The Hague Protocol; a scientific approach to detect child maltreatment based on parental characteristics at the hospital Emergency Department

Introduction

The ‘Hague protocol’, is a key innovation in the detection of child maltreatment. It is based on the fact that child maltreatment effectively can be detected by considering characteristics of parents attending the emergency department in search of treatment for their own medical problems (domestic violence, serious psychiatric problems, and/or substance abuse). The guidelines of the Hague protocol allow Emergency Department (ED) doctors and nurses to refer children to the child welfare program in their municipality when in reasonable doubt about their safety. Specific characteristics of the parents have been shown to yield a high positive predictive value of 91% in the detection rate of child maltreatment in an ED setting.
Thus, these parental characteristics are strong predictors of child maltreatment. A structured registration and report of these predictors may narrow the gap between the actual prevalence of child maltreatment and the number of detected child maltreatment victims. The results of these planned studies are predicted to revise and enhance health policy in Norway and to improve child maltreatment detection and prevention in the future

1. Relevance relative to the call for proposal

Child maltreatment is a serious social problem leading every year to the estimated deaths of approximately 155000 children worldwide [1], and many more suffer lifelong consequences [2]. Prevalence studies from the USA estimated 39.5 per 1000 children as victims of maltreatment in the year 2005/2006 [3]. In the Netherlands, where statistics concerning child maltreatment have been well registered, 34 per 1000 children are estimated to be victims of child abuse every year [4]. The Norwegian government has submitted a strategic document to antagonize/combat child maltreatment [5]. The strategy, valid for the period of 2014 to 2017, has acknowledged child maltreatment as a severe public health challenge and to prioritize detection.

Measures related to parents have previously not been mentioned as potentially relevant to detect child maltreatment. However, recent research in the Netherlands, based on the so-called “Hague Protocol” (derived from its location of origin), has shown that attention to parent conditions and their own complaints, may substantially improve child maltreatment detection [6].
This Hague protocol, which inspires the research in this proposal, adds a new and important component in the combat against child maltreatment, namely a method for detection of child maltreatment based on characteristics observed among parents who visit a hospital for their own health complaints. Measures and research on the Hague Protocol have shown that detection of the child maltreatment on the basis of parental characteristics removes many obstacles in detection and dramatically increases its efficiency [6, 7]. The goal of the present research is to collaborate with the developers of the “Hague Protocol” and to adapt it to a Norwegian Health Care System.

The Hague protocol has shown a high positive predictive value of 91% (PPV= no of true positives/(no of true positives+ no of false positives, hence 9 out of 10 of the detected children is subjected to maltreatment) and can substantially increase the detection rate of child abuse in an Emergency Department setting [6]. Implementation of the Hague Protocol is shown to increase the referrals for child abuse made by EDs from approximately 1 per 100,000 ED attendances to almost 64 per 100,000 attendances. The number of referrals per 100,000 ED visits remained almost

unchanged in the control regions, showing only a very modest increase from 1.5 to approximately 3 per 100,000 ED [6].

Current status of the project: The project is rooted in the management at Sørlandet Hospital, the welfare services in Kristiansand municipality and Barns Beste. We have also established contact with users and user organizations. In April this year 7 key representatives from the above institutions visited H. Diderich-Lolkes de Beer and her colleagues in The Hague, where we went through the project, visited ED, child welfare and protection and similar municipal services as in Norway.

2. Aspects relating to the research project

Background and status of knowledge

According to Norwegian legislation, health professionals are obliged to report to Child Services if they suspect that a child is exposed to maltreatment (Hlspl § 33; Bvl 6-4; Helsetilsynet 2014). Health professionals treating patients should inquire if they have children and make necessary effort to ensure adequate information from the child and appropriate follow-up (Hlspl 10a). However, at present, these recommendations have not recommended to deliberately use parental characteristics as predictor of child maltreatment detection. Thus, while the legal systems emphasise on parental responsibility for the offspring, the medical practice has failed to improve the detection of child maltreatment using parental characteristics. Research by Diderich et al. has shown that the use of three indicators, to be observed among parents visiting a hospital for their own complaints related to domestic violence, serious psychiatric problems and/or substance abuse), leads to an increase in the detection of child maltreatment in an ED setting [8]. These indicators are fairly simple and easy to use.

Being a victim of domestic violence

Recent research in Norway reveals that about 10% of both boys and girls have witnessed physical violence between parents and that 5% have experienced severe physical violence from parents during childhood, and that 11% of boys have experienced psychological violence from their parents [9]. Exposure to intimate partner violence (IPV) places a great burden on children across developmental stages. Developmental impairments have been observed in children from a range of cultural and socioeconomic backgrounds across the world [10]. These impairments include children's developing cognitive abilities, their executive functioning, and their academic performance. These impairments, may in turn, undermine social, educational and professional development [10]. IPV is a serious social problem that affects all members of a household. Research shows that healthcare providers can implement theoretically driven, gender and culturally appropriate interventions for children with a history of IPV exposure with outcomes that positively affect the lives of children [11].

Attempting suicide or having other serious psychiatric disorders

Estimates from the Norwegian Institute of Public Health (2011) indicate that 23% of the children have parents with psychiatric disorders. Every year there are about 530 suicides registered in Norway. Suicide attempts are often counted as ten times the number of suicides [12]. C. Walsh et al show that parents suffering from depression, mania or schizophrenia, is related to a two to threefold increase in the rates of physical, sexual or any abuse by their children. Furthermore, a parental history of antisocial disorder is related to a six fold risk of exposure to physical abuse and by a seven fold risk abuse as a general category [13]. These elevated risks for physical and sexual abuse among respondents reporting a parental history of psychiatric illness, highlights the need to examine the link between parents' maladaptive behavior and their children's maladaptive behavior further and to understand the mechanisms engaged. Clearly, a concerted effort involving not only children, but also parents, the broader social context, and professional expertise and intervention, is needed to break this potentially destructive transmission of abuse and/or maltreatment across generations.

Substance abuse

According to the Norwegian Institute of Public Health (2011), 6,5% of children probably have parents who's alcohol abuse is likely to affect their daily functioning [14]. Many studies have demonstrated the association between substance abuse and child maltreatment [15, 16]. It is also known that substance abuse has negative consequences for the unborn child [17]. Studies indicate that mothers who are substance abusers react less adequately to their babies' needs than parents who are not substance abusers with possibly serious consequences for attachment and relational development [18].

Approaches, hypotheses and choice of method

The goal of the present research is to investigate the applicability of the use of parental characteristics as specified by the "Hague Protocol" for Norwegian Health Care and Norwegian child maltreatment detection. We will be particularly interested in answering the question: "*Can a protocol for screening adults presenting for care in the Emergency Department identify children at high risk for maltreatment in Norway?"*

By providing an answer to this question, we seek to reduce the gap between the prevalence and detection of child maltreatment by increasing scientifically based knowledge on the basis of parental characteristics. The specific aim for the research will be to implement an additional method for detection of child maltreatment based on parental characteristics (The Hague Protocol) at the Emergency Department in a hospital in Norway. During the implementation, we will chart (whereby RG stands for "Research Goal"):

Work Package 1: Efficiency of the Hague Protocol

RG1: Whether the Hague Protocol can identify children at high risk for maltreatment at the ED
RG2: Whether the Hague Protocol can identify children at high risk for maltreatment at the ambulance services
RG3: Whether the Hague Protocol narrows the gap between the prevalence and number of detected child maltreatment victims
RG4: Whether more victims of child maltreatment can be found based on child- or parental characteristics at the Emergency Department
RG5: Whether there are missed cases of child maltreatment based on parental characteristics
RG6: Whether the Hague Protocol causes parents to avoid the Emergency Department

Work Package 2: Follow up by Child Welfare

RG7: Whether the Hague Protocol enables the identification of children not previously known to Child Welfare
RG8: What support and monitoring was offered by Child Welfare after ED referral

Work Package 3: Follow up by the Municipality

RG9: Whether the Hague Protocol enables the municipality earlier access to family problems
RG10: The support and monitoring offered by the municipality

Work Package 4: Can the Hague protocol be successfully implemented in Norway and other regions of Norway?

RG11: Are there practical and critical facilitators to implementation regarding to the implementation of the protocol?

Study Design
The study will be carried out in three hospitals in the South of Norway (Sørlandet sykehus Kristiansand, Arendal og Flekkefjord), all with EDs, one intervention hospital (Kristiansand) where the new protocol will be introduced and two control hospitals. The three hospitals have a total population of 280 000 inhabitants. About 16.3 % have a non-Norwegian background [19].

We will use a quasi-experimental pretest–posttest design with a non-randomized control group. The pretest will concern data from the period 2014 to 2016, using ICD-10 diagnoses from ED. Following the implementation of The Hague protocol starting from early 2017, the posttest period will start early 2017 and will end early 2020. For both pre- and posttests, there will be three annual measurements (i.e. measurements for 2014, 2015, and 2016 for the pre-measure, and measurements for 2017, 2018, and 2019 for the post-measure). The research design can thus be schematically depicted as:

	Pre-Implementation test			**Post-Implementation test**		
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
Intervention Hospital	M_{pre1}	M_{pre2}	M_{pre3}	M_{post1}	M_{post2}	M_{post3}
Control Hospital 1	M_{pre1}	M_{pre2}	M_{pre3}	M_{pre4}	M_{pre5}	M_{pre6}
Control Hospital 2	M_{pre1}	M_{pre2}	M_{pre3}	M_{pre4}	M_{pre5}	M_{pre6}

M_{pre} involves all measurements prior to the implementation of the protocol and M_{post} all measurements after the implementation. Specific measures can be used to answer questions related to the research goals:

RG1: Can the Hague Protocol identify children at high risk for maltreatment at the Emergency Department?
RG2: Can the Hague Protocol identify children at high risk for maltreatment at the ambulance services?

The clinical usefulness of the Hague Protocol is confirmed if a high proportion of the referrals is actually confirmed as cases of child maltreatment by Child Welfare. Efficiency in child maltreatment detection will be assessed on the basis of Positive Predictive Value (PPV). PPV= no of true positives/(no of true positives + no of false positives). Thus, PPV will be determined on the basis of the proportion of true positives by calculating the number of referred cases where child maltreatment was confirmed by Child Welfare, as a proportion of the total number of referred cases. A requirement for this analysis concerns the measurement of a substantial number of referred cases in all hospitals for each year.

RG3: Does the Hague Protocol narrow the gap between prevalence and number of detected child maltreatment victims?

The implementation of The Hague Protocol is expected to substantially increase the number of referrals (i.e. Mpost1, Mpost2, and Mpost3 should have a higher number of referrals relative to the other cells). To the extent the referrals can be confirmed by Child Welfare (as assessed by PPV, see **RG1**), increases in referrals imply a narrowing of the gap between prevalence and number of detected cases.

RG4: Can more victims of child maltreatment be found based on child- or parental characteristics at the Emergency Department?

Next to the implementation of guidelines to detect child maltreatment based on parental characteristics, another adaption will be made in the detection based of child characteristics. In the electronic patient file of all children visiting the ED, a short mandatory questionnaire containing six questions will be added. The goal of adding these questions is to help medical staff remember to think about the possibility of child maltreatment with every child they treat. The effectiveness of this questionnaire will be assessed as an independent component but will also be used in comparison with the new guidelines to detect child maltreatment based on parental characteristics (the Hague protocol).

RG5: Are there missed cases of child abuse based on parental characteristics?

To examine whether there are missed cases in the detection of child maltreatment using parental characteristics, referrals to Child Welfare will be examined. Referrals that are not derived from parental reports from an ED, but that have been confirmed as child maltreatment by Child Welfare, will be gathered for a period of six months during the implementation phase (e.g. July 1 to December 31, 2018). The records of the intervention hospital will then be searched to investigate whether the involved parents had visited the emergency department in the period from July 1 to December 31, 2017. We consider is as a "missed cases" if a parent had visited the ED with complaints pertaining to the Hague Protocol's criteria, but was not referred. With informed consent from the parents' ED records, the reasons for non-referral will be investigated.

RG6: Does the Hague Protocol cause parents to avoid The Emergency Department?

To assess whether The Hague protocol causes parents to avoid the Emergency Department, telephone interviews will be conducted with parents whose children are referred to Child Welfare on the basis of the Hague Protocol, and ask about their experience. These telephone interviews will be held in 2019, i.e. when the Hague Protocol has been implemented. Parents are specifically asked if they would again visit the Emergency Department now that they have experienced the referral procedure.

RG7: Does the Hague Protocol enable the identification of children not priory known to Child Welfare?
RG8: What support has been offered by Child Welfare and how are the families being monitored?

To examine whether The Hague protocol identifies children priory not known to the Child Welfare, the database of the Child Welfare will be used for a search to identify these children. Where these children where already known to Child Welfare or is the ED referral the first to identify the family problems.
To examine and compare 50 cases of child maltreatment based on child characteristics with 50 cases based on parental characteristics and then compare the outcome after investigation by the Child Welfare. The database of Child Welfare will provide all data on the offered support and the outcomes after monitoring these families.

RG9: Whether the Hague Protocol enables the municipality earlier access to family problems?
RG10: The support and monitoring offered by the municipality?

To examine whether The Hague protocol enables the municipality earlier access to family problems, reports from parents will be evaluated, professionals will be involved with the family, and feedback to the emergency room of 100 referred cases. We specifically ask professionals about their assessment of the preventive power of the Hague Protocol. Whether the protocol leads to adequate assistance to children and families that have been investigated will be assessed on the basis of file information from Child Welfare.

RG11: Are there practical obstacles regarding to the implementation of the protocol?

To examine the assessment of implementation (focus group discussions; hospital, child welfare and social workers) performed before and 6 months after introduction by evaluation of a) possible aggression against the protocol and b) decrease in patients with these problems

Recruitment of patients and controls:

Inclusion criteria. Adult patients who, on questioning confirm that they are responsible for the care of under aged children or pregnant (irrespective of whether they are a parent, informal caretaker or legal guardian) and who attended the ED for one of the following reasons, will be included:

a) Intimate partner violence (IPV). This includes not only clear cut cases, but also cases where the adult patient denies being a victim of IPV, but where the ED professional has a strong suspicion that this is the case. According to the Revised conflict tactics scale [20] the sustained injuries fall under the heading of severe partner violence. All patients will be included irrespective of the extent of the sustained injuries, severity of illnesses or depth of the wounds.

b) Suicide attempt or other serious psychiatric disorder. Patients who are seen after a suicide attempt or auto mutilation are included in the protocol, regardless of the amount of pills taken or the way suicide was attempted and irrespective of the depth or size of the wounds in the case of auto mutilation.

c) Serious substance abuse. Patient seen after intoxication with hard drugs. The term "hard drugs" is used to describe psychoactive drugs that are addictive and perceived as especially damaging. Examples of these are Ecstasy or XTC, Heroin, Cocaine and Amphetamine. This term is used to distinguish them from "soft drugs" (Cannabis products, Sedatives and Tranquilizers) that are believed to be less addictive and damaging. Patients who abuse alcohol or "soft drugs" will only be included if, when asked, they confirm that they were responsible for the care of under age children and when the following situations are present:

(i) There appear to be no adequate care for the children.
(ii) The other parent or family members indicate that the substance abuse has adverse effects on the domestic situation(iii) When it appears from hospital records that the patient has previously been admitted several times following abuse of these substances.

Exclusion criteria. Patients who attend the ED for problems other than those mentioned above or who state that they are not responsible for the care of under aged children

The intervention

The ED professional will ask the patient if they are responsible for minors. If the patient is unable to answer the question (as a result of their sustained injuries, severity of illnesses or depth of the wounds) the ambulance professionals or the local police department will be asked for information about the domestic situation.

Patients in the intervention region who fulfill the inclusion criteria will be informed by the ED nurse or doctor about this protocol and that a referral will be made to the Child Welfare. The referral will be documented in the patient's medical record. In those cases where the referral is not substantiated, the referral will be removed from the medical record afterwards. Because ED professionals neither have the time nor the capacity to extensively investigate families for possible child maltreatment, this task will be carried out by Child Welfare workers or social workers.

To make ED professionals aware of the Hague Protocol and its consequences for their daily routine, all personnel of ED in the intervention region will be trained by a hospital medical doctor specialized in child maltreatment, and neglect and Child Welfare workers. They must also implement an e-learning program.
At the same time the local Child Welfare in the intervention region will start a special program, employing extra personnel dedicated for the protocol, to assess these patients and their children. In this way it is possible to prevent flooding their standard system.
The approach to these ED referrals needs to be different to the approach to regular referrals made by pediatricians from the hospital where there is usually more information available about the domestic situation and the specific sustained injuries. We look at the possibility of developing a common IT solution for reporting. Within a week after the referral the Child Welfare or a social worker will talk to the parent(s). A behavioral specialist will evaluate children from the age of six upwards using the CARE-nl (De Ruiter & de Jong, 2005) or similar scoring system. If the first assessment is done by a social worker, they will contact informants around the family. These include the general practitioner, the school, the Well Baby Clinics and the School Health Care system.
Clinical decisions:
"The referral is substantiated" means that the child is a victim of child maltreatment or maltreatment. In these cases, parents will be offered the necessary help and support in a voluntary setting, but if parents do not accept, it could be made mandatory when considered necessary.
"The referral is not substantiated" means that it is not possible to determine whether the child is, or is not, a victim of child maltreatment or neglect. If child maltreatment could not be substantiated, the child's data remained in the Child Welfare system, it will be considered if there is a need for support or if there is no need for help.
"The referral is refuted" means the child is not a victim of child maltreatment or neglect. Parents will be sent a letter of supplementary information about the Child Check by the board of directors of the hospital. A note concerning the refuted referral will be added to the patient's hospital record and the child's data will only be removed at the urging from parents.

<u>*Outcome measures/variables*</u>
Demographic data: Pre-intervention data will be collected from existing archived of ED records and Child Welfare of patients who had attended the ED and had been referred to the Child Welfare over the period January 1st 2014 to December 31st 2017 in both the intervention region and the control regions. All referred cases based on parent characteristics will be collected from hospital EDs, not from other medical providers. All referred cases of child maltreatment, based on parental characteristics, made by the EDs during the before study period, will be collected from the computerized administration of the Child Welfare.
The Hague Protocol will be introduced in December 2017 in the intervention Hospital.
Analyses: Characteristics of referred cases will be used to analyze for: gender of parent, ethnicity, number of children in family, reason for reporting, previously known to Child Welfare and characteristics of maltreatment found after investigation.

A note on anti-discrimination

Both media and professionals have claimed that the threshold for intervention due to domestic violence is higher when it comes to minority groups. Save the Children (2013) pointed out language difficulties as one of several obstacles when municipality health centres were asked about their action of domestic violence within these groups [21]. In this project it is important to prepare for challenges due to language and culture, to secure equal procedure in all cases.

3. The project plan, project management, organisation and cooperation

Organisation

The consortium; name of members and their afflications

Sørlandet Hospital HF: UM Stamnes Köpp (MD, Phd, Pediatrics), E Tallaksen Ulseth (MD, Pediatrics), L Esperaas (Adviser/Psychologist, Dep. director psychiatry), G Dølbakken (Adviser in ED, Kristiansand), S Wetrhus Knutsen (Adviser, children as dependens)
Barns Beste: S Gjesdal (Dep. director), V Ullvær Vallesværd (Adviser)
UIO: Prof T Ruud (Clinic for Health Services Research and Psychiatry, Institute of Clinical Med.)
Kristiansand municipality: S O Ueland (Dep. director Kristiansand municipality), M Brünner (Dep. Director Child Welfare), E Abildsnes (MD, Phd, Public health and general practice), J T Wergeland (Specialist in clinical psychology family), S E Refsnes (Adviser in municipality)
The user organizations: Stine Stine Sophie Foundation by Erik S. Oksavik and in dialogue with Redd Barna
User representatives: Maja Michelsen, Lise Gimre

The present study represents collaboration between Sørlandet Hospital (SSHF), Barns Beste, University in Oslo and Kristiansand municipality with Child Welfare.The research group of the present study is characterized by high scientific and organisational competence. There is a need to adapt the models to the local context as a part of the research and it is important that child welfare and municipality obtain ownership to the model and collaborate to adapt a feasible and useful implementation. The present study is also based on existing cooperation between active participants related to different research areas of specific interest for this application. The research group also represents large institutions with an infrastructure that makes such a study possible. The core study, The Hague Protocol, has its own organisation and an extensive infra-structure and is partly funded by international support.
International collaborators: The project leader will collaborate with the research group at, The Hague Protocol; Hester Diderich-Lolkers de Beer, PhD (Medical Centre Haaglanden), Mark Dechesne, PhD (Leiden University – Faculty of Governance and Global Affairs), Prof. dr. Anne Marie Oudesluys Murphy (Leiden University Medical Centre) and Prof dr. Simone Buitendijk (Imperial College London).

Work Package and Task organization					
	WP-leader	Task Leader		Main Partners	Recruitment of study participants
WP1	U.Köpp	RG1	U.Köpp	Research group at The Hague Protocol	Hosptal Records
		RG2	U.Köpp	SSHF	Referred cases to child welfare
		RG3	U.Köpp	UIO by Prof T Ruud	
		RG4	U.Köpp		
		RG5	U.Köpp		
		RG6	U.Köpp		
WP2	U.Köpp	RG7	E. Abildsnes	Research group at The Hague Protocol	Referred cases to child welfare
	E. Abildsnes	RG8	E. Abildsnes	SSHF	Referred cases to child municipality
	M. Brünner			Child Welfare	
				Kristiansand municipality	
				UIO by Prof T Ruud	
WP3	E. Abildsnes	RG9	E. Abildsnes	Research group at The Hague Protocol	Referred cases to child welfare
	S.O Ueland	RG10	E. Abildsnes	SSHF	Referred cases to child municipality
				Child Welfare	
				Kristiansand municipality	
				UIO by Prof T Ruud	
WP4	U.Köpp	RG11	U.Köpp	SSHF	Employers in:
	E. Abildsnes		E.Abildsnes	Child Welfare	Hospital
	M. Brünner			Kristiansand municipality	Child Welfare
	S.O Ueland			UIO by Prof T Ruud	Child municipality

The consortium as a whole is composed of users/patients organization, highly experienced physicians and researchers in the fields of child maltreatment.
Project leader U M Stamnes Köpp will provide effective project management through proficient planning, a well-organized and active network of WPLs, and transparent decision procedures. She will be responsible for ensuring that finances and reporting are administered in accordance with the terms of the grant agreement. Sørlandet Hospital HF will guarantee for the administration expenses if the project is granted by The Research Council of Norway.
The WP Leaders will coordinate the delivery of tasks within their WP, coordinate activities with other work packages ensuring that they are aware of the progress of key deliverables that are required for progress in their own WP, continuously report progress on milestones and deliverables, and formally report progress on these in the annual and final reports.

4. Key perspectives and compliance with strategic documents

Complience with strategic documents
The project leader and Sørlandet hospital has been a founder of the first supervisor in child maltreatment planned for use by Hospital and in the community of the region of South Norway in 2004, and is today represented in the National supervisor for child maltreatment. In addition the region has for decades promoted interdisciplinary work in this field and is today the only Norwegian hospital holding introductory courses for new interns in child abuse.
Relevance and benefit to society
The society at large, including medical staff, researchers, politicians, and the general public, calls for new knowledge about child maltreatment. Hence, research on child maltreatment is defined as a priority area by the authorities. The proposed study significantly enhances our understanding of the complex etiology of child maltreatment. Our study will contribute with substantial new knowledge to the international child maltreatment research. The information will be important in targeting health education and health promotion programs and activities to reduce the observed prevalence of child maltreatment in Norway and in most other developed countries.
Environmental impact
This study does not in any way influence the environment negatively, and does not represent any hazards to the environment. Regarding equal opportunity, the results will be presented by gender.
Ethical perspectives
Possible disadvantages of the project can be that the child is not a victim of child maltreatment or neglect. Hence article three of the United Nations Convention of the Right of a Child states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the child's best interests shall be a primary consideration." The premise for assessing the child's best interests will have as a starting value matters with dignity and integrity and fundamental rights as the right to life and development, the right to care, health and welfare and the right to inclusion and participation.
The practice of good medical ethics is of particular importance in cases of children maltreatment and personal information will be sufficiently anonymous in order to ensure adequate privacy protection. Prior to inclusion in the study the patient will be given full oral and written information on the nature, objective, significance, expected benefits, potential risks and consequences of the study in compliance with the Declaration of Helsinki. The study needs to be approved by the Regional Committee on Ethics in Health Research

5. Dissemination and communication of results

This protocol aims to improve patient care, promote scientific discovery, define key challenges and ‘gaps’ and fuel future research endeavors, and establish a collaborative network of researchers. The main target groups include medical staff, researchers, policy makers and the general public. The results of the present study will be published in international journals. The publication plan includes

11 main publications. Furthermore, the research group will have further publications outlined by the research questions addressed in this study. We will also publish on the popular level aiming public health and health personnel. If the model proves successful, we will recommend that it to be implemented also in other parts of Norway.

Communication with users

It will be important to arrange seminars for knowledge transfer between research and practice fields and will want to cooperate with different organizations, among others Stine Sophie Foundation, Redd Barna, our user representatives and other user organizations.

6. Additional information specifically requested in the call for proposals

In this project, empowerment is central. With a high quality result and a national potential for the project in mind, it is necessary to include persons with relevant experiences in all parts of the process. In our search for the right persons, we have used the three categories as a point of departure. As a start we have two people who have experienced domestic violence, suicide and suicide attempts, severe mental illness and drug maltreatment by parents as a child.
The chosen persons are included already from the point of developing the project description and proposal. They will meet and communicate regularly with the project workers, report on texts and be brought in for meetings.

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