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Facilitators and barriers to the successful implementation of a protocol to detect child abuse based on parental characteristics☆

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ABSTRACT

To determine the critical facilitating and impeding factors underlying successful implementation of a method to detect child abuse based on parental rather than child characteristics known as the Hague Protocol. The original implementation region of the protocol (The Hague) was compared to a new implementation region (Friesland), using analysis of referrals, focus group interviews ($n = 6$) at the Emergency departments (ED) and at the Reporting Centers for Child abuse and Neglect (RCCAN) as well as questionnaires ($n = 76$) at the EDs. Implementation of the Hague Protocol substantially increased the number of referrals to the RCCAN in both regions. In Friesland, the new implementation region, the number of referrals increased from 2 out of 92,464 patients (three per 100,000) to 108 out of 167,037 patients (62 per 100,000). However in Friesland, child abuse was confirmed in a substantially lower percentage of cases relative to the initial implementation region (62% vs. 91%, respectively). Follow-up analyses suggest that this lower positive predictive value may be due to the lack of training for RCCAN professionals concerning the Hague Protocol. The focus group interviews and questionnaires point to time limitations as the main impediment for implementation, whereas an implementation coach has been mentioned as the most important facilitating factor for success. The Hague Protocol can be used to detect child abuse beyond the initial implementation region. However, training is essential in order to assure a consistent evaluation by the RCCAN.

Introduction

The 'Hague Protocol' offers a solution to the pervasive problem of the underreporting (see Benger & Pearce, 2002; Bleeker, Vet, Haumann, van Wijk, & Gemke, 2005) of child maltreatment by adding a new approach to the existing protocols that focus

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on child characteristics. It uses parental characteristics rather than characteristics of the maltreated child as a detection tool in adult emergency departments (EDs). As shown in a recent US child maltreatment report (US Department of Health and Human Services, 2011), parents are the perpetrators in 81.2% of cases of child maltreatment. The Hague Protocol recommends that children of parents who present at an adult ED with complaints related to (1) domestic violence, (2) substance abuse, or (3) a suicide attempt be referred to the Reporting Center for Child Abuse and Neglect (RCCAN), the federal assessor and support provider for child maltreatment in The Netherlands (see Diderich et al., 2013). This organization will investigate whether the children are victims of child abuse and, when this is the case, offer the family voluntary community-based services to stop the maltreatment.

The Hague Protocol is based on a Dutch definition of child abuse: 'Every form of actual or threatened violence or neglect, whether physical, mental or sexual, inflicted actively or passively, by parents or other persons on whom the child is dependent, where severe damage is caused, or may be caused, to the child in the form of physical or mental injury' (Article 1 Wet op de Jeugdzorg, 2005).

Evaluation has shown that implementation of the Hague Protocol yielded a significant increase in the number of cases of child abuse referrals to the RCCAN (from 1 per 100,000 to 64 per 100,000 ED visitors) and a high rate of child abuse detection (high positive predictive value of 0.91) (Diderich et al., 2013). Moreover, Diderich, Verkerk et al. (2014) showed that only 6.6% of child abuse cases detected on the basis of parental characteristics were missed by ED professionals using these guidelines. Of the children referred to the RCCAN based on the Hague Protocol, two-thirds were unknown to the RCCAN prior to referral by the ED (Diderich et al., 2013).

There are multiple reasons for the increase in detection rates and the high positive predictive value as a result of implementing the Hague protocol. First, not all forms of child maltreatment result in clearly observable physical signs. Second, parents who are responsible for child maltreatment may avoid seeking medical care for their children for fear of being detected. Third, even if physical signs are found, it is difficult to be certain that the child's injury is the result of child maltreatment by the caretaker. Conversely, using parental characteristics to screen for child maltreatment has a number of advantages. First, because the caretaker arrives at the ED with serious problems that also affect the ability to take care of children, it is easier to broach the subject of the negative domestic situation and discuss child maltreatment. In other words, it is easier to relate the caretaker's physical problems (as specified by the protocol) to a child's well-being than it is to relate the child's physical problems to the caretaker's acts. In addition, the caretaker may be more motivated to visit an ED based on the serious nature of his or her injuries (or others may be more motivated to bring the caretaker to the ED) than when the child is injured, in which case the caretaker may wish to conceal the injuries of the maltreated child. Finally, the criteria of the Hague Protocol leave little room for interpretation: domestic violence, substance abuse and suicide attempts are indications of serious domestic problems that can be easily identified as such. Accordingly, there is much less ambiguity in assessing child maltreatment using parental characteristics compared with using child markers.

All of these factors might have contributed to the increased positive predictive value of child maltreatment assessment after the implementation of the Hague Protocol (Diderich et al., 2013). In fact, in July 2013, the Dutch government issued a mandate to make the use of parental characteristics obligatory for all health care professionals who work with adult patients and clients (e.g., ambulance services, general practitioners) to enable screening for child abuse (Ministrie of Volksgezondheid Welzijn en Sport, 2013).

The current study is part of a large research project in which the following topics were investigated: (i) the effectiveness of the Hague Protocol, (ii) whether implementation leads to parents' avoiding medical care, (iii) the number of missed cases, (iv) whether the parental categories should be extended and (v) what help was offered to the families after referral to the RCCAN. The study was submitted for evaluation to the Medical Ethical Committee (number 11-040), which decided that their approval was not required. The majority of these studies have already been published or accepted for publication (Diderich, Dechesne, Pannebakker, Buitendijk, & Oudesluys-Murphy, 2014).

In this study, the aim was to explore whether the Hague Protocol guidelines can be successfully implemented in EDs in other regions outside the original intervention region and to identify critical facilitators or barriers to implementation. The implementation was evaluated and compared in two regions: (a) the urban, multicultural region of The Hague, where the Protocol was developed in 2010 as a cooperative initiative between hospital EDs and the RCCAN, and (b) the more rural province of Friesland as a new implementation region. In The Hague, the protocol was developed using a bottom-up process by which the practices at the ED and the RCCAN were gradually formalized. Implementing the protocol in a different region in a top-down fashion would reveal the blind spots in the implementation process.

In this study, we were less interested in the distinction between bottom-up versus top-down implementation of the process and more interested in whether the Hague Protocol could also be implemented in a region other than the region from which it originated. In the original implementation region, the protocol developed through accumulated experience that only gradually led to a formal instrument for detecting child maltreatment. As a result, in the original implementation region, the formal protocol coincided with many practices that remain implicit but can nonetheless play a decisive role in its execution. By considering the implementation of the protocol in a new region, it becomes possible to separate the effectiveness of the formal protocol from the more implicit professional practices that may also have contributed to the acceptance of the protocol's use by ED personnel and its high positive predictive value in the original implementation region.