendix B in Supplementary material includes all text fragments per factor.

Forty-two out of the 124 fragments could not be labelled as a facilitator or barrier, because the respondents reported having no experience (yet) with consulting that organization type (seven fragments), the fragment entailed a general or neutral experience, e.g. "good" (29 fragments), or the fragment gave a description of a factual situation (e.g. policy) instead of an experience (six fragments). The agreement with regard to labelling the text fragments between the two encoders (AK and MB) was 77% (95/124). Cohen's kappa was 0.73, indicating substantial agreement (Viera & Garrett, 2005).

4.1.1. Factors related to the consultee

Eight factors were identified in relation to the consultee. The factor 'Support' was identified most often, mainly as a facilitator and most often in relation to preventive child healthcare. Another factor that was identified relatively often was 'Undertaking action'. Respondents reported mainly positive experiences in relation to different services. 'Accessibility' was identified as both a facilitator and barrier. Respondents who mentioned this factor were positive about the ease and speed of contact with the Advice and Reporting Center, preventive child healthcare, preschool services, maternity care organizations, and obstetric care organizations. Three participants reported barriers regarding 'Accessibility'. Their experiences concerned difficulties contacting organizations, including the Advice and Reporting Center and mental healthcare. The factor 'Regard', including the feeling of being taken seriously, was only identified as a facilitator, in relation to preventive child healthcare and mostly by obstetricians. 'Willingness to cooperate' was mentioned in relation to the Advice and Reporting Center, mental healthcare, general practice, preventive child healthcare, and preschool services. 'Knowing the family' was also identified as a factor that may influence professionals' intentions to seek inter-organizational consultation. Multiple professionals mentioned that preventive child healthcare professionals are very familiar with the child and its family. 'Quality of information' was mentioned only in relation to preschool services and mainly as a barrier.

4.1.2. Factors related to the consuler

Four factors were found in relation to the consuler. These factors include 'Consequences for the family', 'Consequences for the professional', 'Familiarity with the organization', and 'Privacy of clients'. The text fragments exposed only barriers. For example, with regard to the factor 'Privacy of clients', one participant is reluctant to seek consultation from general practice because (s)he feels it may conflict with the privacy of his/her clients.

Table 2
Sociomatrix regarding seeking inter-organizational consultation: in-degree-centrality (n) and normalized in-degree centrality (%) (n = 55).

Organization type that respondents represent	Number of respondents	Organization types that respondents prefer to consult									
		General practice	Maternity care	Mental healthcare	Obstetric care	Preventive child healthcare	Medical specialist (not specified by the respondent)	Preschool services	Social care	Youth work	Advice and Reporting Center ^a
<i>Health care services</i>											
General practice	1	–						1	1		1
Maternity care	17	7	–	1	7	15	1	1	1	1	8
Mental healthcare	5	3		–		2		3		1	2
Obstetric care	1	1			–				1		
Pediatric care	3	3				3					2
Preventive child healthcare	5	1		2		–		5			1
Specific healthcare services ^b	6	1				3		2	1		2
<i>Preschool services</i>											
Social services	9	2		1		8		–	1	1	2
care	4	2									
Youth work	2	2	1	1	1	2		3	–	–	
Care for the disabled	2	1				2		2		1	1
Total number of respondents	55										
In-degree centrality (n)		23	1	5	8	35	1	17	5	4	19
Normalized in-degree centrality (%)		43	3	10	15	70	2	37	10	8	35

^a The Advice and Reporting Center did not meet the inclusion criteria for participation in this study (no provision of services to children up to four years of age), so no respondents in this study represent the Advice and Reporting Center.

^b Specific healthcare services include dental care (DENT) (n = 0), dietetics (DIET) (n = 2), speech therapy (SPEE) (n = 3) and physical therapy (PHYS) (n = 1).

Table 3

Factors associated with the consultee and the consultor identified as facilitators and/or barriers in professionals' experiences with inter-organizational consultation in case of suspected CAN.

#	Factor	Description of factors	Number of fragments that entailed a facilitator (n)	Number of fragments that entailed a barrier (n)	Example quotes facilitators	Example quotes barriers
Factors associated with the consultee						
1	Support	The degree of support or assistance received by the respondent from a consultee.	60	14	"Professionals are always willing to work collaboratively", about preventive child healthcare	"They asked for information, but they said that we needed to act immediately. It became an annoying situation", about the Advice and Reporting Center
2	Undertaking action	The extent to which a consultor is undertaking action	16	2	"They immediately undertake action", about obstetric care	"They sometimes act indolent", about general practice
3	Regard	The way in which respondent experiences the reaction (e.g. taken seriously, commitment) by consultees	8	1	"They take me seriously", about preventive child healthcare	"It is my experience that they do not take me seriously", about social work
4	Accessibility	Accessibility or availability of a consultee	7	3	"The organization can be reached quickly", about the Advice and Reporting Center	"Difficult to get in touch with", about mental health care
5	Willingness to cooperate	The extent to which a consultee is willing to cooperate	5	1	"The organization helped me when it comes to asking for advice", about the Advice and Reporting Center	"In case of filing a report, it is often very difficult, particularly because it goes no further than a suspicion in most cases", about the Advice and Reporting Center
6	Familiarity with the family	The extent to which the consultee knows the child and/or his/her family	4	2	"They are often very familiar with the family", about preventive child healthcare	"Is not always very familiar with the family", about general practice
7	Quality of information	The quality of information that a consultee provides (e.g. relevance and reliability of information)	1	2	"Information is reliable", about preschool services	"Little relevant information", about preschool services
8	Expertise	Perceived expertise or experience of a particular profession or consultee	1	1	"They have a lot of experience", about preventive child healthcare	"They sometimes believe the problem to be bigger than it is in reality", about youth work
Factors associated with the consultor						
9	Consequences for the family	Perceived consequences of consulting for the child and/or his/her family	0	8	–	"Being careful to prevent the problem from growing bigger", about preschool services
10	Consequences for the professional	Perceived consequences of consulting for the professional	0	2	–	"Being reticent to protect oneself", about medical specialists
11	Familiarity with the organization	The extent to which the professional is familiar with the organization type	0	1	–	"I don't know who I should call. Currently, there is little familiarity with it in the organization" about the Advice and Reporting Center
12	Privacy of clients	Professional's attitudes towards handling the privacy of clients	0	3	–	"Being careful with the privacy of clients", about general practice
Total number of fragments			60	22		
Total number of factors			8	12		

*The word 'professionals' refers to professionals who are involved with the delivery of services to the child and/or his/her family.

Fig. 1. Inter-organizational consultation network displaying the consultation relationships for which the respondents' experience entailed a facilitator.

Abbreviations: ARC: Advice and Reporting Center; DENT: Dental care; DIET: Dietary advice; DISA: Care for the disabled; GP: General practice; MATE: Maternity care; MENT: Mental health care; MEDI: Medical specialists; OBST: Obstetric care; PEAD: Pediatric care; PRES: Preschool services; PCHC: Preventive child health care; PHYS: Physiotherapy; SOCI: Social care; SPEE: Speech therapy; YOUT: Youth work.

Figs. 1 and 2 display two-mode networks, showing the consultation relationships for which the experiences of the respondents entailed a facilitator (Fig. 1) or a barrier (Fig. 2). It is notable that only one barrier was identified from professionals' experiences regarding preventive child healthcare, the organization type that was listed most often. A relatively large number of barriers in this study were mentioned in relation to the Advice and Reporting Center, including poor support and poor accessibility. Furthermore, no barriers were identified in relation to maternity care, obstetric care, care for the disabled, or specific healthcare services.

5. Discussion

Through the use of a vignette that described a case of CAN, we aimed to study professionals' preferences for and experiences with inter-organizational consultation to assess suspicions of CAN.

action (Herendeen et al., 2014; Talsma et al., 2015), and accessibility (Gunn et al., 2005). The factors identified as barriers (22 out of 82 text fragments, related to all 12 factors) concerned the consultee as well as the consulter and illustrated a wide variation in types of negative experiences. Many of these factors have also been seen in previous studies on barriers to inter-organizational collaboration, mainly in relation to reporting CAN to child protection services, such as different perceptions on dealing with privacy issues, personal disadvantages and negative consequences for the family (Darlington et al., 2005; Gunn et al., 2005; Konijnendijk, Boere-Boonekamp, Haasnoot-Smallegange, & Need, 2014). Factors that were not found often in previous studies on inter-organizational collaboration may be particularly relevant in relation to inter-organizational consultation, namely the extent to which the consultee knows the family and the quality of information a certain professional can provide.

Although consultation preferences varied, one organization type was especially popular: a majority of the respondents outside the preventive child healthcare setting (normalized in-degree centrality: 70%) preferred to consult preventive child healthcare professionals. The popularity of preventive child healthcare as a consultee is not surprising, as almost all children visit this free public service, resulting in a comprehensive and up-to-date client record. Moreover, one of the key tasks of preventive child healthcare is the prevention of CAN; experts on CAN believe that child healthcare physicians spend approximately 20% of their work week on this task (Visser & van Stel, 2017). The popularity of preventive child healthcare may also be explained by most respondents having mainly good experiences in relation to this type of organization. It is very plausible that positive experiences in the past result in consulting preventive child healthcare services again in the future (Ajzen, 2002).

Other organization types that were reported relatively often include general practice and preschool services (normalized in-degree respectively 42% and 37%). The finding that most child healthcare professionals did not prefer to consult general practice is consistent with the research by Visser and van Stel (2017), who found that only 27% of child healthcare professionals intend to contact general practice when they suspect CAN. Furthermore, professionals' intention to consult maternity care, obstetrics, and gynecology was remarkably low. Obstetrics was popular among maternity care professionals and not among other professions, despite the fact that the mother in the case in the vignette recently delivered. In the Netherlands, a maternity care nurse will come to the family's house to support the mother and child for the first eight days after birth and is thus intensively involved with the family for that period. The finding that maternity care is unpopular as a consultation partner is remarkable, as one could conclude from the vignette that a maternity care professional and an obstetrician were recently and very intensively involved with the family, and would thus have valuable information on the family situation.

The Advice and Reporting Center was listed by one-third of the respondents (normalized in-degree centrality 35%). The Advice and Reporting Center can provide a professional opinion, but in most cases cannot provide client information. For professionals who wish to consult organizations to gather additional client information, the Advice and Reporting Center is not a logical choice. This could explain why the center was not mentioned by all respondents. Another explanation may be that professionals experienced barriers that hindered them from consulting the center. A relatively large number of barriers were mentioned in relation to this organization type. Professionals' reluctance to collaborate with child protection services has been reported in many articles, where it has been attributed to factors including negative attitudes and low trust, as well negative experiences such as inadequate feedback and delayed investigations (Feng & Levine, 2005; Flaherty et al., 2008; Gunn et al., 2005; Herendeen et al., 2014).

5.1. Strengths and limitations

A strength of this study is that it brings additional understanding of a complex issue about which the literature currently provides little information. Another strength is that virtually all invited organization types were represented. As such, this study provides a sample picture of professionals' preferences for and experiences with inter-organizational consultation.

It is important to bear in mind several limitations. It was impossible to map how many professionals did not respond to, or declined, our invitation to participate. As a result, the exact response rate could not be calculated and we do not know whether the sample is equally balanced with regard to professions. Moreover, the ultimate number of respondents was relatively low and professionals who do not find inter-organizational consultation important may have been less inclined to participate in this study. Possibly, non-respondents are less willing to seek consultation than respondents resulting in an overestimation of consultation seeking intentions. For these reasons, our findings regarding inter-organizational consultation should be interpreted carefully. Furthermore, the vignette study does not monitor real practices, merely preferences, and is as such vulnerable to socially desirable answers. Since we only used one vignette, a note of caution regarding generalizability is also due here.

5.2. Implications for future research

The present exploratory study raises several opportunities for further research. A quantitative design can be useful to study statistical correlations between factors associated with seeking inter-organizational consultation and consultation preferences, or to study statistical correlations between type of organization, professions, and factors. Second, further qualitative research should be undertaken to investigate reasons for not seeking consultation from health, social, or preschool services, especially regarding maternity care and general practice. These reasons may expose important barriers in general or in relation to specific children's services that are decisive in professionals' decisions about which organization types to consult in case of suspected CAN. Third, this study could also be extended using a historical perspective by investigating actual inter-organizational consultation practices in real CAN cases, using children's medical records. Such research measurements would be valuable in studying actual practices and testing the reliability of our results.

5.3. Implications for practice

The popularity of preventive child healthcare should improve further, considering their expertise, their client information, and the positive experiences of consultants. Also, professionals could better utilize the knowledge of general practitioners, who usually have an overview of the medical and social situation of all family members. Furthermore, in situations where a new-born is involved maternity care should become more visible as a consultation partner.

Several professional-oriented strategies may be used to promote professionals' awareness of what members of other professions can offer with regard to client information and support in suspected CAN cases. For example, by organizing interactive small group meetings including professionals in health, social, and preschool services who operate in the same neighborhood (Grol & Grimshaw, 2003; Grol, Wensing, Eccles, & Davis, 2013). These meetings could be provided by a trained individual who could provide information, aids, and feedback on current practice (Grol et al., 2013). Furthermore, educational efforts may focus on making professionals aware of personal barriers that were addressed in this study, such as handling privacy issues and fear of personal consequences. Meetings in which multiple disciplines participate may also facilitate inter-organizational communication, mutual trust, respect, and commitment.

Declaration of interest

None.

Acknowledgements

This work was supported by the Netherlands Organisation for Health Research and Development (ZonMw) (grant number 159010003).

Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.chiabu.2018.10.013>.

References

- Ajzen, I. (2002). Residual effects of past on later behavior: Habituation and reasoned action perspectives. *Personality and Social Psychology Review*, 6(2), 107–122.
- Alink, L. R. A., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Pannebakker, F. D., Vogels, T., & Euser, S. (2011). *Kindermishandeling in Nederland anno 2010: De Tweede Nationale Prevalentiestudie Mishandeling van Kinderen en Jeugdigen (NPM-2010) (national report)* Retrieved from Leiden.
- Association of Dutch Youth Care (2013). *Annual report dutch advice and reporting centre* Retrieved from <http://www.jeugdzorgnederland.nl/contents/documents/amk-2012.pdf>.
- Benjamins, S. J., Damen, M. L. W., & van Stel, H. F. (2015). Feasibility and impact of doctor-nurse task delegation in preventive child health care in the Netherlands, a controlled before-after study. *PloS One*, 10(10), e0139187.
- Brandon, M., Dodsworth, J., & Rumball, D. (2005). Serious case reviews: Learning to use expertise. *Child Abuse Review*, 14(3), 160–176.
- Bross, D. C., Ballo, N., & Korfmacher, J. (2000). Client evaluation of a consultation team on crimes against children. *Child Abuse & Neglect*, 24(1), 71–84.
- Converse, L., Barrett, K., Rich, E., & Reschovsky, J. (2015). Methods of observing variations in physicians' decisions: The opportunities of clinical vignettes. *Journal of General Internal Medicine*, 30, 586–594.
- Cukovic-Bagic, I., Welbury, R. R., Flander, G. B., Hatibovic-Kofman, S., & Nuzzolese, E. (2014). Child protection: Legal and ethical obligation regarding the report of child abuse in four different countries. *The Journal of Forensic Odonto-stomatology*, 31(1), 15–21.
- Darlington, Y., Feeney, J. A., & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse & Neglect*, 29(10), 1085–1098.
- Deater-Deckard, K. (1998). Parenting stress and child adjustment: Some old hypotheses and new questions. *Clinical Psychology Science and Practice*, 5(3), 314–332.
- Douglas, E. M., & Cunningham, J. M. (2008). Recommendations from child fatality review teams: Results of a US nationwide exploratory study concerning maltreatment fatalities and social service delivery. *Child Abuse Review*, 17(5), 331–351.
- Dutch Ministry of Health Welfare and Sport (2013). *Meldcode Kindermishandeling en Huiselijk geweld (Dutch reporting code child abuse and domestic violence)* Retrieved from.
- Elo, S., & Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115.
- Feng, Fetzter, S., Chen, Y. W., Yeh, L., & Huang, M. C. (2010). Multidisciplinary collaboration reporting child abuse: A grounded theory study. *International Journal of Nursing Studies*, 47(12), 1483–1490.
- Feng, & Levine, M. (2005). Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. *Child Abuse & Neglect*, 29(7), 783–795.
- Flaherty, E. G., Sege, R. D., Griffith, J., Price, L. L., Wasserman, R., Slora, E., et al. (2008). From suspicion of physical child abuse to reporting: Primary care clinician decision-making. *Pediatrics*, 122(3), 611–619.
- Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients' care. *Lancet*, 362(9391), 1225–1230.
- Grol, R., Wensing, M., Eccles, M., & Davis, D. (2013). *Improving patient care. The implementation of change in health care (2nd revised edition)*. Chichester: John Wiley & Sons, Ltd.
- Gunn, V. L., Hickson, G. B., & Cooper, W. O. (2005). Factors affecting pediatricians' reporting of suspected child maltreatment. *Ambulatory Pediatrics*, 5(2), 96–101.
- Herendeen, P. A., Blevins, R., Anson, E., & Smith, J. (2014). Barriers to and consequences of mandated reporting of child abuse by nurse practitioners. *Journal of Pediatric Health Care*, 28(1), e1–e7.
- Hillis, S. D., Mercy, J. A., & Saul, J. R. (2017). The enduring impact of violence against children. *Psychology, Health & Medicine*, 22(4), 393–405.
- Hoefnagels, C., & Zwikker, M. (2001). The bystander dilemma and child abuse: Extending the latané and darley model to domestic violence. *Journal of Applied Social Psychology*, 31(6), 1158–1163.
- Horwath, J., & Morrison, T. (2011). Effective inter-agency collaboration to safeguard children: Rising to the challenge through collective development. *Children and Youth Services Review*, 33(2), 368–375.
- Ikkink, A. J., Boere-Boonekamp, M. M., De Bont, M., De Boer, A., Duys, H., Haasnoot, R., et al. (2010). Landelijke Eerstelijns Samenwerkingsafpraak

- Kindermishandeling. *Huisarts En Wetenschap*, 53(8), S15–20.
- Johnson, L., Zorn, D., Yung Tam, B., Lamontagne, M., & Johnson, S. (2003). Stakeholders' views of factors that impact successful interagency collaboration. *Exceptional Children*, 69(2), 195–209.
- Jones, R., Flaherty, E. G., Binns, H. J., Price, L. L., Slora, E., Abney, D., et al. (2008). Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the child abuse reporting experience study research group. *Pediatrics*, 122(2), 259–266.
- Kanste, O., Halme, N., & Perälä, M. L. (2013). Functionality of cooperation between health, welfare and education sectors serving children and families. *International Journal of Integrated Care*, 13(OCT/DEC).
- Konijnendijk, A. A. J., Boere-Boonekamp, M. M., Haasnoot-Smallegange, R. M. E., & Need, A. (2014). A qualitative exploration of factors that facilitate and impede adherence to child abuse prevention guidelines in Dutch preventive child health care. *Journal of Evaluation in Clinical Practice*, 20(4), 417–424.
- Kruize, A., Boendermaker, M., & Bieleman, B. (2015). *Monitor 2015 huiselijk geweld Twente*. Retrieved from.
- Medical Research (Human Subjects) Act (1998). *Medical research (human subjects) act*. Retrieved from: <http://www.ccmo.nl/attachments/files/wmo-engelse-vertaling-29-7-2013-afkomstig-van-vws.pdf>.
- Netherlands Youth Institute (2011). *Combating child abuse and neglect in the Netherlands* Retrieved from Utrecht. Retrieved from: <http://www.youthpolicy.nl/yp/downloadsyp/Daphne-report-The-Netherlands.pdf>.
- Paavilainen, E., & Flinck, A. (2013). National clinical nursing guideline for identifying and intervening in child maltreatment within the family in Finland. *Child Abuse Review*, 22(3), 209–220.
- Percy-Smith, J. (2006). What works in strategic partnerships for children: A research review. *Children & Society*, 20(4), 313–323.
- Rowley, J. (2002). Using case studies in research. *Management Research News*, 25(1), 16–27.
- Saperia, J., Lakhanpaul, M., Kemp, A., & Glaser, D. (2009). When to suspect child maltreatment: Summary of NICE guidance. *BMJ (Clinical Research Ed)*, 339, b2689.
- Siderius, E. J., Carmiggelt, B., Rijn, C. S., & Heerkens, Y. F. (2016). Preventive child health care within the framework of the dutch health care system. *The Journal of Pediatrics*, 177, S138–S141.
- Spath, R., Werrbach, G., & Pine, B. (2008). Sharing the baton, not passing it: Collaboration between public and private child welfare agencies to reunify families. *Journal of Community Practice*, 16(4), 481–507.
- Taillieu, T. L., Brownridge, D. A., Sareen, J., & Afifi, T. O. (2016). Childhood emotional maltreatment and mental disorders: Results from a nationally representative adult sample from the United States. *Child Abuse & Neglect*, 59, 1–12.
- Talsma, M., Boström, K. B., & Östberg, A. L. (2015). Facing suspected child abuse – What keeps Swedish general practitioners from reporting to child protective services? *Scandinavian Journal of Primary Health Care*, 33(1), 21–26.
- The Association of Dutch Municipalities, & Quality Institute Dutch Municipalities (2017). *The association of dutch municipalities, & quality institute dutch municipalities*. Waarstaatjegemeente.nl. Retrieved from: <http://www.waarstaatjegemeente.nl/dashboard/>.
- Thielen, F. W., Ten Have, M., de Graaf, R., Cuijpers, P., Beekman, A., Evers, S., et al. (2016). Long-term economic consequences of child maltreatment: A population-based study. *European Child & Adolescent Psychiatry*, 25(1297), 1–9.
- Tiyyagura, G., Gawel, M., Koziel, J. R., Asnes, A., & Bechtel, K. (2015). Barriers and facilitators to detecting child abuse and neglect in general emergency departments presented at the eastern society for pediatric research meeting, March 2014, Philadelphia, PA; And the pediatric Academic Societies meeting, May 2014, Vancouver, British Columbia, Canada. *Annals of Emergency Medicine*, 66(5), 447–454.
- Viera, A. J., & Garrett, J. M. (2005). Understanding interobserver agreement: The kappa statistic. *Family Medicine*, 37(5), 360–363.
- Vincent, S., & Petch, A. (2017). Understanding child, family, environmental and agency risk factors: Findings from an analysis of significant case reviews in Scotland. *Child & Family Social Work*, 22(2), 741–750.
- Visscher, S. J. A., & van Stel, H. F. (2017). Variation in prevention of child maltreatment by Dutch child healthcare professionals. *Child Abuse & Neglect*, 70, 264–273.
- Vulliamy, A. P., & Sullivan, R. (2000). Reporting child abuse: Pediatricians' experiences with the child protection system. *Child Abuse & Neglect*, 24(11), 1461–1470.
- Wasserman, R., & Faust, K. (2009). *Social network analysis. Methods and applications*. Cambridge University Press.