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**Special Feature Article**

# Prevention of Child Abuse at a Children's Hospital by Multiple Medical Departments and Services: Support for Mental Stability in Child Raising

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## Abstract

Supporting the state of mind of child-rearing mothers is important for preventing child abuse. In our hospital, which is a general hospital for children, there are many medical departments, such as the perinatal and pediatric medical departments, and many occupations support medical treatment, but it is necessary to respond cooperatively. In obstetrics in the perinatal department, awareness of the prevention of child abuse from the pregnancy phase is increasing, and DV screening and surveys of social high-risk pregnant women (young, mental, and social) are being conducted. In the 2012-2016 survey of socially high-risk pregnant women, between 11% and 15% pregnant women of the 1,600 births per year were at social high-risk, and 4% had mental problems. At the time of visiting the obstetrics department, there are patients who continue to visit the psychiatry department, but there are many whose visits are interrupted or who do not visit. Patients who consent to visiting the psychiatry department in order to continue their pregnancy and prepare for childbirth are allowed visits, and after childbirth, we introduce them to a local psychiatry clinic and strive to provide information through public health nurses and other organizations. If the child needs to visit the hospital after childbirth, information is shared with the neonatal and pediatric medical departments. In the pediatric medical department, there are many mothers who are mentally unstable or are mentally ill. In such cases, psychologists and public health nurses are also involved, and it is important to discuss the burden of child care considering the mental state of the

caregiver and to establish a cooperative system with related organizations. When inappropriate child care affects the child's development, we cooperate with the child psychiatry department to support child care. In cases with a high risk of abuse, the Child Abuse Prevention Committee shares information throughout the hospital and cooperates with multiple departments, including the perinatal department, pediatric medicine department, social workers, public health nurses, and psychologists, in order to continuously respond. We report on the collaboration in and outside of our hospital.

**Keywords**: child abuse, children's hospital, obstetrics, psychiatry, collaboration

## Introduction

Osaka Women's and Children's Hospital (hereafter referred to as "our hospital") started operation in October 1981 to provide advanced and specialized medical care for pregnant women, low-birth-weight infants, and newborns who are difficult to treat at local medical institutions, as a core facility specializing in perinatal care in the Osaka Prefecture area. In 1991, a pediatric medicine department (Children's Hospital) was established to provide comprehensive medical care for infants and young children from the neonatal period.

The research institute with our hospital is engaged in elucidating the causes of diseases affecting mothers and children, and developing diagnostic, therapeutic, and preventive methods. As of April 2021, 38 children's hospitals or facilities in Japan were members of the Japanese Association of Children's Hospitals and Related Institutions, with our hospital being one of them. Our hospital has a wide range of departments, including the perinatal department, pediatric medicine department (surgery and internal medicine), and Central Medical Service. The obstetric medicine and neonatal medicine departments of perinatal center were initially established to provide advanced and specialized medical care for pregnant women, low-birth-weight infants, and newborns who are difficult to treat at local medical institutions, as a core facility specializing in perinatal care. As a result, many physically, mentally, and socially high-risk pregnant women from throughout the prefecture are referred to our hospital for examination. In addition to children referred to the pediatric medicine department for treatment of various congenital diseases, in recent years, many

pregnant women have been referred because of prenatal diagnoses of congenital diseases of the fetus. Thus, there are many high-risk cases of abuse at our hospital, and we are pressed to respond to them.

## I. Abuse Risk among Pregnant Women Visiting Our Hospital

Risk factors leading to abuse include: child factors such as being an infant, premature birth, having a disability or illness, or having a child with special needs; caregiver factors such as unwanted pregnancy, young pregnancy, mentally unstable pre- or postnatal period, mental illness, or physical illness; caregiver environment such as economic instability, isolation from relatives and the community, single-parent families (including unmarried women), remarried families, repeated relocation, domestic violence (DV), etc.

The Department of Obstetric medicine and Neonatal medicine, which is the perinatal center of our hospital, receives pregnant women whose fetuses have been diagnosed with congenital surgical diseases, malformation syndromes, congenital metabolic diseases, infectious diseases, chromosomal diseases, and other diseases through prenatal diagnosis. The emotional burden on such pregnant women is marked, and more detailed care is considered necessary. In addition, there are also many high-risk pregnant women who have visited our hospital since their childhood due to congenital heart disease, malignant tumors, diabetes, etc., pregnant women who have an unstable first-visit status, such as not having received a pregnancy checkup, pregnant women who need social support due to poverty, domestic violence, mental illness, intellectual disabilities, young age, or old age, pregnant women who have been transferred to our hospital due to preterm labour without delivery, and mothers of preterm babies who are hospitalized in NICU.

Therefore, we believe that a multidisciplinary support system is necessary for pregnant women with a high psychological burden and high-risk factors for abuse to provide a safe environment for their newborn children, taking into consideration their social and psychological status from the time of pregnancy.

## II. Support for Socially High-risk Pregnant Women in Obstetrics

Obstetrics departments have been providing support for socially high-risk pregnant women with awareness of abuse prevention from the pregnancy period 3). Socially high-risk pregnant women are those who are young pregnant women in high school or under 18 years of age, pregnant women with

mental health problems such as psychiatric disorders, those economically deprived, suffering domestic violence, single, and not receiving obstetric examinations or pregnancy checkups. Looking at the changes in the numbers of deliveries and socially high-risk pregnant women: in 2011, before the start of support, 49 (3.1%) out of 1,585 deliveries a year; in 2012, after the start of support, 180 (11.3%) out of 1,591 deliveries; in 2013, 226 (14.1%) out of 1,607; in 2014, 249 (15.4%) out of 1,622; in 2015, 249 (15.5%) out of 1,607; in 2016, 233 (15.1%) out of 1,547. These systematic investigations and support clarified the presence of socially high-risk pregnant women.

Systematic support for socially high-risk pregnant women is conducted in stages (STEPS 1, 2, and 3), with STEP 1 identifying the risks to the pregnant woman and her family. At the time of the prenatal checkup, the midwife meets with the pregnant woman individually, separately from the doctor's examination, and provides health guidance and advice on childbirth and childcare according to the time of the pregnancy. In addition, DV screening is conducted at the time of the first medical examination, during the second trimester, and on the first day of the postpartum period. The Violence Against Women Screen (VAWS) (Table), which is used for DV screening, is a "screening scale for violence against women" that has validity and reliability for use in the Japanese perinatal period and is considered a useful tool to screen for DV among pregnant women 2). The percentage of VAWS-positive patients (scoring 9 or higher) at our hospital is approximately 20%, and we provide counseling, devise responses during medical examinations, referrals and collaboration with related institutions, etc., depending on the results regarding physical, psychological, and sexual violence.

In STEP 2, in order to facilitate objective recognition of the risk, we categorize the cases into Young (pregnant women themselves in high school or under 18 years old), Psychosis (history of psychiatric and psychosomatic medicine department visits and medication), and Social (economic deprivation, domestic violence, single, no obstetrician visits etc.). Each social risk is identified and handled as follows. In cases where the patient is young or anxious, an individual interview is conducted with a designated staff member to ensure that the patient feels at ease; in cases of financial hardship, a meeting with a medical social worker is set up; in cases where the patient's visits are often interrupted, such as not seeing the

doctor on the appointed day, the patient is told by phone or letter that their appointment is coming; in cases where the patient is being subjected to domestic violence, they are given opportunities to talk to staff members separately from their partners, and other risk-based measures are taken.

In STEP 3, information is shared among multiple professionals and policies are confirmed. The socially high-risk pregnancy working group meets monthly with obstetricians, neonatologists, public health physicians, nurses, midwives, in-hospital public health nurses, and medical social workers to conduct assessments. The group then collaborates through multidisciplinary members in the hospital, community collaboration conferences, and hospital abuse response teams as needed.

## III. Support for Pregnant Women at Mental Risk

Among socially high-risk pregnant women, only 16 (1.0%) out of 1,585 deliveries in 2011, before the start of support, involved mental health problems. After the start of support, however, certain percentages of cases were found: 54 (3.4%) out of 1,591 cases in 2012, 76 (4.7%) out of 1,607 cases in 2013, 88 (5.4%) out of 1,622 cases in 2014, 64 (4.0%) out of 1,607 cases in 2015, and 64 (4.1%) out of 1,547 cases in 2016. Thus, systematic investigation and support increased the recognition of pregnant women at mental risk.

Among the pregnant women who had a history of psychosomatic or psychiatric consultations or medications, or who reported a history of psychiatric disorders, some had been diagnosed with depression, panic disorder, anxiety neurosis, etc. In addition, there were cases in which the patients were or were not attending a psychiatrist at the time of their visit to our obstetrics department. For pregnant women with psychiatric disorders who were attending other hospitals, we encouraged them to continue their visits, and for those who had stopped their visits or had not yet been treated, we explained to them that they needed to see a psychiatrist in order to continue their pregnancy and prepare for delivery, and if they agreed, we recommended that they see the psychiatrist who handles pregnant women in our hospital. If the patient continues to require psychiatric consultation after the obstetric follow-up has been completed, we refer her to a psychiatrist in the community and provide information and cooperation through public health nurses at the health center.

## IV. Our Approach to Child Abuse and Multidisciplinary Collaboration

In our hospital, the Child Abuse Prevention Committee was established to work on the prevention of abuse through case reviews, manual preparation, and educational activities, and when a case occurs, a meeting is held to determine the policy. In addition, for cases where abuse is a concern, the abuse response team provides a place for consultation on specific cases, and each ward is patrolled to create a system for consultation. From the perspective of abuse prevention, multidisciplinary teams including child psychiatrists, nurses, public health nurses, medical social workers, and psychologists are consulted regarding intervention methods and responses with regard to cases of suspected abuse, cases of concern, and cases that are difficult to respond to. The teams support early responses to cases, assess abuse, share information within the teams, and collaborate with many agencies within the hospital and community when necessary 1).

When the risk of abuse is identified in the socially high-risk working group in the obstetrics department, the relevant team responds in collaboration with the abuse response team. By collaborating, a support system can be created for cases such as when a caregiver continues to have unstable mental conditions after childbirth. In accordance with the collaboration system of the Child Abuse Prevention Committee, we make the relevant departments in the hospital, including the pediatric department, aware of the situation and ask them to get involved. Specifically, the committee will collaborate with nurses in the pediatric outpatient department, nurses on the ward where the child is scheduled to be admitted, physicians in the pediatric medicine department where the child will be examined, public health nurses, medical social workers, psychologists, clerical staff, and other multidisciplinary staff members. In cases where it is important to establish a cooperative system with related organizations, we respond in cooperation with health centers, family child consultation offices, child consultation centers, daycare centers, kindergartens, and schools. By creating such a system and working in collaboration with multiple disciplines, we are working to prevent abuse.

## Conclusion

We have reported on efforts to prevent abuse at a children's hospital involving many departments, including obstetrics, psychiatry, pediatrics, and surgery, as well as by many different professions. For pregnant women who are considered to be at high-risk of abuse, socially at high-risk, or in need of psychological care, it is important to

have an evaluation and support system in place from the time of pregnancy. Even after delivery, it is important to establish a system that leads to collaboration among multiple departments, such as the perinatal department, pediatric medicine department, outpatient clinics, hospital wards, and abuse response teams, as well as by other types of multidisciplinary cooperation within the hospital, and also with external organizations.

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## Table: Violence Against Women Screening Scale

## (VAWS: Violence Against Women Screen)

| | Item | |
|---|---|---|
| 1 | When a dispute arises between you and your partner, do you sometimes find it difficult to resolve it through discussion? | □Very difficult □Somewhat difficult □Not difficult |
| 2 | Do you sometimes feel afraid of what your partner does or says? | □Often □Occasionally □Not at all |
| 3 | Does your partner sometimes yell at you when he/she doesn't like something? | □Often □Occasionally □Not at all |
| 4 | Does your partner get angry and hit the wall or throw things when he/she doesn't like something? | □Often □Occasionally □Not at all |
| 5 | Does your partner force you to have sexual intercourse even though you don't want to? | □Often □Occasionally □Not at all |
| 6 | Does your partner ever act aggressively such as hitting you, pushing you hard, or pulling your arm? | □Often □Occasionally □Not at all |
| 7 | Does your partner ever hit or strike you? | □Often □Occasionally □Not at all |